

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335767	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/15/2024
NAME OF PROVIDER OR SUPPLIER Our Lady of Mercy Life Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2 Mercycare Lane Guilderland, NY 12084	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>48615</p> <p>Based on observation, interview and record review conducted during a recertification survey, the facility did not ensure each resident was treated in a dignified manner for 1 (Resident #29) of 31 residents reviewed. Specifically, Resident #29 was left to soil themselves because staff did not attend to the resident in a timely fashion, leaving the resident feeling humiliated on more than one occasion.</p> <p>This is evidenced by:</p> <p>Resident #29 was admitted to the facility with diagnoses of cutaneous abscess of back (a pus-filled pocket that forms under the skin), atrial fibrillation (a fast irregular heartbeat), and difficulty walking. The Minimum Data Set (an assessment tool) dated 8/28/2024 documented the resident was able to be understood, understand others, was minimally cognitively impaired and required significant assistance with activities of daily living.</p> <p>A facility policy titled Resident Rights, dated 11/28/2016, documented that the facility would ensure residents had the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. Additionally, the facility documented that the resident had a right to safe, clean, comfortable, and homelike environment, including but not limited to receiving treatments and supports for safe daily living.</p> <p>Resident #29's Comprehensive Care Plan for Bladder and Bowel incontinence dated 8/22/2024 documented the resident's goals included maintaining dignity and hygiene. Interventions included provide access to call bell, assess for patterns, and provide routines and verbal cue as needed to toilet per demonstrated success, encourage a routine bowel management plan, and respond quickly, provide access to urinal and bedpan as needed.</p> <p>During an interview on 10/08/2024 at 11:18 AM, Resident #29 stated that the facility was short on staff, that it took weeks to get a shower, and that they would lay in bed for hours after having a bowel movement waiting to get cleaned up.</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a subsequent interview on 10/08/2024 at 11:29 AM, Resident #29 stated that they had pain in their rectum, and because of their irritable bowel syndrome, they had to have a bowel movement immediately after having a meal. Because staff were frequently still helping residents eat in the dining room, they had been left to wait for assistance for more than a few times after soiling themselves because they could not get staff to help them.</p> <p>During an interview on 10/15/2024 at 10:51 AM, Resident #29 stated that on 10/08/2024, they waited for assistance to go to bathroom and soiled themselves while waiting. Resident #29 stated there was one Registered Nurse that responded quickly to their call bell, but that it all depended on who was on duty. They further stated that it was humiliating that they frequently soiled their pants while waiting for help by staff.</p> <p>During an interview on 10/15/2024 at 11:11 AM, Registered Nurse #7, stated that Resident #29 was not having as much of a problem with loose stools and had been ordered Metamucil to help. Additionally, Registered Nurse #7 stated that Resident #29 had an appointment with gastroenterology coming up soon.</p> <p>During an interview on 10/15/2024 at 12:05 PM, Director of Nursing #1 stated that chronic conditions should have been care planned for all residents. This further stated that Registered Nurses were responsible for updating care plans and making sure care plans accurately reflected resident needs.</p> <p>During an interview on 10/16/2024 at 12:11 PM, Director of Nursing #1 was asked what an acceptable amount of time was to wait to have a call bell answered. Director of Nursing #1 stated that depending on the problem, 2 minutes could feel like hours. When asked if 15 minutes would be acceptable, Director of Nursing #1 stated that it depended on what else was happening on the unit. Director of Nursing #1 was unable to state how long a resident was expected to wait for assistance when they pushed their call bell.</p> <p>10 New York Code Rules and Regulations 415.3(c)(1)(i)</p>		

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>48615</p> <p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>Based on observation, interview, and record review during a certification survey, the facility did not ensure the interdisciplinary team appropriately assessed a resident to self-administer medications for 1 (Resident #29) of 1 resident reviewed for self-administration of medication. Specifically, for Resident #29, there were medications observed at the bedside. Resident's ability to self-administer medication was not periodically assessed by the interdisciplinary team.</p> <p>This is evidenced by:</p> <p>Resident #29 was admitted to the facility with diagnoses of cutaneous abscess of back (a pus-filled pocket that forms under the skin), atrial fibrillation (a fast irregular heartbeat), and difficulty walking. The Minimum Data Set (an assessment tool) dated 8/28/2024 documented the resident was able to be understood, understand others, was minimally cognitively impaired and required significant assistance with activities of daily living.</p> <p>A Facility policy titled Storage and Expiration Dating of Medication and Biologicals dated 12/01/2007, documented the following:</p> <p>2. Facility should ensure that medication and biologicals are stored in an orderly manner in cabinets, drawers, carts, refrigerators/freezers of sufficient size to prevent crowding.</p> <p>5. Facility should ensure that all medications and biologicals, including treatments items, were securely stored in a locked cabinet/cart or locked medication room that was inaccessible by resident and visitors.</p> <p>7. Topical use medications or other medications should be stored separately from oral medications when infection control issues may be a consideration.</p> <p>19. 1. Facility should not administer/provide bedside medications or biologicals without a Physician/Prescriber order and approval by the Interdisciplinary Care Team and facility administration.</p> <p>19. 2. Facility should store bedside medications or biologicals in a locked compartment within the resident's room.</p> <p>Resident #29's Safe Self Administration of Medication comprehensive care plan dated 8/20/2024 documented that the resident was assessed and was not a candidate at that time due to safety concerns. Goal included allowing staff to administer their medications. Interventions listed included administering medications as ordered, assess, and note resident ability to administer own medications prior to establishing routine, and explain procedure as needed.</p> <p>Physician's order dated 8/22/2024 at 3:18 PM documented that Resident #29 was ordered Acetaminophen tablet 325 milligrams, 2 tablets by mouth every 6 hours as needed for pain or fever.</p> <p>There were no documented physician orders for Voltaren cream or ALI probiotics.</p> <p>(continued on next page)</p>		

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 10/15/2024 at 10:44 AM, Resident #29 was noted to have medications at their bedside, including Tylenol 325 milligram tablets, Voltaren arthritis cream, and ALI probiotics.</p> <p>During an interview on 10/15/2024 at 11:27 AM, Licensed Practical Nurse #4 stated that to their knowledge, no resident could self-administer medications and medications should not be left at the bedside.</p> <p>During an interview on 10/15/2024 at 11:30 AM, Registered Nurse #5 verbalized the 6 Rights of Medication Administration, which included making sure resident took the pills then sign for the pills. Registered Nurse #5 acknowledged that pills were left at Resident #29's bedside.</p> <p>During an interview on 10/16/2024 at 11:47 AM, Nurse Educator #1 stated they would train new hires, after which the hires would be paired up with preceptors. Once new staff went to the units, the Nurse Educator would meet with the hires weekly to see how they were doing. When asked what kind of teaching was done for new hires, Nurse Educator #1 stated competencies were completed during orientation. Orientation consisted of a 3-day, in-classroom education and the rest then completed with a preceptor. Nurse Educator #1 further stated that three times a year, staff completed refresher--reinforcement training on documentation and medication administration documentation, with all nursing staff requiring to pass a medication pass exam prior to being left to work alone on the units. Nurse Educator #1 stated that medications should never be left at the bedside; that no residents were allowed to self-medicate in the facility; and that no medications should be brought in from home.</p> <p>During an interview on 10/15/2024 at 12:05 PM, Director of Nursing #1 stated all nurses completed competencies on health stream in addition of up to 5 days in class training for all new hired nurses. There were annual competencies including an exam for medication pass. Director of Nursing #1 stated that if there was an order to do so and the resident had passed the 3-day trial and questionnaire, Nurses could leave medication at the bedside. Additionally, to the best of their knowledge, there were no residents allowed to self-medicate in the facility at that time.</p> <p>10 New York Codes Rules and Regulations 415.3 (e)(1)(vi)</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51742</p> <p>Based on interviews and record reviews during the recertification survey, the facility did not ensure that the resident had the right to make choices about aspects of their life in the facility that were significant to the resident for 2 (Resident #15 and 60) of 4 residents reviewed for choices. Specifically, Resident #'s 15 and 60 repeatedly requested more than 1 bed bath/shower per week, but the facility continued to provide 1 bed bath/shower per week to them, respectively.</p> <p>This is evidenced by:</p> <p>Resident #15 was admitted with diagnoses that included multiple sclerosis (a chronic disease that damages the central nervous system, including the brain, spinal cord, and optic nerves), dysarthria (a speech impairment) following cerebral infarction (a stroke), and hemiplegia and hemiparesis (weakness or paralysis on one side of the body) following cerebral infarction. Resident #15's Minimum Data Set (an assessment tool) dated 9/21/2024 documented the resident was minimally cognitively impaired, could usually be understood, and usually able to understand others. The Resident required significant assistance with activities of daily living.</p> <p>Resident #15's Comprehensive Care Plan for Activities of Daily living, initiated 6/19/2019, documented Resident #15 needed total assistance with all activities of daily living. Bath/showers were documented to be on Tuesday on the 7-3 shift and if the resident declined care, the Registered Nurse and supervisors were to document the resident's refusal.</p> <p>Resident #15's Comprehensive Care Plan for inappropriate behaviors, initiated 11/04/2019, documented that Resident #15 had a history of refusing care, allowed only arm pits to be washed instead of a full bath, and Resident #15's parent stated Resident #15 was not getting bathed despite their awareness that Resident #15 refused. Goal listed Resident #15 to be able to choose what they want with their care and the staff would encourage Resident #15 and their family to allow Resident #15 the autonomy to make choices. Interventions listed included explain all procedures prior to initiating them, reapproach resident at a later time, offer simple choices, provide calming and reassuring techniques, and reporting refusal to the staff so that Resident #15's family could be informed.</p> <p>Resident #15's Nursing Admission Assessment, effective 08/23/2021, revealed that Resident #15 preferred tub baths, typically 1 time per week.</p> <p>During an interview on 10/09/2024 at 10:18 AM, Resident #15 expressed that they did not get bed baths nor showers even weekly, and that staff would clean the resident after a bowel movement from the waist down. The resident further explained that their upper body was cleaned occasionally, but not even weekly. Resident #15 stated they felt the lack of bathing and cleaning led to their lower legs having a yellow flaking fungus infection. Resident #15 stated that they went 3 months without their hair being washed and was told staff had to use a lift to take the resident to shower and that was why it was not done.</p> <p>During an observation on 10/09/2024 at 10:20 AM, Resident #15's lower legs were both yellow and flaking skin with a dry appearance and yellow toenails.</p> <p>(continued on next page)</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a subsequent interview on 10/09/2024 at 1:13 PM, Resident #15 stated they did not receive a bed bath weekly as care planned and they informed staff on multiple occasions that they wanted 2-3 showers weekly, but the resident was told staff would get to it when they could.</p> <p>Resident #60 was admitted with diagnoses that included need for assistance with personal care, hemiplegia, and hemiparesis (inability to move one side of the body) following cerebral infarction (stroke), anxiety, and chronic pain. Resident #60's Minimum Data Set, dated dated [DATE], documented the resident was able to understand others, be understood, was cognitively intact, and required significant assistance with activities of daily living.</p> <p>Resident #60's Care Plan, initiated 10/01/2021, revealed a focus initiated on 09/26/2024 that stated the resident required enhanced barrier precautions (staff wear gloves and gowns when providing direct care) related to the resident's feeding tube. Resident #60 had a focus of impaired ability to perform activities of daily living, and an intervention initiated on 10/25/2022 that stated Resident #60 took showers on Thursdays between 3:00 PM and 11:00 PM. Another focus initiated on 09/30/2021 revealed that Resident #60 had alteration to skin integrity with an intervention initiated on 02/13/2024 to monitor feeding tube for signs of infection or skin breakdown.