| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 335793 | A. Building<br>B. Wing | 12/19/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Kendal at Ithaca | 2230 North Triphammer Road<br>Ithaca, NY 14850 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46276<br><br>Based on observations, record review, and interviews during the recertification survey conducted 12/16/2024-12/19/2024, the facility did not ensure the development and implementation of a comprehensive person-centered care plan for 2 of 2 residents (Resident #7 and #37) reviewed. Specifically, Resident #7 did not have a care plan for oxygen use, and Resident #37's fall prevention care planned interventions were not consistent with the care instructions and point of care tasks.<br><br>The facility policy, Fall Prevention Program, revised 1/19/2016, documented after each resident fall, the interdisciplinary team would update the resident's fall care plan and the nurse doing the incident report would add any interventions immediately to the resident's fall care plan.<br><br>The facility policy, Care planning/Interdisciplinary Team, revised 12/15/2019, documented the Interdisciplinary Team would provide person centered care plans for the residents. The care plan was available to all disciplines, was used to guide care, and contained a list of problems, goals, and approaches in use.<br><br>The facility policy, Incidents/Accidents, revised 10/15/2021, documented if after a fall the nurse placed new interventions into the care plan, a care plan update alert would be sent to nursing staff, including nurses and certified nurse aides.<br><br>1) Resident # 7 had diagnoses including respiratory syncytial virus (RSV), asthma, and pneumonia. The 10/23/2024 admission Minimum Data Set assessment documented the resident had intact cognition, was independent for activities of daily living, and used oxygen.<br><br>The 10/17/2024 Admission Assessment completed by Registered Nurse #25 documented the resident had rhonchi (coarse, low-pitched, bubbling sounds heard in the lungs during breathing) in all lung fields, had a productive cough, and did not use oxygen.<br><br>Physician orders documented:<br><br>- on 10/19/2024 oxygen 2 liters via nasal cannula as needed.<br><br>- on 10/22/2024 oxygen 2-3 liters via nasal cannula as needed with a goal to keep oxygen saturations at 94% and above.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - on 11/21/2024 oxygen 2-3 liters via nasal cannula, as needed with a goal to keep oxygen saturations at 92% and above.<br><br>The Comprehensive Care Plan initiated 10/21/2024 documented the resident had shortness of breath related to asthma, pneumonia, and respiratory syncytial virus. Interventions included medications per physician orders, keep head of bed elevated as much as resident tolerated, assist with activities of daily living, maintain droplet precautions, and notify physician of any changes in condition.<br><br>The Comprehensive Care Plan did not include oxygen therapy.<br><br>The 11/1/2024 Care Plan Meeting documented the resident was diagnosed with respiratory syncytial virus during an emergency room visit on 10/14/2024 and admitted to the facility on [DATE]. The resident had been on supplemental oxygen via nasal cannula. On 10/31/2024 the resident's oxygen saturation (amount of oxygen in blood) dropped while on 2 liters of oxygen. The resident was sent to the emergency room and returned the same day with a diagnosis of pneumonia.<br><br>During an interview on 12/19/2024 at 8:37 AM, Registered Nurse # 4 stated physician orders were either placed into the computer or given verbally and nursing was given discretion regarding treatment orders. Registered Nurse #4 stated the resident required oxygen and their physician order was oxygen as needed. Oxygen was not on the resident's care plan, and it should have been. They stated the Unit Manager was responsible for care plans.<br><br>During an interview on 12/19/2024 at 10:31 AM, Registered Nurse Unit Manager #6 stated oxygen required a physician order and should be on the care plan. They were responsible for developing and updating the comprehensive care plans. Care plans were reviewed quarterly and more often if the situation warranted a review. Registered Nurse #6 stated the resident was on oxygen and should have been care planned for it. It was important to have oxygen care planned to ensure the resident was receiving the correct therapy.<br><br>During an interview on 12/19/2024 at 11:12 AM, the Director of Nursing stated Registered Nurse Unit Manager #6 was responsible for monitoring and updating care plans. Care plans were reviewed and updated quarterly, during significant changes and as needed if there were a change with the resident. All information on the care plans, point of care, and resident care instructions should be consistent and match to ensure staff knew how to care for the resident.<br><br>2) Resident #37 had diagnoses including dementia and history of falls. The 10/10/2024 Minimum Data Set assessment documented the resident had severely impaired cognition, required maximum assistance with most activities of daily living, had a motion sensor alarm, had two or more falls with no injuries and one fall with a non-major injury.<br><br>Fall Incident Reports documented the following interventions:<br><br>- on 8/31/2024 at 10:30 AM the resident would have a Dycem and a cushion in their wheelchair to prevent further sliding.<br><br>- on 9/21/2024 at 7:31 AM the resident had a motion sensor.<br><br>- on 10/14/2024 at 7:25 PM the resident had a motion detector.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - on 11/9/2024 at 4:50 AM the resident had a motion detector for staff to use at their discretion.<br><br>- on 12/8/2024 at 5:30 AM the resident had a low bed and floor mat.<br><br>The Comprehensive Care Plan, revised 12/2/2024, documented the resident was at risk for falls. Interventions included Dycem (a non-slip pad) to be used in their chair. Interventions did not include a motion sensor alarm or a low bed with floor mattress when in bed.<br><br>The certified nurse aide daily charting tasks documented the resident had a low bed with floor mattress when in bed. There was no documentation for use of Dycem or a motion detector.<br><br>The 12/17/2024 resident care instructions (care card) documented Resident #37 had a motion detector. There was no documented evidence of a low bed, mattress on the floor, or use of Dycem.<br><br>During an observation on 12/18/2024 at 9:21 AM, there was no motion detector in or outside the resident's room.<br><br>During an observation on 12/18/2024 at 1:31 PM, the resident's wheelchair was in their bathroom. There was no Dycem on or underneath the chair cushion.