</p> <p>Resident #60's Nursing Admission Assessment, effective 08/23/2021, revealed that Resident #60 preferred showers, typically 4-5 times per week.</p> <p>During an interview on 10/10/2024 at 9:13 PM, Resident #60 stated that they wished they could have more than 1 bath per week and had informed staff on several occasions, but nothing was done.</p> <p>During an interview on 10/15/2024 at 9:43 AM, Social Worker #1 stated when residents want to have more than 1 shower or bath a week, staff figure out how to help make that happen. Social Worker #1 stated that they knew staff came in on the weekend or extra shifts to help give extra shower. Sometimes residents refuse to shower when the staff came in on off shifts and then told their families that they were not bathed at all.</p> <p>10 New York Code of Rules and Regulations 415.5(b)(1,3)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>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.</p> <p>48615</p> <p>Based on observations, interviews, and record review conducted during a recertification survey, the facility did not ensure that residents had the right to, and the facility must make, prompt efforts to resolve grievances the resident may have for all residents reviewed for grievances. Specifically during resident council meeting, 6 Residents reported they did not know there was a grievance process or a process by which grievances could be filed or resolved.</p> <p>This is evidenced by:</p> <p>The Facility's 2024 Admission Agreement, Part 17.6, documented Grievance Procedure. Facility has a Grievance Procedure if Resident, Resident's representative, or a family member wishes to file a complaint about the services provided by Our Lady of Mercy Life Center facility or its staff. This procedure has been developed in order to help residents, family members and/or designated representative bring a problem to the attention of staff so that the grievance can be resolved in an appropriate manner.</p> <p>The Facility Policy titled Complaints and Grievances dated 1/2016, documented that the procedure of filing complaints and grievances will be explained in full to each resident, their relatives and/or designated representative on admission. All nursing, social services and other appropriate personal would be advised of this policy to enable them to assist residents, next of kin or other designated representative in making a complaint or recommendation. Complaints that cannot be addressed by the nursing staff on the unit where the resident resided would be brought to the attention of the social worker. The social worker is the grievance official or the person responsible for addressing complaints. Residents who wish to make complaint would be scheduled to be seen by the social worker or designee or would have the responsibility of presenting the complaint in writing to the social worker. Social services would advise the administrator of all complaints within 2 days of receipt. A response would be made to the resident, next of kin or designated representative within 21 days of the day the complaint /recommendation was made. The response would contain the action taken or the reason why an action was taken. A copy of all written responses would be sent to the administrator. Where the response is not in writing, a written summary of the action taken, and outcome would be forwarded to the administrator. Annually, the social worker would review and evaluate the effectiveness of this procedure. Complaints or grievances would be reviewed at each Quality Assurance Performance Initiative meeting and analyzed for trends.</p> <p>During general observations from 10/08/2024 through 10/16/2024, no grievance forms, boxes for completed forms, or signage stating how to complete a grievance were noted in the facility on any unit.</p> <p>During Resident Council meeting on 10/09/2024 at 10:32 AM, residents present stated that they had never heard of the Ombudsman, were not advised they could file a grievance and were unsure of where information pertaining to contacting the Ombudsman and New York State Department of Health were located. Residents stated they bring issues to the Resident Council President, and they have issues handled directly through leadership.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 10/15/2024 at 9:40 AM, Social Worker #1 stated grievance forms were kept in their office. They believed there were also forms at the nurse's station as well. They stated there was a separate form used for missing laundry. When asked about the process to file a grievance, Social Worker #1 stated when a resident would come with a complaint of missing items, the Social Worker would fill out the form, searches for missing items, bring the missing items to the nurse managers attention, check with housekeeping, complete a room search, email the facility staff including housekeeping to keep an eye out for missing things. They stated that grievances were given to the Nurse Manager to do interviews with the staff. They further stated that the resident's mental capacity was considered when determining the validity of a complaint. Social Worker #1 stated they encouraged staff to 'see something, say something' and residents were encouraged to come directly to Social Worker #1 with their complaints. They stated Social Work would fill out the grievance form because a lot of residents could not fill out any kind of form on their own.</p> <p>During an interview on 10/15/2024 at 10:12 AM, Social Worker #3 stated Social Work would fill out grievance forms, not residents. The department named in the grievance received the form once they were filled out. The form was also given to the Director of Nursing and the Administrator for resolution and to talk to the family if needed. They all worked for a swift resolution to resident's issues. They stated that there was a different specific form for missing property. When asked where the forms were kept, Social Worker #3 stated the forms were kept at the nurse's station and the social work office. Asked if a resident had access to the form without talking to staff in case the resident was afraid of retaliation, Social Worker #3 replied that they encouraged residents to come to the staff first and they really like to talk to the resident to try to keep the number of hands involved to a minimum. They stated there should not be any fear of retaliation and that everyone in the facility believed that the first thing was to protect the resident.</p> <p>During an interview on 10/16/2024 at 9:15 AM, Registered Nurse #4 stated grievances were handled by Social Work. The grievance forms could be started by floor staff, but they could not tell if forms were anywhere except the social work office. When asked what they would do if a resident came and wanted to file an anonymous grievance, Registered Nurse #4 stated they would give the resident the New York State complaint hotline number.</p> <p>During an interview on 10/16/2024 at 9:49 AM, Social Worker #2 stated the grievance policy was part of the admission agreement and that residents could file grievances with Social Work, the Director of Nursing, the Assistant Director of Nursing, or any staff member. When asked if resident could file a grievance anonymously, Social Worker #2 stated that it was a good question and that no resident had ever asked to file a grievance anonymously.</p> <p>During an interview on 10/16/2024 at 10:40 AM, Registered Nurse Supervisor #1 stated if a resident came and wanted to file a grievance, they would be directed to social work. If the resident had an issue with staff or their assigned social worker, Registered Nurse Supervisor #1 stated they would get the social worker from another unit or the Director of Nursing to try and help address the issue.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 10/16/2024 at 12:10 PM, Director of Nursing #1 stated grievances could be started by whoever the resident reported their complaint to. Once the form was filled out it went to whatever department that would handle the subject of the complaint for resolution. Grievances were always discussed in morning report among the staff. Director of Nursing #1 stated they were hopeful that the staff passed complaints up the chain to management and that most issues were handled in house. If there was an issue that a resident wanted to report anonymously, staff could be switched to give the resident the feeling of safety to speak their mind.</p> <p>During an interview on 10/16/2024 at 2:15 PM, Administrator #1 stated grievances raised by residents were part of the Quality Assessment meetings. Administrator #1 stated they had an open-door policy and that the residents knew they could come and talk to them if the residents felt they were not being heard; however, social work department was the leader for grievances, and they work collaboratively. Residents were aware to talk to the staff, however the residents might not know that there were forms.</p> <p>10 New York Code Rules and Regulations 415.3(c)(1)(i)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51742</p> <p>Based on interviews and record reviews during the recertification survey, the facility did not ensure that residents were free from abuse, neglect, and exploitation for 1 (Resident #60) of 7 residents reviewed for abuse. Specifically, Resident #60 stated their roommate (Resident #69) made threatening remarks about them to the point where Resident #60 was terrified, which caused sleeplessness. Resident #60 stated they feared for their life from 3/02/2023 to 03/19/2023 until Resident #60 was finally moved to a new unit. Subsequently, Resident #60 was moved on 6/13/2023 next door to Resident #69 and Resident #69 continued harassing Resident #60 until Resident #69 was moved on 9/30/2023 to a separate unit.</p> <p>This is evidenced by:</p> <p>Cross-referenced to: F609: Reporting of Alleged Violations.</p> <p>Resident #60 was admitted with diagnoses that included hemiplegia and hemiparesis (inability to move one side of the body) following cerebral infarction (stroke) affecting side of the body and anxiety. The Minimum Data Set (an assessment tool) dated 7/11/2024, documented the resident usually understood others, usually understand others, was cognitively intact and required significant assistance to perform activities of daily living.</p> <p>A facility policy titled, Abuse Prevention and Investigation, dated 6/27/2023, documented that:</p> <p>Residents had the right to be free from verbal, sexual, physical, and mental abuse; neglect, mistreatment, corporal punishment, involuntary seclusion, exploitation, and misappropriation of property (hereafter abuse shall be understood to include all of the above).</p> <p>All employees had an obligation to report such abuses when they have reasonable cause to believe that such an incident had occurred. The facility shall follow guidelines as outlined in federal/state regulations, Dear Administrator Letters (DALs), CMS State Operations Manual Appendix PP, and [NAME] Health/SPHP policies and procedures. The staff shall report any incident or allegation/suspicion of abuse as outlined above to the Administrator, Director of Nursing Services, or their designee immediately. In cases where a crime is suspected, the facility leadership is expected to report the same to local law enforcement under the Elder Justice Act; see Elder Justice Act Policy for more details.</p> <p>Comprehensive Care Plan for Alteration in Mobility related to limited mobility, initiated 10/01/2021 and revised on 10/04/2024, documented that Resident #60 required extensive 2-person assistance for bed mobility.</p> <p>The Care plan titled Potential for physical/psychological injury/victim of abuse due to aggressive behaviors of another resident was initiated 10/01/2021 and revised 10/04/2024 revealed the resident's safety would be maintained through the review date, the rights would be maintained, and the resident would be free of injury caused by another resident through the next review. The interventions included to offer a quiet environment, and provide reassurance of resident's safety.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Our Lady of Mercy Life Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2 Mercycare Lane Guilderland, NY 12084	
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A progress note dated 3/02/2023 at 11:57 AM revealed Resident #60 was moved into room [ROOM NUMBER]W.</p> <p>A psychotherapy progress note dated 3/06/2023 at 6:31 PM documented Resident #60 had anxiety and frustration due to adjustment to having a new roommate.</p> <p>A progress note dated 3/18/2023 at 10:45 AM by Licensed Practical Nurse #6, documented that the Resident #60 reported that roommate continued to make disparaging (negative or belittling) comments towards them. It documented Resident #60 stated their roommate (Resident #69) thinks I'm a freak and called me a retard. When this nurse entered room to check residents blood sugar, roommate stated loudly, What do you have to do, clean [their] ass? Registered Nurse supervisor made aware. Will continue to monitor to ensure resident feels comfortable in their room for the remainder of shift.</p> <p>There was no documented incident report regarding this incident when requested from the facility, nor was there an investigation provided to the survey team upon request.</p> <p>A progress note dated 3/19/2023 at 11:10 AM by Licensed Practical Nurse #6, documented that Resident #60 was upset and screamed for the nurse, the resident then stated they could not breath and was in pain. After pain medicine and anxiety medicine were administered to Resident #60, the resident explained to the staff member that they were terrified of their roommate (Resident #69) and could not stay in the room with Resident #69 another night as they commented on the care Resident #60 received and called Resident #60 retarded and a freak. It further documented Resident #60 was moved to another room on a different unit (room [ROOM NUMBER] D).</p> <p>Resident #60's Medication Administration Record dated March 2023 documented that Resident #60 received 25 doses of the alprazolam (anti-anxiety medication) 0.5 milligram every 12 hours as needed for anxiety and on 5 days the resident needed two doses per day, whereas in February 2023, Resident #60 required 9 doses of the same anxiety medication and never more than one dose per day.</p> <p>A progress note dated 6/13/2023 at 9:28 AM, documented Resident #60 was moved to 428W, which was next door to Resident #69 in room [ROOM NUMBER].</p> <p>A psychotherapy progress note dated 9/08/2023 at 3:54 PM documented the session focused on difficulties that Resident #60 experienced in their relationship with their previous roommate. It further documented Resident #60 had feelings of depression and frustration related to recent events and concerns with the previous roommate.</p> <p>A progress note dated 09/09/2023 at 2:28 AM stated Resident #60 was seen on safety rounds sleeping.</p> <p>A progress note dated 9/10/2023 at 9:10 PM documented Resident #60 complained the next room neighbor (Resident #69) sprayed Lysol in their room and turned the light on in their room. Talked to resident and assured that the staff would advise the neighbor not to come to their room.</p> <p>A progress note dated 9/11/2023 at 4:13 PM documented incoming call from family, nurse supervisor assured family that nursing supervisor would continue hourly rounding to be certain Resident #60 feels safe in their environment. Family verbalized understanding and expressed appreciation.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/08/2024 at 1:34 PM, Resident #60 stated their old roommate (Resident #69) caused them distress by calling them names and turning on the light at night. They stated Resident #69 had been moved to another unit, but it took the facility a long time to respond to their complaints.</p> <p>During a subsequent interview on 10/16/2024 at 9:59 AM, Resident #60 stated that for 2-3 months they did not feel safe, lost sleep, anxious and worried, unsure of what their roommate Resident #69 would do to them. Resident #60 stated they told nurses on several occasions of verbal abuse and pushing, but nothing was done; had fear daily until Resident #69 was moved to another unit.</p> <p>Resident #69 was admitted with diagnoses that included non-pressure chronic ulcer of unspecified with necrosis of muscle (a chronic wound on leg with dead muscle involvement), peripheral vascular disease (decreased blood flow to lower legs), and adjustment disorder with depressed mood. The Minimum Data Set, dated dated [DATE] documented that the resident could be understood, understood others, was cognitively intact and needed some assistance with activities of daily living. The annual Minimum Data Set, dated dated [DATE] documented Resident #69 had verbal behavioral symptoms directed toward others 4-6 days, but not daily during the lookback period and that the behaviors significantly interfered with the resident's participation in activities or social interaction. It further revealed that the behavior significantly disrupted care or the living environment.</p> <p>The Care Plan titled Potential for Physical/Psychological Injury/Victim of abuse comprehensive care plan dated 5/30/2020 and last revised 10/18/2024, documented the resident had potential for being a victim of abuse related to aggressive behaviors of another resident. Interventions documented included offer quiet environment, provide environmental barriers to ensure safety, provide reassurance of elder safety, redirect away from abusive resident, remind resident not to provide fluids or food to other residents, and remove resident from immediate danger if able, when other resident exhibits outbursts or aggressive behaviors.</p> <p>The Care Plan titled Alteration in Behavior dated 3/05/2021 and last revised 12/28/2023 documented the resident exhibited inappropriate behaviors of verbal outbursts towards staff members, interference with others care, hoarding items in their room, impulsive behaviors, inappropriate comments to female care givers and difficulty with sharing room with another as poor coping skills and interactions with others. Goals included decreased these behaviors. Interventions listed included but were not limited to reminding resident not to make inappropriate comments or be verbally aggressive with staff, encourage the resident not to interfere with other resident's care, be appropriate to their roommate, provide a physical barrier such as extra chair between resident and others, and discuss behaviors and reapproach if necessary and report any behaviors to staff.</p> <p>A progress note dated 3/18/2023 at 2:14 PM documented that the nurse observed Resident #69 making disparaging (negative) comments about Resident #60 within Resident #60's hearing.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A progress note dated 3/19/2023 at 10:57 AM, documented Resident #69 had been verbally abusive to staff and fell ow residents. Resident #69's roommate was moved to another room as the roommate (Resident #60) stated I cannot stay here in this room any longer. Resident #69 called me a [NAME] and retard; laughs every time I need to be cleaned and that I am a freak. Resident #69 also made the kitchen server upset to the point they had left their food station and refused to enter the dining room until Resident #69 left. Resident #69 was asked not to use foul language and to be mindful of others as Resident #69 were getting the whole unit upset, if they could not compose themselves, the situation would be reported. Management made aware.</p> <p>A progress note dated 3/21/2023 at 11:15 AM, documented an Interdisciplinary Team meeting was held with Administrator, Assistant Director of Nursing, Social Work, Resident #69, and their family. Team reviewed behavior contract after reports of inappropriate behaviors directed at other staff, residents, and past roommate (Resident #60). Resident #69 was agreeable to seeing psychologist and Social Work once a week to help develop better coping skills.</p> <p>There were no documented incident reports provided when survey team requested.</p> <p>A review of Behavioral Contract dated 11/22/2021 revealed several unacceptable behaviors which included touching residents, going into other residents' rooms, and crude remarks/negative behavior. It further revealed that Resident #69 would be given a 30- day notice if the resident did not comply with the behavioral contract. It was not signed, but a note was written that stated it was reviewed with the resident. Also attached was a document that stated Resident #69 had violated facility policies which included being non-critical and tolerant of others' handicaps or disabilities, using profane or abusive language towards other residents or staff was prohibited. This page was signed by Resident #69.</p> <p>A review of Behavioral Contract dated 2/22/2024 revealed unsafe behaviors, which included feeding and touching residents and crude (rude) remarks toward staff and swearing at staff. It stated failure to comply would result in a 30 -day discharge notice. Resident #69 signed the contract.</p> <p>A psychotherapy progress note dated 3/22/2023 at 11:50 AM documented the psychologist met with the resident to address recent psychological functioning and address issues that the resident experienced anger and conflict management, which the resident reported having some difficulties in that area.</p> <p>A psychiatry consultation form dated 3/29/2023 for Resident #69 documented the reason for consult was verbal aggression, belligerent behavior; findings were resident was irritable, had poor hygiene, room disheveled, easily frustrated, and verbally assertive; resident was unwilling to consider additional medication at that time.</p> <p>A progress note dated 3/31/2023 at 11:00 PM, written by Registered Nurse #11, documented a Certified Nurse Aide informed them that Resident #69 was being mean to other residents and telling them to not come to dining room or Resident #69 would beat them and was being mean to other confused residents too.</p> <p>A psychiatry consultation form dated 4/26/2023 for Resident #69 stated staff were concerned about adjustment to new roommate and findings included that Resident #69 remained verbally aggressive.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A progress note dated 5/08/2023 at 12:15 AM documented that Resident #69 was upset about the floor mat that was in the room for the roommate's (Resident #66) safety and Resident #69 would continue to move the mat for Resident #69's mobility.</p> <p>Progress note dated 5/23/2023 at 10:26 PM, written by Licensed Practical Nurse #7, documented the writer witnessed Resident #69 pushing another resident in their wheelchair when they could not see who it was behind them. After the resident complained for a few seconds, Resident #69 stopped pushing them.</p> <p>A progress note dated 5/24/2023 at 3:39 PM documented while doing resident treatment in Resident #69's room, another resident was wheeling past the room and Resident #69 started calling the other resident hey it's the swamp thing! You dirty Pig; go take a shower again in the toilet. Resident #69 was told to be the bigger person and not call other names etc. but Resident #69 continued to call the other resident names and got the other resident upset. The unit manager was notified of the situation.</p> <p>A progress note dated 5/24/2023 at 4:38 PM documented Resident #69 had a vulgar outburst with female resident. Providers were notified.</p> <p>A progress note dated 5/28/2023 at 9:52 AM documented that another resident approached Resident #69 and without provocation in the dining room and attempted to twist the other resident's arm. No signs or symptoms of injury noted. Residents were separated. Physician made aware.</p> <p>A psychotherapy progress note dated 7/23/2023 at 2:15 PM documented treatment for physical aggression and the session focused on anxiety and frustration related to residing with peers. The psychologist counseled Resident #69 regarding the importance of refraining from verbal and physical aggression.</p> <p>A progress note dated 8/03/2023 at 4:51 PM documented Resident #69 was noted to be making fun of the resident at the table. Redirected with little to no effect.</p> <p>A progress note dated 8/06/2023 at 2:40 PM documented Resident #69 picked on residents in the dining room. Redirected. Resident #69 also turned on the light in Resident #60's room to upset the resident in 428. Will continue to monitor behavior.</p> <p>A progress note dated 8/07/2023 at 12:51 AM documented Resident #60 reported that Resident #69 passed by their room and flipped on the light switch and closed the door. Resident #60 stated that Resident #69 had done this several times during the day which was noted by 7-3 shift. No further incident reported. The staff intervention was to notify the supervisor as Resident #60 asked to speak to the supervisor.</p> <p>A psychotherapy progress note dated 8/10/2023 at 5:23 pm documented treatment for physical aggression and the session focused on anxiety and frustration related to residing with peers.</p> <p>A progress note dated 8/16/2023 at 10:12 PM documented Resident #69 was arguing with another resident early in the shift, mood was agitated after complaining that someone cleaned their room without the resident there. Residents had to be separated.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A psychotherapy progress note dated 8/27/2023 at 12:08 PM documented treatment for physical aggression and the session focused on frustration and anxiety regarding difficulties that arise in relationships with those round Resident #69. Therapist counseled Resident #69 of the likely negative consequences of engaging in verbally aggressive behaviors in their interactions with others.</p> <p>A psychotherapy progress note dated 9/07/2023 at 1:37 PM documented treatment for physical aggression and the session focused on Resident #69 struggling with depression and frustration regarding difficult events they experienced with peers earlier in the week. Psychologist counseled regarding the importance of refraining from engaging in verbally or physically aggressive behaviors toward their peers.</p> <p>A progress note dated 9/8/2023 at 1:33 PM documented the social worker met with Resident #69 and reviewed behavioral contracts and reminded Resident #69 that enough violations could lead to a 30-day involuntary discharge notice. Resident #69 asked writer to let it lie' and that they would keep a low profile. Resident #69 did not want to leave the facility. Writer will continue to monitor.</p> <p>A psychotherapy progress note dated 9/11/2023 at 1:27 PM documented treatment for physical aggression and the session focused on Resident #69's ability to manage conflicts and feelings of anger in their relationships with those around the resident. Resident #69 reported difficulties in this area; psychologist explored and reviewed recent events that caused feelings of anger toward those around them.</p> <p>A psychiatry consultation note dated 10/04/2023 stated the reason for consult was increased agitation/aggression. Provider documented Resident #69 felt like they were being attacked and staff blamed them for everything.</p> <p>On 10/01/2023 Resident #69 moved to another room.</p> <p>During an interview on 10/16/2024 at 2:27 PM, Resident #69 stated last time there was a problem with another resident, that resident was moved, and Resident #69 was told to stay away from that resident and the facility would handle it.</p> <p>During an interview on 10/09/2024 at 9:06 AM, Licensed Practical Nurse #2 stated that prior to Resident #60 being moved, Licensed Practical Nurse #2 was aware of problems with roommates. Resident #69 was moved next door to Resident #60, but still went back into Resident #60's room in the middle of the night and flipped the light on.</p> <p>During an interview on 10/11/2024 at 3:30 PM, Registered Nurse #6 stated Resident #69 was 'constantly' being aggressive with staff, residents, and moved often to different units' due to behavior.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/16/2024 at 8:44 AM, Administrator #1 stated Resident #69 was torture for the nurse manager, had been moved to [NAME] unit for a while and had been giving residents food to other residents that they were not allowed to have, struggled with roommates, and was determined to be roommate incompatible. The facility's main issue was the way Resident #69 was treating staff, getting other residents worked up to cause problems, obsessive compulsive disorder, and hoarding. Administrator #1 stated that they could not discharge the resident. Resident #69 seemed to be doing better on Lourdes, though there were still issues. Administrator did not believe that Resident #69 had done anything that was reportable. They stated Social Workers, medical staff, and psychologists were working with Resident #69.</p> <p>During an interview on 10/16/2024 at 9:01 AM, Social Worker #1 stated Resident #69 had extensive verbal and physical interactions with residents. Social Worker #1 stated they were aware that Resident #69 had been verbally aggressive with roommates and other residents. The facility tried to place Resident #69 on [NAME] which started out fine. Eventually Resident #69 struggled with understanding others have dementia. The facility had gone over resident rights, presented behavioral plan to Resident #69, and reinforce rules. Resident #69 seems to have been better on Lourdes unit. They stated psychologists were working with Resident #69. Social Worker #1 denied knowing about the issues with Resident #60 but stated that due to the verbal and physical interactions with residents, Resident #69 was given a behavior plan on 11/22/2021 and another on 2/22/2024 that reminded Resident #69 of the behavioral requirements to remain at the facility.</p> <p>10 New York Codes, Rules, and Regulations 415.4(b)(1)(i)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51742</p> <p>Based on interviews and record reviews during the recertification survey, the facility did not ensure that in response to allegations of abuse were reported immediately, but not later than 2 hours after the allegation was 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 #60) of residents reviewed. Specifically, Resident #60 reported allegation of abuse by Resident #69 to facility staff and was not reported to Department of Health.</p> <p>This is evidenced by:</p> <p>Cross-referenced to: F600: Free from Abuse and Neglect.</p> <p>Resident #60 was admitted with diagnoses that included need for assistance with personal care, hemiplegia, and hemiparesis (inability to move one side of the body) following cerebral infarction (stroke) one side of the body, anxiety, and major depressive disorder. The Minimum Data Set (an assessment tool) dated 07/11/2024, documented the resident usually understood others, usually understand others, was cognitively intact and required significant assistance to perform activities of daily living.</p> <p>A facility policy titled Abuse Prevention and Investigation Policy dated 06/27/2023, documented Residents have the right to be free from verbal, sexual, physical, and mental abuse; neglect, mistreatment, corporal punishment, involuntary seclusion, exploitation, and misappropriation of property (hereafter abuse shall be understood to include all of the above). All required notifications (physician, family, and government/legal authority) must be made timely by community administration or their designees.</p> <p>There were no documented reported incidents involving abuse reported by Resident #60 to the Department of Health.</p> <p>The Comprehensive Care Plan titled, Potential for Physical/Psychological Injury, to be a victim of abuse caused by aggressive behaviors of another resident that initiated on 10/01/2021 and last revised on 10/04/2024, with a related goal of maintaining Resident #60's rights and Resident #60 would be free of injury caused by another elder through the next review date 10/12/24.</p> <p>There were documented interventions to prevent abuse of offer Resident #60 quiet environment and to provide reassurance about Resident #60's safety.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A progress note dated 3/18/2023 at 10:45 AM documented that the resident reported that their roommate (Resident #69) continued to make disparaging comments towards him. Resident stated 'He thinks I'm a freak. He calls me a retard.' When this nurse entered room to check residents blood sugar, roommate (Resident #69) stated loudly, 'What do you have to do, clean his ass?' Registered Nurse supervisor made aware. Will continue to monitor to ensure resident feels comfortable in his room for the remainder of shift.</p> <p>A progress note dated 03/19/2024 at 11:10 AM documented that the resident explained to the staff member that they were terrified of their roommate, Resident #69, and could not stay in the room with them another night as they comment on the care Resident #60 received and called Resident #60 retarded and a freak. Additionally documented was that Resident #60 was moved to another room (342 D).</p> <p>A progress note dated 9/10/2023 at 9:10 PM Resident #60 complained the next room neighbor (Resident #69) sprayed Lysol in their room and turned light on in their room. Talked to resident and assured that the staff would advise the neighbor not to come to their room.</p> <p>A progress note dated 9/11/2023 at 4:13 PM documented a call from family asked that staff would do hourly rounding on Resident #60 to ensure they were comfortable and felt safe.</p> <p>During an interview on 10/08/2024 at 1:34 PM, Resident #60 stated that old roommate caused them distress by calling Resident #60 names and turned on the light at night. Resident #69 had been moved to another unit, but it took the facility a long time to respond to the complaints.</p> <p>During a subsequent interview on 10/16/2024 at 9:59 AM, Resident #60 stated that for 2-3 months with a roommate (Resident #69), they did not feel safe, lost sleep, anxious and worried, unsure of what Resident #69 would do to them, told nurses on several occasions of verbal abuse and pushing, but nothing was done; had fear daily until Resident #69 was moved to another unit.</p> <p>During an interview on 10/09/2024 at 09:06 AM, Licensed Practical Nurse #2 stated that prior to Resident #60 being moved, Licensed Practical Nurse #2 was aware of problems with roommates behaviors of calling Resident #60 derogatory names, making rude comments on Resident #60's care needs, and interruptive behaviors with other residents cares, such as giving them foods not on their diet restrictions/textures like whole grapes to a puree diet resident. Resident #69 was moved next door to Resident #60, but still went back into Resident #60's room in the middle of the night and flipped the light on.</p> <p>During an interview on 10/16/2024 at 8:44 AM, Administrator #1 stated that Resident #69 was torture for the nurse manager, had been moved to [NAME] unit for a while and had been giving residents foods the other residents were not allowed to have, struggled with roommates and was determined to be roommate incompatible. The facility's main issue was the way Resident #69 was treating staff, getting other residents worked up to cause problems, obsessive compulsive disorder, and hoarding. Administrator #1 stated they did not believe that Resident #69 had done anything that was reportable. Social Workers, medical staff and psychologists were working with Resident #69.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Our Lady of Mercy Life Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2 Mercycare Lane Guilderland, NY 12084	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/16/2024 at 9:01 AM, Social Worker #1 stated Resident #69 had 'extensive' verbal and physical interactions with residents. The facility tried to place Resident #69 on [NAME] unit which started out fine. Eventually Resident #69 struggled with understanding others have dementia. The facility had gone over resident rights, presented behavioral plan to Resident #69, and reinforce rules. Resident #69 seemed to have been better on Lourdes unit. Additionally, the facility was struggling to find an alternative place for Resident #69 to go. Social Worker #1 stated no other facility wanted Resident #69 because of behaviors. There was the need for a lot of re-direction, and the reviewed plans/contracts. Psychologists were working with Resident #69. Social Worker #1 denied knowing about the issues with Resident #60.</p> <p>10 New York Codes, Rules, and Regulations 415.4(b)(3)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51742</p> <p>Based on interviews and record reviews during the recertification survey from 10/08/2024 - 10/16/2024, the facility did not ensure that all alleged violations of abuse were thoroughly investigated for 1 (Resident #60) of 7 residents reviewed for abuse. Specifically, Resident #60 reported to facility staff on 3/18/2024 they were verbally abused by Resident #69. There was no documented evidence that a thorough investigation was completed by the facility when the allegation of verbal abuse was made.</p> <p>As evidenced by:</p> <p>Cross-referenced to: F600: Free from Abuse and Neglect.</p> <p>A facility policy titled Abuse Prevention and Investigation Policy dated 6/27/2023, documented that residents have the right Residents have the right to be free from verbal, sexual, physical, and mental abuse; neglect, mistreatment, corporal punishment, involuntary seclusion, exploitation, and misappropriation of property (hereafter abuse shall be understood to include all of the above).</p> <p>All employees have an obligation to report such abuses when they have reasonable cause to believe that such an incident has occurred. The facility shall follow guidelines as outlined in federal/state regulations, Dear Administrator Letters (DALs), CMS State Operations Manual Appendix PP, and [NAME] Health/SPHP policies and procedures. The staff shall report any incident or allegation/suspicion of abuse as outlined above to the Administrator, Director of Nursing Services, or their designee immediately. In cases where a crime is suspected, the facility leadership is expected to report the same to local law enforcement under the Elder Justice Act; see Elder Justice Act Policy for more details. If known, the alleged perpetrator must be removed immediately. Staff accused of abuse will be suspended from working at the facility pending the outcome of the investigation. (Note: for the purposes of this policy, staff includes employees, consultants, contractors, volunteers, and any other caregivers who provide care and services to a resident on behalf of the community).</p> <p>Resident #60 was admitted with diagnoses that included need for assistance with personal care, hemiplegia, and hemiparesis (inability to move one side of the body) following cerebral infarction (stroke) affecting the left and right side of the body, anxiety, major depressive disorder, and chronic pain. The Minimum Data Set (an assessment tool) dated 7/11/2024, documented the resident usually understood others, usually understand others, was cognitively intact and required significant assistance to perform activities of daily living.</p> <p>The Care plan titled Potential for physical/psychological injury/victim of abuse due to aggressive behaviors of another resident was initiated 10/01/2021 and revised 10/04/2024 revealed the resident's safety would be maintained through the review date, the rights would be maintained, and the resident would be free of injury caused by another resident through the next review. The interventions included to offer a quite environment and provide reassurance of resident's safety.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A progress note dated 3/18/2023 at 10:45 AM by Licensed Practical Nurse #6, documented that Resident #60 reported that roommate (Resident #69) continued to make disparaging (negative or belittling) comments towards them. It documented they roommate (Resident #69) stated [they] thinks I'm a freak and. [they] calls me a retard. When this nurse entered room to check residents blood sugar, roommate (Resident #69) stated loudly, What do you have to do, clean [their] ass? Registered Nurse supervisor made aware. Will continue to monitor to ensure resident feels comfortable in [their] room for the remainder of shift.</p> <p>There was no documented incident report regarding this incident when requested from the facility, nor was there an investigation provided upon request.</p> <p>A progress notes dated 3/19/20234 at 11:10 AM by Licensed Practical Nurse #6, documented that the Resident #60 was upset and screamed for the nurse, the resident then stated the resident could not breath and was in pain. After pain medicine and anxiety medicine were administered to Resident #60, the resident explained to the staff member that they were terrified of their roommate, Resident #69, and Resident #60 could not stay in the room with Resident #69 another night as they commented on the care Resident #60 received and called Resident #60 retarded and a freak. It additionally documented that Resident #60 was moved to another room on a different unit.</p> <p>There was no documented incident report regarding this incident when requested from the facility, nor was there an investigation provided upon request.</p> <p>During an interview on 10/08/2024 at 1:34 PM, Resident #60 stated that old roommate caused then distress by calling Resident #60 names and turning on the light at night. Resident #69 has been moved to another unit, but it took the facility a long time to respond to the complaints.</p> <p>During an interview on 10/16/24 at 9:59 AM, Resident #60 stated that for 2-3 months as roommate did not feel safe, lost sleep, anxious and worried, unsure of what Resident #69t would do to, told nurses on several occasions of verbal abuse and pushing, but nothing was done; was afraid until Resident #69 was moved to another unit.</p> <p>Resident #69 was admitted with diagnoses that included non-pressure chronic ulcer of unspecified part of left lower leg with necrosis of muscle (a chronic wound on leg with dead muscle involvement), peripheral vascular disease (decreased blood flow to lower legs), and adjustment disorder with depressed mood. The Minimum Data Set, dated dated [DATE] documented that the resident could be understood, understood others, was cognitively intact and needed some assistance with activities of daily living.</p> <p>The Care Plan titled Potential for Physical/Psychological Injury/Victim of abuse comprehensive care plan initiated 5/30/2020 and last revised 10/18/2024, documented the resident had potential for being a victim of abuse related to aggressive behaviors of another resident. Interventions documented included offer quiet environment, provide environmental barriers to ensure safety, provide reassurance of elder safety, redirect away from abusive resident, remind resident not to provide fluids or food to other residents, and remove resident from immediate danger if able, when other resident exhibits outbursts or aggressive behaviors.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Care Plan titled, Alteration in Behavior, initiated 3/05/2021 and last revised 12/28/2023, documented the resident exhibited inappropriate behaviors of verbal outbursts towards staff members, interference with others care, hoarding items in their room, impulsive behaviors, inappropriate comments to female care givers and difficulty with sharing room with another as poor coping skills and interactions with others. Goals included decreased these behaviors. Interventions listed included but were not limited to reminding resident not to make inappropriate comments or be verbally aggressive with staff, encourage the resident not to interfere with other resident's care, be appropriate to their roommate, provide a physical barrier such as extra chair between resident and others, and discuss behaviors and reapproach if necessary and report any behaviors to staff.</p> <p>A progress note dated 3/19/2023 at 10:57 AM documented Resident #69 had been verbally abusive to staff and fell ow residents. Resident #60's roommate was moved to another room as the roommate stated I cannot stay here in this room any longer. Resident #69 called me a [NAME] and retard; laughs every time I need to be cleaned and that I am a freak. Resident #69 also made the kitchen server upset to the point they had left their food station and refused to enter the dining room until Resident #69 left. Resident #69 was asked not to use foul language and to mind full others as they were getting the whole unit upset, if he cannot compose himself the situation would be reported. Management made aware.</p> <p>A progress note dated 3/21/2023 at 11:15 AM documented an Interdisciplinary Team meeting was held with Administrator, Assistant Director of Nursing, Social Work, Resident #,69 and their family. Team reviewed behavior contract after reports of inappropriate behaviors directed at other staff, residents, and past roommate. Resident #69 was agreeable to seeing psychologist and Social Work once a week to help develop better coping skills.</p> <p>A progress note dated 8/7/2023 at 12:51 AM documented (Resident #60) reported that Resident #69 passed by their room and flipped on the light switch and closed the door. It further documented Resident #60 stated that Resident #69 had done this several times during the day which was noted by 7AM-3PM shift.</p> <p>During an interview on 10/16/2024 at 8:44 AM, Administrator #1 stated that Resident #69 had multiple incidents, mostly with staff and roommates; the Administrator did not feel any of the incidents were reportable and could not provide incident reports or investigations.</p> <p>10 New York Codes, Rules, and Regulations 483.12(c)(2 - 4)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>48744</p> <p>Based on observation, record review, and interviews conducted during a recertification survey, the facility did not develop and implemented a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframe's to meet a resident's medical, nursing, mental, and psychosocial needs that were identified in the comprehensive assessment. for 1 (Resident #62) of 31 residents reviewed for Care Plans. Specifically, Resident #62's behavior interventions were not implemented when Resident #62 was having behaviors during meals.</p> <p>This is evidenced by:</p> <p>A facility policy titled Interdisciplinary Care Conference and Care Planning dated 6/27/2023 documented that a comprehensive resident centered plan of care had a follow up evaluation after a significant change in condition. The policy further stated that the plan will be updated quarterly and with any significant change thereafter. The entire interdisciplinary team will participate in the development and implementation of each resident's care plan, working together contributing their knowledge and skill set in an effort to provide the greatest benefit to the resident.</p> <p>Resident #62 was admitted to the facility with the diagnoses of Alzheimer's Disease (a degenerative neurological disease causing changes in memory and behavior), chronic kidney disease (an always present dysfunction of the kidneys), unspecified asthma (general issues involving poor lung function). The Minimum Data Set (an assessment tool) dated 7/12/2024, documented the resident was able to be understood, understand others, and was significantly cognitively impaired, and required some assistance for activities of daily living.</p> <p>The Comprehensive Care Plan for Alteration in Behavior date initiated 8/17/2023 and last updated 3/29/2024, documented that the resident had occasionally have verbal outbursts/arguments. Goal included Resident #62 would not show any verbal/physical aggressive actions towards other residents. Interventions included encourage decreased verbal outbursts and use slow and reassuring techniques during verbal outbursts.</p> <p>During lunch observations on 10/09/2024 at 12:00 PM, Resident #62 was seen and heard talking to themselves saying a bitch and drop dead loudly enough to be heard by everyone in the main dining room. Resident #62 was not removed from the dining room or interacted with by staff to decrease the behaviors.</p> <p>During lunch observations on 10/09/2024 at 11:50 AM, Resident #62 was seen and heard voicing several insults and making statements that contained foul language in the main dining room around other residents. The resident was also observed answering questions not directed at them and joining in other residents' conversation at other resident tables. Resident #62 was not removed from the dining room or interacted with to decrease the behaviors.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Physician's order dated 9/16/2022, no end date, documented that the resident consulted with Psychologist for treatment for major depressive disorder, recurrent, psychotic disturbances, mood disturbances and anxiety.</p> <p>A Progress Note dated 10/10/2024 at 2:30 PM documented that the resident was swearing at their roommate upon waking up that morning, pinching, hitting, and spitting at staff during care. Yelling out and swearing at other resident during meals.</p> <p>During an interview on 10/16/2024 at 9:06 AM, Licensed Practical Nurse #3 stated Resident #62 had a lot of issues with another resident. The staff tried to keep Resident #62 separated from other residents because it seemed like abuse to other residents to the aggressive nature of Resident #62's behaviors. When asked how the staff worked with Resident #62, Licensed Practical Nurse #3 stated that they reminded the resident to be nice, remove the resident when they were particularly worked up.</p> <p>During an interview on 10/16/2024 at 9:20 AM, Registered Nurse #4 stated if Resident #62 was being particularly unpleasantly vocal, the staff would move the resident and separate them from other residents. The staff were working with psychiatry to alter their medications try to get the behaviors under control.</p> <p>During an interview on 10/16/2024 at 10:40 AM, Unit Manager #1 stated that Resident #62's behavior did not start until the doctors put them on Rexulti. The physicians were in the process of weening the resident off the medication with the hope that the behaviors would stop once the resident was no longer taking the medication. Unit Manager #1 stated that if Resident #62 was behaving badly, the staff removed them and provided distractions. Additionally, staff members were given shift to shift report where they discussed behaviors or issues from the previous shift.</p> <p>During an interview on 10/16/2024 at 11:32 AM, Registered Nurse #2, Nurse Educator stated the behavior team met weekly. The educator encouraged staff to join committees to be able to have people bounce ideas off each other. Registered Nurse #2 taught documentation, nonpharmacological interventions, therapeutic one on ones, photo books and distraction techniques. Huddles were held with teams if a resident was having behaviors or falling and it was discussed with all the staff involved with the resident.</p> <p>During an interview on 10/16/2024 at 12:11 PM, Director of Nursing #1 stated that care plans should support how to handle behaviors and needs and be updated regularly. Director of Nursing #1 had been working with staff to keep behaviors under control. The staff have been working with the doctors to see if medications would help. Director of Nursing #1 stated the focus was protecting other residents from residents that have bad behaviors.</p> <p>10 New York Code of Rules and Regulations 415.11(c)(1)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48744</p> <p>Based on observation, record review, and interview conducted during a recertification survey, the facility did not ensure the comprehensive care plans were reviewed and revised with measurable objectives, time frame and appropriate interventions for 1 (Resident #23) of 31 residents reviewed. Specifically, for Resident #23, resident's Safety Awareness Deficit Care plan was not updated following a fall on 3/13/2024, 5/9/2024, 7/14/2024, 7/16/2024, and 9/04/2024.</p> <p>This is evidenced by:</p> <p>A facility policy titled Interdisciplinary Care Conference and Care Planning dated 6/27/2023 documented that a comprehensive resident centered plan of care had a follow up evaluation after a significant change in condition.</p> <p>A facility policy titled Falls Management Policy dated 10/4/2021 documented that falls and fall risks were managed through the process of assessment, planning, implementation, and evaluation. The resident who was at risk for falls would have an individualized care plan developed which identified interventions to reduce fall risk. Additionally, the community would incorporate a resident's choices into the plan of care.</p> <p>Resident #23 was admitted to the facility with the diagnoses of Parkinson's disease without dyskinesia (a neurological disorder causing tremors and muscle rigidity), hallucinations (seeing or hearing things that are not real), and pulmonary hypertension (a type of high blood pressure that affects the arteries in the lungs and right side of the heart). The Minimum Data Set (an assessment tool) dated 7/26/2024, documented the resident was able to be understood, understand others, and was minimally cognitively impaired, and required some assistance for activities of daily living.</p> <p>The Comprehensive Care Plan for Safety Awareness Deficit related to history of falls, initiated 7/25/2023, documented the resident had multiple falls. The care plan was not updated post the resident's falls on 3/13/2024, 5/09/2024, 7/14/2024, 7/16/2024, and 9/04/2024 with intervention to prevent further falls. The care plan had multiple interventions listed for other falls dates. For example, after the resident's fall on 5/09/2024, there were no new interventions put into place. However, after the resident fell on [DATE], interventions were added on 5/11/2024 for encouraging the resident to call for help prior to toileting/ambulation/transfers and monitoring for orthostatic hypotension; alert pharmacy and medical provider.</p> <p>Physician's order dated 3/15/2024, documented the resident be evaluated by occupational therapy and treated as required.</p> <p>Physician's order dated 4/22/2024 documented the resident be evaluated physical therapy and treated as required.</p> <p>Physician's order dated 6/17/2024 documented the resident again be evaluated by occupational therapy and treated as required.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Physician's order dated 7/11/2024 documented the resident again be evaluated by physical therapy and treated as required.</p> <p>Physician's order dated 9/10/2024 documented the resident again be evaluated by occupational therapy and treated as required.</p> <p>During an interview on 10/15/2024 at 12:05 PM, Director of Nursing #1 stated that chronic conditions should be documented in the care plans and that any Registered Nurse can update care plans.</p> <p>During a subsequent interview on 10/16/2024 at 12:11 PM, Director of Nursing #1 stated that care plans should support resident needs and should be updated regularly.</p> <p>During an interview on 10/16/2024 at 2:15 PM, Administrator #1 stated it was also the expectation that the nursing staff would update care plans.</p> <p>10 New York Code Rules and Regulations 415.11(c)(2) (i-iii)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51742</p> <p>Based on interviews and record reviews during the recertification, the facility did not ensure that residents received treatment and care in accordance with professional standards of practice for 1 (Resident #2) of 31 residents reviewed for quality of care. Specifically, for Resident #2 had a blood sugar of 525 on 06/14/2024 at 8:23 AM, 10 units of insulin were administered. There was no monitoring until the next blood sugar was done at 4:29 PM; Resident #2 was transported to the hospital at 6:49 PM and admitted to the hospital for hyperglycemia and severe sepsis.</p> <p>This is evidenced by:</p> <p>Resident #2 was admitted to the facility with the diagnoses of insulin dependent type 2 diabetes mellitus, history of urinary tract infections and neuromuscular dysfunction of bladder. The Minimum Data Set (an assessment tool) dated 6/23/2024 documented the resident could be understood, understood others, was significantly cognitively impaired and needed significant assistance with activities of daily living.</p> <p>A facility policy titled Diabetic Management dated 8/25/2003 documented that all resident who were diabetic would be managed through an established diabetic protocol. Any change in a diabetic resident's blood sugar (less than 70 milligrams per deciliter or greater than 400 milligrams per deciliter) will be assessed by a registered nurse and documentation in the resident's medical records would reflect the assessment and interventions per policy. The physician or nurse practitioner must be notified of any blood sugar results less than 70 milligrams per deciliter or greater than 400 milligrams per deciliter. The purpose documented that consistently manage resident with diabetes by maximizing therapeutic response to the treatment plan, as well as reducing the possibility of an adverse event related to diabetes. Whenever a resident's blood sugar is below 70 or greater than 400, there must be an assessment of the resident by a registered nurse and the assessment (noted above) must be documented in the resident's medical record and the physician/nurse practitioner must be notified. Document provider notification in the resident's medical record.</p> <p>Comprehensive Care Plan for Alteration in endocrine function as manifested by elevate blood glucose initiated 2/18/2019 and revised 11/13/2023, include interventions to report any abnormal values to Medical Doctor and assess resident every 30 minutes until glucose is within normal limits (this intervention was initiated 02/18/2019, revised 10/20/2022).</p> <p>An abnormal blood sugar progress note dated 06/14/2024 at 8:23 AM documented Resident #2's blood glucose was 525, medical was updated and 10 units of short acting insulin, Humalog, were ordered now; resident was documented as asymptomatic.</p> <p>An abnormal blood sugar progress note dated 6/14/2024 at 4:29 PM documented Resident #2's blood sugar was high, documented as 600 on the vitals. The practitioner ordered 10 units of short-acting insulin, Humalog, now and recheck blood glucose in 2 hours.</p> <p>Review of the vitals section revealed no vitals were performed on 6/14/2024 after 9:00 AM and before 4:28 PM. There was no documented evidence that the blood sugar was rechecked every 30 minutes as indicated per Resident #2's care plan.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335767	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/15/2024
NAME OF PROVIDER OR SUPPLIER Our Lady of Mercy Life Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2 Mercycare Lane Guilderland, NY 12084	
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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A nursing note dated 6/14/2024 at 6:41 PM documented the resident had a blood glucose that read high on the glucometer indicating that the resident's blood glucose was over 600 and the machine could not read the sugar level. The resident was noted to be pale and was having trouble maintaining normal oxygen levels on room air. The staff notified the nurse practitioner.</p> <p>An interdisciplinary progress note dated 6/14/2024 at 6:43 PM documented oxygen was given at 2 liters per minute to Resident #2 and the nurse practitioner was updated.</p> <p>A nursing administration note dated 06/14/2024 at 6:49 PM documented that Resident #2 was slightly lethargic (sleepy), abdomen was distended (enlarged), no bowel sounds, lips were pale and that the resident had a history of urinary tract infection and pneumonia, so the plan was to send the resident to the emergency room .</p> <p>An interdisciplinary progress note dated 6/14/2024 at 7:35 PM documented that emergency medical services reported the blood pressure at 87/50 and that the resident was less responsive and appeared pale and transported the resident to the hospital.</p> <p>The hospital discharge summary for admitted [DATE] thru 6/20/2024 revealed the resident was treated for severe sepsis and type 2 diabetes with hyperglycemia (high blood sugar) which was over 600.</p> <p>During an interview on 10/15/2024 at 11:42 AM, Registered Nurse #8 stated that the expectation would be to notify the doctor and give the ordered treatment. If the doctor did not state to recheck the blood sugar, then the Registered Nurse would not recheck the blood sugar. Registered Nurse #8 further stated they would not need any other vitals unless the resident was showing symptoms of high blood sugar. The facility protocol, per Registered Nurse #8's understanding, was check blood sugar before meals and before bed.</p> <p>During an interview on 10/16/2024 at 4:35 PM, Director of Nursing #1 stated with blood sugar over 400, the nurse should notify the practitioner. They stated blood sugar over 500 was more severe and was a critical value that would require closer monitoring.</p> <p>10 New York Codes, Rules, and Regulations 415.12</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48615</p> <p>Based on observation, interviews and record review during the recertification and abbreviated survey (Case #: NY00329064 and NY00353346), the facility did not ensure 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 minimum staffing levels were not met every day on multiple shifts and multiple units between 10/08/2024 and 10/15/2024. Additionally, there were multiple residents and family complaints regarding the lack of sufficient staffing resulting in staff's timely response to call lights, and not providing scheduled showers and treatments.</p> <p>This is evidenced by:</p> <p>The facility's Facility Assessment, section titled Staffing Plan, documented that Federal regulations would require that facilities provide 3.48 hours per resident, per day, of direct care with 0.55 hours per resident, per day, Registered Nurses and 2.45 hours per resident, per day, from Certified Nurse Aides. The remaining 0.48 hours per resident, per day, can be a combination of nurse staff or nurse aides. The staffing plan also documented there was a Registered Nurse Supervisor in house Monday through Thursday 3PM-11PM and 11PM-7AM, Friday and Saturday/Sunday 24/7. The staffing requirements were broken down by unit as follows:</p> <p>Unit,Registered Nurse,Licensed Practical Nurse,Certified Nurse Aides</p> <p>[NAME],Manager 1,, 7 AM - 3 PM,,2,6 3 PM - 11 PM,,2,5 11 PM - 7 AM,,1,2 Lourdes,Manager 1,, 7 AM - 3 PM,3 ,2,5 3 PM - 11 PM,2,2,4 11 PM - 7 AM,1,1,3 [NAME]/Rosary,Managers 2,, 7 AM - 3 PM,,2,5 3 PM - 11 PM,,2,4</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>11 PM - 7 AM,,1,2</p> <p>Upon entrance to the facility on [DATE] at 8:30 AM, there were 146 residents in the facility.</p> <p>The Staff Assignment Sheets that documented the number of nursing staff present to provide care in the facility on 10/08/2024 noted the following:</p> <p>1 Registered Nurse Supervisor for 3 PM-7 AM in the facility</p> <p>[NAME] Unit:</p> <p>1 Nurse Manager from 8AM to 4 PM.</p> <p>Day shift - 1 Licensed Practical Nurse and 3 Certified Nurse Aides.</p> <p>Evening Shift - 1 Licensed Practical Nurse, 4 Certified Nurse Aides (1 of the Certified Nurse Aides worked from 3PM-7PM.)</p> <p>Night Shift - 1 Licensed Practical Nurses, and 2 Certified Nurse Aides</p> <p>Rosary Unit:</p> <p>1 Nurse Manager 8AM to 4 PM.</p> <p>Day shift - 1 Registered Nurses (Registered Nurses worked 11AM-3PM), 2 Licensed Practical Nurses, 4 Certified Nurse Aides</p> <p>Evening shift - 2 Licensed Practical Nurses, 4 Certified Nurse Aides</p> <p>Night Shift - 1 Licensed Practical Nurse, 2 Certified Nurse Aides</p> <p>[NAME] Unit</p> <p>Day shift 1 Registered Nurses, 1 Licensed Practical Nurse, 3 Certified Nurse Aides</p> <p>Evening shift - 3 Licensed Practical Nurses (1 Licensed Practical Nurse worked 3PM-8PM and 1 Licensed Practical Nurse worked 7PM-11PM), and 7 Certified Nurse Aides (2 Certified Nurse Aides worked 3PM-7PM, 1 Certified Nurse Aides worked 3PM-9PM, 1 Certified Nurse Aides worked 7PM-11PM)</p> <p>Night shift - 1 Licensed Practical Nurse and 2 Certified Nurse Aides</p> <p>Lourdes</p> <p>Day shift - 1 Registered Nurses, 2 Licensed Practical Nurses, 3 Certified Nurse Aides (1 Certified Nurse Aides worked 7AM-11AM)</p> <p>Evening shift - 2 Registered Nurses (1 Registered Nurse worked 3PM-9PM), 2 Licensed Practical Nurses, and 4 Certified Nurse Aides (1 Certified Nurse Aides worked 7PM-11PM)</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Night shift - 1 Registered Nurses, 1 Licensed Practical Nurses, and 1 Certified Nurse Aides</p> <p>The Staff Assignment Sheets that documented the actual numbers of nursing staff present to provide care in the facility on 10/09/2024 was documented as follows:</p> <p>[NAME] Unit:</p> <p>1 Nurse Manager from 8AM to 4 PM.</p> <p>Day shift - 1 Licensed Practical Nurse and 4 Certified Nurse Aides.</p> <p>Evening Shift - 2 Licensed Practical Nurse, 6 Certified Nurse Aides (1 of the Certified Nurse Aides worked from 3PM-7PM)</p> <p>Night Shift - 1 Licensed Practical Nurse, and 3 Certified Nurse Aides</p> <p>Rosary Unit:</p> <p>Day shift - 2 Licensed Practical Nurses, 3 Certified Nurse Aides</p> <p>Evening shift - 3 Licensed Practical Nurses (1 Licensed Practical Nurse worked 3PM-7PM), 4 Certified Nurse Aides (1 Certified Nurse Aides worked 3PM-7PM)</p> <p>Night Shift - 1 Licensed Practical Nurse, 2 Certified Nurse Aides</p> <p>[NAME] Unit</p> <p>Nurse Manager 8-4</p> <p>Day shift 1 Registered Nurses, 2 Licensed Practical Nurses, 3 Certified Nurse Aides</p> <p>Evening shift - 2 Licensed Practical Nurses (1 Licensed Practical Nurse worked 3PM-8PM), and 3 Certified Nurse Aides (1 Certified Nurse Aide worked 3PM-9PM, 1 Certified Nurse Aides 3PM-7PM)</p> <p>Night shift - 1 Licensed Practical Nurse and 1 Certified Nurse Aides</p> <p>Lourdes</p> <p>Day shift - 1 Registered Nurses, 3 Licensed Practical Nurses (1 Licensed Practical Nurse worked 11AM-3PM), 4 Certified Nurse Aides</p> <p>Evening shift - 5 Registered Nurses (2 Registered Nurses worked 3PM-7PM), 3 Licensed Practical Nurses (1 Licensed Practical Nurse worked 3PM-7PM), and 4 Certified Nurse Aides (1 Certified Nurse Aide worked 7PM-11PM)</p> <p>Night shift - 1 Registered Nurse, 1 Licensed Practical Nurses, and 3 Certified Nurse Aides</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The Staff Assignment Sheets that documented the actual numbers of nursing staff present to provide care in the facility on 10/10/2024 was documented as follows:</p> <p>1 Registered Nurse Supervisor for 3PM-7AM in the facility</p> <p>[NAME] Unit:</p> <p>1 Nurse Manager from 8AM to 4PM.</p> <p>Day shift - 2 Licensed Practical Nurse and 3 Certified Nurse Aides</p> <p>Evening Shift - 3 Licensed Practical Nurses (1 Licensed Practical Nurse worked 5:30-11), 5 Certified Nurse Aides</p> <p>Night Shift - 1 Licensed Practical Nurse, and 2 Certified Nurse Aides</p> <p>Rosary Unit:</p> <p>1 Nurse Manager 8AM-4PM</p> <p>Day shift - 2 Licensed Practical Nurses, 3 Certified Nurse Aides (1 Certified Nurse Aide worked 7AM-12PM)</p> <p>Evening shift - 2 Licensed Practical Nurses, 4 Certified Nurse Aides (1 Certified Nurse Aide worked from 3PM-7PM)</p> <p>Night Shift - 1 Licensed Practical Nurse, 2 Certified Nurse Aides</p> <p>[NAME] Unit</p> <p>Nurse Manager 8AM-4PM</p> <p>Day shift - 2 Licensed Practical Nurses, 4 Certified Nurse Aides (1 Certified Nurse Aide worked 11AM-3PM)</p> <p>Evening shift - 2 Licensed Practical Nurses, and 4 Certified Nurse Aides (1 Certified Nurse Aide worked 3PM-7PM)</p> <p>Night shift - 1 Licensed Practical Nurse and 2 Certified Nurse Aides</p> <p>Lourdes</p> <p>Day shift - 4 Registered Nurses (1 Registered Nurse worked 11AM-3PM), 3 Licensed Practical Nurses, 2 Certified Nurse Aides</p> <p>Evening shift - 2 Registered Nurses, 2 Licensed Practical Nurses, and 4 Certified Nurse Aides</p> <p>Night shift - 3 Licensed Practical Nurses, and 2 Certified Nurse Aides</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The Staff Assignment Sheets that documented the actual numbers of nursing staff present to provide care in the facility on 10/11/2024 was documented as follows:</p> <p>1 Registered Nurse Supervisor for 3PM-11PM in the facility</p> <p>[NAME] Unit:</p> <p>1 Nurse Manager from 8AM to 4 PM.</p> <p>Day shift - 2 Licensed Practical Nurse and 2 Certified Nurse Aides.</p> <p>Evening Shift - 2 Licensed Practical Nurses, 5 Certified Nurse Aides (1 of the Certified Nurse Aide worked from 7PM to 11PM.)</p> <p>Night Shift - 0 Licensed Practical Nurses, and 3 Certified Nurse Aides</p> <p>Rosary Unit:</p> <p>1 Nurse Manager 8AM - 4PM</p> <p>Day shift - 1 Registered Nurses, 2 Licensed Practical Nurses (1 Licensed Practical Nurse worked 7AM -11AM), 2 Certified Nurse Aides from 7AM -3PM and 1 Certified Nurse Aide from 6AM-11AM)</p> <p>Evening shift - 2 Licensed Practical Nurses, 3 Certified Nurse Aides</p> <p>Night Shift - 1 Licensed Practical Nurse, 1 Certified Nurse Aides</p> <p>[NAME] Unit</p> <p>Nurse Manager 8AM-4PM</p> <p>Day shift 1 Registered Nurse, 2 Licensed Practical Nurses, 3 Certified Nurse Aides</p> <p>Evening shift - 2 Licensed Practical Nurses (1 Licensed Practical Nurse worked 3PM-8PM), and 3 Certified Nurse Aides (1 Certified Nurse Aide worked 7PM-11PM)</p> <p>Night shift - 1 Licensed Practical Nurse and 1 Certified Nurse Aide</p> <p>Lourdes</p> <p>Day shift - 1 Registered Nurse, 4 Licensed Practical Nurses, 4 Certified Nurse Aides</p> <p>Evening shift - 3 Registered Nurses, 3 Licensed Practical Nurses, and 2 Certified Nurse Aides</p> <p>Night shift - 1 Registered Nurse, 2 Licensed Practical Nurses, and 1 Certified Nurse Aide</p> <p>The Staff Assignment Sheets that documented the actual numbers of nursing staff present to provide care in the facility on 10/12/2024 was documented as follows:</p> <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>1 Registered Nurse Supervisor for all shifts in the facility</p> <p>[NAME] Unit:</p> <p>Day shift - 1 Licensed Practical Nurse and 3 Certified Nurse Aides, 1 Service Associate.</p> <p>Evening Shift - 1 Licensed Practical Nurse, 4 Certified Nurse Aides (2 of the Certified Nurse Aides worked from 7PM to 11PM.)</p> <p>Night Shift - 1 Licensed Practical Nurse, and 2 Certified Nurse Aides</p> <p>Rosary Unit:</p> <p>Day shift - 2 Licensed Practical Nurses, 4 Certified Nurse Aides</p> <p>Evening shift - 2 Licensed Practical Nurses, 5 Certified Nurse Aides (2 Certified Nurse Aides worked 3PM-7PM)</p> <p>Night Shift - 1 Licensed Practical Nurse, 2 Certified Nurse Aides</p> <p>[NAME] Unit</p> <p>Day shift 3 Licensed Practical Nurses, 2 Certified Nurse Aides</p> <p>Evening shift - 2 Licensed Practical Nurses (1 Licensed Practical Nurse worked 3PM-7PM), and 4 Certified Nurse Aides</p> <p>Night shift - 1 Licensed Practical Nurse and 2 Certified Nurse Aides</p> <p>Lourdes</p> <p>Day shift - 3 Registered Nurses, 4 Licensed Practical Nurses, 4 Certified Nurse Aides (1 Certified Nurse Aide worked 11AM-3PM)</p> <p>Evening shift - 3 Registered Nurses (2 Registered Nurses worked 3PM-7PM and 1 Registered Nurse worked 7PM-11PM), 3 Licensed Practical Nurses, and 3 Certified Nurse Aides (1 Certified Nurse Aide worked 7PM-11PM)</p> <p>Night shift - 1 Registered Nurse, 2 Licensed Practical Nurses, and 2 Certified Nurse Aides</p> <p>The Staff Assignment Sheets that documented the actual numbers of nursing staff present to provide care in the facility on 10/13/2024 was documented as follows:</p> <p>1 Registered Nurse Supervisor for all shifts in the facility</p> <p>[NAME] Unit:</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Day shift - 1 Licensed Practical Nurse (Licensed Practical Nurse worked 5AM-1PM) and 3 Certified Nurse Aides.</p> <p>Evening Shift - 1 Licensed Practical Nurse, 4 Certified Nurse Aides (1 Certified Nurse Aide worked from 7PM to 11PM.)</p> <p>Night Shift - 0 Licensed Practical Nurses, and 3 Certified Nurse Aides</p> <p>Rosary Unit:</p> <p>Day shift - 2 Licensed Practical Nurses, 2 Certified Nurse Aides</p> <p>Evening shift - 4 Licensed Practical Nurses (1 Licensed Practical Nurse worked 3PM-5PM, 1 Licensed Practical Nurse worked 7PM-11PM), 5 Certified Nurse Aides (1 Certified Nurse Aide worked 3PM-7PM)</p> <p>Night Shift - 1 Licensed Practical Nurse, 2 Certified Nurse Aides</p> <p>[NAME] Unit</p> <p>Day shift - 2 Licensed Practical Nurses, 3 Certified Nurse Aides</p> <p>Evening shift - 2 Licensed Practical Nurses, and 1 Certified Nurse Aides</p> <p>Night shift - 1 Licensed Practical Nurse and 2 Certified Nurse Aides</p> <p>Lourdes</p> <p>Day shift - 2 Registered Nurses, 3 Licensed Practical Nurses (1 Licensed Practical Nurse worked 11AM-3PM), 2 Certified Nurse Aides (1 Certified Nurse Aide worked 11AM-3PM)</p> <p>Evening shift - 2 Registered Nurses (both worked 3PM-7PM), 2 Licensed Practical Nurses, 3 Certified Nurse Aides (1 Certified Nurse Aide worked 7PM-11PM)</p> <p>Night shift - 2 Licensed Practical Nurses and 1 Certified Nurse Aide</p> <p>The Staff Assignment Sheets that documented the actual numbers of nursing staff present to provide care in the facility on 10/14/2024 was documented as follows:</p> <p>[NAME] Unit:</p> <p>1 Nurse Manager from 8AM to 4 PM.</p> <p>Day shift - 1 Licensed Practical Nurse and 2 Certified Nurse Aides.</p> <p>Evening Shift - 2 Licensed Practical Nurse (1 Licensed Practical Nurse worked 4PM-7PM), 4 Certified Nurse Aides (1 of the Certified Nurse Aide worked from 7 PM to 11PM.)</p> <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Night Shift - 0 Licensed Practical Nurses, and 3 Certified Nurse Aides</p> <p>Rosary Unit:</p> <p>1 Nurse Manager 8AM-4PM</p> <p>Day shift - 1 Registered Nurse, 1 Licensed Practical Nurse, 3 Certified Nurse Aides</p> <p>Evening shift - 2 Licensed Practical Nurse, 3 Certified Nurse Aides (1 Certified Nurse Aide worked 4PM-9PM)</p> <p>Night Shift - 1 Licensed Practical Nurse, 2 Certified Nurse Aides</p> <p>[NAME] Unit</p> <p>Nurse Manager 8AM-4PM</p> <p>Day shift 1 Registered Nurses, 2 Licensed Practical Nurses, 4 Certified Nurse Aides</p> <p>Evening shift - 4 Licensed Practical Nurses (1 Licensed Practical Nurse worked 530PM-11PM and 1 Licensed Practical Nurse worked 7PM-11PM), and 2 Certified Nurse Aides (1 Certified Nurse Aide worked 3PM-6PM)</p> <p>Night shift - 1 Licensed Practical Nurse and 2 Certified Nurse Aides</p> <p>Lourdes</p> <p>Day shift - 2 Registered Nurses, 2 Certified Nurse Aides</p> <p>Evening shift - 3 Registered Nurses (1 Registered Nurse worked 3PM-9PM, 2 Registered Nurses worked 3PM-7PM), 1 Licensed Practical Nurse (worked 5PM-11PM), and 4 Certified Nurse Aides (1 Certified Nurse Aide worked 7PM-11PM, 1 Certified Nurse Aide worked 3PM-7PM, 1 Certified Nurse Aide worked 4PM-11PM)</p> <p>Night shift - 2 Licensed Practical Nurses, and 0 Certified Nurse Aides</p> <p>The Staff Assignment Sheets that document the actual numbers of nursing staff present to provide care in the facility on 10/15/2024 was documented as follows:</p> <p>[NAME] Unit:</p> <p>1 Nurse Manager from 8AM to 4PM.</p> <p>Day shift - 1 Licensed Practical Nurse and 3 Certified Nurse Aides.</p> <p>Evening Shift - 1 Licensed Practical Nurse, 5 Certified Nurse Aides</p> <p>Night Shift - 0 Licensed Practical Nurse, and 2 Certified Nurse Aides</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Rosary Unit:</p> <p>1 Nurse Manager 8AM-4PM</p> <p>Day shift - 1 Registered Nurse, 2 Licensed Practical Nurses, 4 Certified Nurse Aides</p> <p>Evening shift - 2 Licensed Practical Nurses, 5 Certified Nurse Aides (1 Certified Nurse Aide worked 3PM-7PM)</p> <p>Night Shift - 1 Licensed Practical Nurse, 1 Certified Nurse Aide</p> <p>[NAME] Unit:</p> <p>1 Nurse Manager from 8AM to 4PM.</p> <p>Day shift -1 Registered Nurses, 1 Licensed Practical Nurse, and 5 Certified Nurse Aides.</p> <p>Evening Shift - 3 Licensed Practical Nurses (1 Licensed Practical Nurse worked 7PM-11PM), 4 Certified Nurse Aides</p> <p>Night Shift - 1 Licensed Practical Nurse, and 1 Certified Nurse Aide</p> <p>Lourdes</p> <p>Day shift - 3 Registered Nurses (1 Registered Nurse worked 11AM-3PM), 3 Licensed Practical Nurses (1 Licensed Practical Nurse worked 11AM-3PM), 3 Certified Nurse Aides</p> <p>Evening shift - 3 Registered Nurses, 1 Licensed Practical Nurse, and 3 Certified Nurse Aides (1 Certified Nurse Aide worked 6PM-11PM)</p> <p>Night shift - 2 Licensed Practical Nurses, and 1 Certified Nurse Aide</p> <p>During general observations of [NAME] Unit on 10/08/2024 at 11:01 AM, Resident #93 was noted to be in their room, soiled and waiting for staff to come and assist them.</p> <p>During general observations of [NAME] Unit on 10/10/2024 at 7:37 AM, 2 call bells were noted to be ringing on [NAME] Unit, rooms [ROOM NUMBERS]. The call bell in room [ROOM NUMBER] was answered at 7:49 AM. The call bell in room [ROOM NUMBER] was answered at 8:12 AM.</p> <p>During general observations of [NAME] Unit on 10/13/2024 between 11:00 AM and 3:00 PM, call lights were noted to ring for 16-17 minutes before being answered during the evening shift. The first call light was engaged at 3:04 PM and answered at 3:20 PM; the second call light was engaged at 4:14 PM and answered at 4:31 PM.</p> <p>During general observations of Rosary Unit on 10/13/2024 at 2:48 PM, a red bathroom call light was engaged and not answered until 2:57 PM in room [ROOM NUMBER]. At the same time another call bell was initiated in room [ROOM NUMBER]. It was not answered until 3:21 PM.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Our Lady of Mercy Life Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2 Mercycare Lane Guilderland, NY 12084	
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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During general observations of Rosary Unit on 10/13/2024 at 2:56 PM, a strong urine odor was noted outside of room [ROOM NUMBER] and 225. The odor was still present at 3:15 PM.</p> <p>During the Resident Council meeting on 10/09/2024 at 10:32 AM, residents stated that they experienced long wait times when they used the call bell.</p> <p>During an interview on 10/08/2024 at 11:01 AM, Resident #93 stated that they were left soiled in bed waiting for assistance frequently, especially on weekends. They stated they have been left for hours without assistance.</p> <p>During an interview on 10/09/2024 at 9:54 AM, Resident #27 stated they took care of themselves because they were understaffed. The staffing problem was not just nights, it was also bad on weekends. Additionally, the resident stated that the call light was under the bed and always out of reach.</p> <p>During an interview on 10/09/2024 at 10:15 AM, Resident #76 stated that the unit had a staffing problem. Resident #76 stated that there was no Registered Nurses on some weekends.</p> <p>During an interview on 10/13/2024 at 2:47 PM, Certified Nurse Aide #3 and Certified Nurse Aide #4 stated that it was hard.</p> <p>During an interview on 10/15/2024 at 9:40 AM, Social Worker #1 was asked if residents could request more than 1 shower a week. Social Worker #1 stated that staff were encouraged not to say the facility was understaffed; staff would try to borrow aides from other units if it was really needed.</p> <p>During an interview on 10/16/2024 at 12:10 PM, Director of Nursing #1 stated staffing was a lot because they just got a new system to use for staffing. Additionally, to cover staffing holes, the staff would split shifts with managers. Incentives and bonuses were offered to entice staff to work extra shifts. The facility also used agency staff, but they were careful to choose agency staff that they believed would be a good fit for their teams. Certified Nurse Trainees were not counted in staffing plans. Director of Nursing #1 stated supervisors would come in to help if it was needed. There was always a registered nurse on call to come in if they were needed. When asked what the expectation was regarding timely call bell response, Director of Nursing repeatedly stated it depended on what was happening on the unit when the call bell went off and that it was hard to put a time limit on how long people should have had to wait for attention.</p> <p>48744</p> <p>During an interview on 10/16/2024 at 2:15 PM, Administrator #1 stated that staffing was always a part of the Quality Assessment meetings. The facility had been trying to recruit staff working with students and the training program. Additionally, Administrator #1 stated that they had an open-door policy and that the residents knew they could come and talk to them if the residents felt they were not being heard.</p> <p>During the exit conference on 10/16/2024 at 5:18 PM, Resident Representative #1 stated that the staff that were employed at the facility were great but that there were 'just not enough of them.'</p> <p>10 New York Code Rules and Regulations 415.13(a)(1)(i-iii)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>48615</p> <p>Based on observation, interview and record review conducted during a recertification survey, the facility did not ensure that its medication error rate did not exceed 5% for 1 (Resident #106) of 4 residents observed during a medication pass for a total of 28 observations. This resulted in a medication error rate of 17.86 percent.</p> <p>This is evidenced by:</p> <p>The Facility's Policy and Procedure titled Medication Administration, effective date: 12/21/2023, documented applicable to nursing responsibility, note times medications were due, doses to be held, and any other pertinent information. Note carefully the name, dose, amount of administration and expiration date. Be sure the frequency and time schedules correspond. Review the electronic Medical Administration Record, check for known allergies, prepare all medications for the individual resident observing the 5 Rights of Medication Administration 1. Right medication. 2 Right resident. 3 Right time. 4 Right route. 5 Right dose.</p> <p>Resident #106 was admitted to the facility with diagnosis of fracture around internal prosthetic hip joint; diverticulitis (inflammation of irregular bulging pouches in the wall of the large intestine) and atrial fibrillation (an irregular and often very rapid heart rhythm). The Minimum Data Set (an assessment tool) dated 9/05/2024, documented the resident was cognitively intact, could be understood, and understand others.</p> <p>A medication observation was conducted on 10/11/2024 at 9:29 AM on the Lourdes Unit, Side 2. Licensed Practical Nurse #1 administered Resident #106's medications, which included Carafate oral suspension 10 milliliters orally; Lovenox 40 milligram subcutaneous injection; Lidocaine External Patch 5% to left knee; 1 Protonix 40 milligrams delayed release tablet orally; 2 Colace 100 milligram capsules orally; 1 Lasix 20 milligram tablet orally; 1 hydrochlorothiazide 12.5 milligram tablet; 1 Losartan 100 milligram tablet.</p> <p>The current physician orders on the Medication Administration Record dated 10/2024 revealed that the resident should receive Carafate suspension before meals at 07:30 AM, Lovenox subcutaneous Injection Solution Prefilled Syringe 40 milligram at 08:00 AM. Lidocaine External Patch 5 % to left knee at 08:00AM, Protonix 40 milligrams at 08:00 AM.</p> <p>The current physician orders dated 08/31/2024 documented: Crush all allowable meds every shift. During a medication observation on 10/11/2024 at 09:29 AM, Licensed Practical Nurse #1 administered the following medications whole: 1 Lasix 20 milligram tablet orally; 1 hydrochlorothiazide 12.5 milligram tablet; 1 losartan 100 milligram tablet.</p> <p>During an observation on 10/11/2024 at 9:35 AM, Licensed Practical Nurse #1 was observed administering Carafate 10 milliliter suspension after Resident #106 consumed breakfast.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/11/2024 at 9:35 AM, Licensed Practical Nurse #1 stated they were late starting the medication pass due to short staffing, and they were passing 8:00 AM medications at 9:35 AM. Licensed Practical Nurse #1 stated they did not notify the physician of late medication pass and would notify the physician only if the medication were time sensitive. Otherwise, they would give the medication late at their discretion.</p> <p>During an interview on 10/15/2024 at 12:05 PM, Director of Nursing #1 stated all nursing staff received 5 days of classroom training upon hire. Afterwards they were assigned to a preceptor who completes skills checklist for nurses which included medication administration. In addition, all nurses were required to pass a medication administration exam prior to administering medication. They further stated that nursing staff completed annual competency training online.</p> <p>During an interview on 10/16/2024 at 11:47 AM, Nurse Educator #1 stated nursing staff completed a 3-to-5-day classroom training which included medication administration and documentation. Nursing staff were then assigned a preceptor to sign off on skills including medication administration. They further stated that nurses would then need to pass a medication administration exam prior to administering medication.</p> <p>10 New York Codes, Rules, and Regulations 415.12 (m)(1)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48615</p> <p>Based on observation, record review, and interviews conducted during the recertification survey, the facility did not ensure drugs and biologicals were labelled and stored in accordance with professional standards of practice. Specifically, (a.) opened medications had no open and/or expiration dates; (b.) medication carts were left unlocked while unattended. (c.) personal items were stored in a medication cart; (d.) a pre-poured medication cup was noted at a resident's bedside; and (e.) a narcotic lock box had a broken lock. This was evident for 4 out of 5 medication carts reviewed ([NAME] Unit Cart #1; Lourdes Unit Cart #1; Lourdes Unit side 2 back half; [NAME] Unit Cart #2), and for 1 out of 5 narcotic lock boxes reviewed ([NAME] Unit).</p> <p>This is evidenced by:</p> <p>The Facility's Policy and Procedure titled, Storage and Expiration Dating of Medications and Biologicals, revised on [DATE] documented:</p> <ul style="list-style-type: none"> - Once any medication or biological package was opened, facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the primary medication container (i.e., vial, bottle, inhaler) when the medication has a shortened expiration date once opened. Facility staff may record the calculated expiration date based on date opened on the primary medication container. If a multi-dose vial of an injectable medication had been opened or accessed (example, needle punctured), the vial should be dated and discarded within 28 days unless the manufacturer specified a different (shorter or longer) date for that opened vial. - When an ophthalmic solution or suspension has a manufacturer shortened beyond use date once opened, facility staff should record the date opened and the date to expire on the container. Facility should ensure that resident medication and biological storage areas were locked and did not contain non-medication/biological items. - (In New York- controlled substances must be securely stored in a double locked cabinet, affixed to the wall or floor until the beginning of the medication pass. Upon completion of the medication pass controlled substances must be returned to the cabinet.) <p>Facility should store bedside medications or biologicals in a locked compartment within the resident's room.</p> <ul style="list-style-type: none"> - Facility staff should evaluate the continued sterility of the product based on clinical judgment or contamination of the dispenser after contact with eye, eyelid, lashes or finger removed reference to expire all ophthalmic solutions and suspensions 28 days after opening. <p>The Facility's Policy and Procedure titled Medication Administration, effective date: [DATE], documented applicable to nursing responsibility. The nurse who prepared the medication must administer it. Never leave the medication at the bedside unless ordered by the physician.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on [DATE] at 2:31 PM, [NAME] Unit, medication Cart 1 contained 1 Basaglar and 1 Fiasp insulin pens with open dates and 30 day instead of 28 day expiration dates; 1 Aspart insulin pen with open date but no expiration date; 1 Lantus and 1 Lispro insulin pen with open date and no expiration date. At the time of observation, Licensed Practical Nurse #2 was unable to verbalize correct expiration date. [NAME] Unit Team 1 narcotic lock box inside lock was broken.</p> <p>During an interview on [DATE] at 2:31 PM, Licensed Practical Nurse #2 stated the lock sometimes got stuck and they left it open. The unit received new narcotic boxes last month that have not worked properly since they received them. Licensed Practical Nurse #2 stated the Unit Manager had been out sick and several other managers were covering. They stated they did not put in a work order for the broken lock.</p> <p>During an observation on [DATE] at 9:58 AM, Lourdes Unit, Cart #1 contained 1 expired Lispro insulin pen, open date was [DATE], expiration date was [DATE] greater than 28-day manufacturer recommendation.</p> <p>During an observation on [DATE] at 10:26 AM, Lourdes Unit, Cart #2 contained 1 Lispro pen with no open and no expiration date, 1 Glargine insulin pen with open date of [DATE] but no expiration date.</p> <p>During an observation on [DATE] at 11:23 AM, Resident #247 was noted to have a medication cup with 2 pills left at the bedside.</p> <p>During an observation and interview on [DATE] at 10:03 AM, [NAME] Unit, Medication Cart #1 was observed unattended and unlocked. On [DATE] at 11:08 AM, [NAME] Unit, Medication Cart #1 was observed unattended and unlocked. Registered Nurse #10 stated this was not their norm, and they were usually diligent about locking medication cart.</p> <p>During an observation on [DATE] at 2:45 PM, [NAME] unit, Medication Cart #1 was unattended and unlocked. Licensed Practical Nurse # 5 stated they forgot to lock the cart. It was not their norm, but this was not their unit and at that time it was hectic.</p> <p>During an observation on [DATE] at 10:51 AM, [NAME] Unit, Medication Cart #2 contained two pair of eyeglasses; 1 eyeglass case, 1 watch; 1 television remote in the drawer along with 2 insulin syringes and five 10cc syringes.</p> <p>During an interview on [DATE] at 12:05 PM, Director of Nursing #1 stated all nurses attended general orientation including medication administration and 5 days of classroom training. Nurses were then assigned to a preceptor who would sign nurse off on skills. Each nurse was required to pass a medication competency exam prior to administering medication. Nurses were required to complete annual competencies via online training (HealthStream). Director of Nursing # 1 stated there were no residents currently in the facility who self-medicate. During medication administration, medication should never be left at the bedside.</p> <p>During an interview on [DATE] at 11:47 AM, Nurse Educator #1 stated all nurses completed a 3-day classroom training including medication administration. Before administering medication, the nurse should note the open and expiration dates. Upon opening a new multi vial dose medication, the nurse was to label medication with open and expiration dates. Additional training was annually and as needed. Nurses must pass a medication administration exam prior to passing medications.</p> <p>(continued on next page)</p>		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10 New York Codes, Rules, and Regulations 415.18(d)		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>48413</p> <p>Based on observation and interviews during the recertification survey, the facility did not ensure that food was stored, prepared, distributed, or served in accordance with professional standards for food service safety in 3 of 4 resident unit (Units two, three, and four) kitchenettes. Specifically, appliances and surfaces were not clean.</p> <p>This is evidenced by:</p> <p>A review of the policy titled Sanitation and Infection Prevention/Control revised on January, 2024 documented that the supervisor would assign special cleaning tasks on a daily basis which included kitchenette refrigerators.</p> <p>During observations on Unit two on 10/08/2024 at 10:56 AM, the resident kitchenette was dirty, and dust-covered on the top of the refrigerator, and food particles were not cleaned on the freezer and refrigerator seals. The freezer also had ice build-up inside and around the seals.</p> <p>During observations on Unit three on 10/08/2024 at 11:13 AM, the resident kitchenette was dirty, and dust-covered on the top of the refrigerator, and food particles were not cleaned on the freezer and refrigerator seals. The freezer also had ice build-up inside and around the seals. The microwave oven had food particles inside, and the coffee machine had excessive build-up on the screen at the bottom of the machine.</p> <p>During observations on Unit four on 10/08/2024 at 11:24 AM, the resident kitchenette was dirty, and dust-covered on the top of the refrigerator, and food particles were not cleaned on the freezer and refrigerator seals. The refrigerator and freezer door seals were cracked and broken. It appeared the facility attempted to correct the problem by placing a sealant or caulking in the seal.</p> <p>During an interview on 10/10/2024 at 09:51 AM, Director of Food Services #1 stated staff should be cleaning the kitchenettes every day and signing off when done. They stated the outside and seals were cleaned by environmental service individuals. The Director of Food Services was shown the refrigerators and seals. They stated they should not have been like that and should have been cleaned or reported to maintenance.</p> <p>During an interview on 10/11/2024 at 12:34 PM, Environmental Services Supervisor #1 stated their staff was responsible for cleaning the kitchenettes and outside of the refrigerators and freezers weekly as well as wiping down the seals of the refrigerators. The Environmental Services Supervisor was shown the refrigerators and seals. They stated they should not have been like that and should have been cleaned or reported to maintenance. They stated they would discuss the cleaning with their staff.</p> <p>During an interview on 10/11/2024 at 2:34 PM, Director of Maintenance #1 stated they were notified on 10/10/2024 about the seals on the refrigerator in unit 4. They stated that they were not notified of the issue before yesterday. They stated they ordered new seals for the refrigerator and freezer, and they would be arriving on Thursday 10/16/2024.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a subsequent interview on 10/15/2024 at 11:54 AM, Director of Maintenance #1 stated they received the seals for the refrigerator and freezer that day and would replace them.</p> <p>10 New York Codes, Rules, and Regulations 415.14(h)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>51609</p> <p>Based on observations and staff interviews during the recertification survey, the facility did not ensure infection prevention control practices were followed to help prevent the spread, development, and transmission of communicable diseases and infections. Specifically, the staff did not use proper hand hygiene practices while placing clothing protectors on residents and preparing resident meal trays.</p> <p>This is evidenced by:</p> <p>The facility 2024 Infection Prevention and Control and Antibiotic Stewardship Plan-Continuing Care Division 2024 documented that the facility would maintain a continuing educational program for all personnel related to the prevention and control of infections and the use of Standard Precautions.</p> <p>During an observation on 10/08/2024 at 12:33 PM, Dietary staff had gloves on and picked up plates to stack on the top of the warming cart, took the cord from the warming cart and plugged it into the wall, stood up and flipped the switch on the wall. The Dietary staff then grabbed utensils for serving and placed them in the respective foods, picked up a plate and sat it on the warming cart. They then went over to the standing tray cart and pulled out a tray of sandwiches took a couple back over to the warming cart opened one of them and placed it on a plate, and then prepared to plate food for a resident by grabbing a resident ticket all without changing gloves. The Dietary staff then grabbed a prepared hamburger and placed it on a plate for a resident using the same gloved hands.</p> <p>During an interview on 10/08/2024 at 12:46 PM, Registered Nurse #2 confirmed dietary staff should not have touched the cart cord, the power switch, the tickets, and all the rest without having changed gloves and perform hand hygiene. Registered Nurse #2 attempted to educate the dietary staff, returned and stated they would have another dietary staff come finish serving. Registered Nurse #2 stated that staff were educated upon hire and annually on infection control practices.</p> <p>During an interview on 10/16/2024 at 11:40 AM, Registered Nurse #3 stated dietary staff should not have worn the same gloves and touched dirty objects and then touched foods. Registered Nurse #3 stated that the staff were educated upon hire and annually as well as when they went around and saw that on the spot education was needed regarding infection control.</p> <p>10 New York Code of Rules and Regulations 415.19(b)(4)</p>