<br><br>During an interview on 12/18/2024 at 1:36 PM, Registered Nurse #4 stated the care cards were updated by Registered Nurse Manager #6 and had information regarding mobility, diet, and any safety interventions. The certified nurse aides were expected to take a copy of one each day to review.<br><br>During an interview on 12/19/2024 at 8:53 AM, Certified Nurse Aide #5 stated the care cards included fall prevention interventions such as motion detectors and grips on the floor. Dycem, low beds, and floor mats would not be listed on the care card but would be listed as a daily documentation task. It was their responsibility to make sure those interventions were in place. Daily documentation of tasks was usually completed at the end of the day. It was possible something could be missed in the interim of the start of the shift and when charting was completed if interventions were not listed on the care card. Resident #37 fell frequently. They had a low bed, a mattress on the floor, and a motion detector. Only the motion detector was listed on the care card. They got the resident up that morning and thought the detector was on their mattress when they did so. After checking the resident's room, they stated they could not find the motion detector. They did not believe the resident was supposed to have Dycem in their chair as it was not in their chair that morning and they did not put one in the chair. After checking the resident's cushion, they confirmed there was no Dycem on or under the cushion. If something was on the care card it was important it was in place to make sure residents were safe and did not fall.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 12/19/2024 at 9:44 AM Registered Nurse Unit Manager #6 stated they updated the care plans. Unit Clerk #11 generated and updated the care cards based on alerts and communication they received from the interdisciplinary team members. There was not a process in place to check for accuracy. They expected specific fall prevention measures to be in the care plan, on the care card, and listed as a daily documentation task. The aides usually charted after lunch and if interventions were listed as a daily documentation task, but not on the care card then some interventions could be missed until later in the day when charting occurred. Resident #37 had multiple falls from both the bed and chair. Their current care plan interventions included Dycem to the chair. It did not include a motion detector, a low bed, or a floor mat. They thought a low bed and floor mattress had been put in place but was unsure as it was not listed on their care plan. The resident's care card listed a motion detector as the only safety precaution, but it had been discontinued due to a decline in mobility. It did not list a low bed, floor mattress, or Dycem. The only safety related daily documentation task was a low bed with floor mattress. The resident should not have a motion detector, a floor mattress, or low bed because it was not on their care plan. They should have Dycem because it was on their care plan. Consistent, accurate resident care information was important because the resident could fall, roll out of bed, and get injured.<br><br>During an interview on 12/19/2024 at 11:12 AM the Director of Nurses stated the registered nurses were responsible for monitoring and updating the care plans. Care plans were reviewed/updated quarterly, with significant changes, and as needed. All information on the care plan, daily documentation tasks, and care card instructions should be consistent and match. This was important for resident safety, consistency, and so staff knew what they should be doing for the residents.<br><br>10NYCRR 415.11(c)(1)<br><br>50561 |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>46276<br><br>Based on observations, record review, and interviews during the recertification survey conducted 12/16/2024-12/19/2024, the facility did not ensure residents received adequate supervision to prevent accidents for 1 of 6 residents (Resident #146) reviewed. Specifically, Resident #146 had a stroke, was on comfort care measures, could not swallow, did not have a clear diet consistency order, and was assisted with eating food before a swallowing evaluation was performed to determine the appropriate diet consistency.<br><br>Findings include:<br><br>The facility policy, Diet Order Procedures, dated 5/2015, documented the following diets had been approved for use in the facility and approved by the Medical Director and Dietitian as defined in the diet manual for long-term care residents: house diet, no added salt, limited concentrated sweets, full liquid, clear liquid, regular or normal consistency, mechanical soft and pureed.<br><br>The facility policy, Consistency of Foods, revised 4/2018, documented upon admission the resident would have a diet as ordered by the physician and a consistency best tolerated by the resident. This would be dependent on the resident's ability to chew and swallow.<br><br>The undated facility policy, Comfort Care Protocol Orders, documented diet and activity as tolerated. If unable to swallow, make nothing by mouth and discontinue all by mouth medications.<br><br>The undated Pleasure Feeding Guidelines documented a physician order would be required for pleasure feeding and a resident assessment would be completed by a physician, licensed nurse, or dietitian to assess the suitability for pleasure feeding. Factors considered would be swallowing, dental status, cognition, and medical conditions. Staff would follow safe feeding practices including positioning the resident upright, giving small amounts of food or fluids, and monitoring for signs/symptoms of choking or aspiration (inhaling food into the lungs).<br><br>Resident #146 had diagnoses including cerebral infarct (stroke) The Minimum Data Set admission assessment had not yet been completed.<br><br>The 12/13/2024 Admission Assessment completed by Registered Nurse #18 documented the resident was dependent for all activities of daily living; was rarely/never understood; and was not oriented to person, place, or time.<br><br>The 12/13/2024 Comprehensive Care Plan documented:<br><br>- the resident had impaired functional status related to stroke and was on comfort care. A decline in functional status was anticipated. Interventions included extensive assistance of 1 for eating and diet as tolerated.<br><br>- the resident was at risk for weight loss due to swallowing and chewing problems related to stroke.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interventions included the resident would be provided with foods that brought them comfort or pleasure as long as they could safely tolerate them; the resident was fed by the nursing staff; and the resident would be provided with a physician diet order and consistency as tolerated.<br><br>The undated resident care instructions documented Resident #146's dietary needs were a normal consistency, thin liquid, house diet.<br><br>The 12/13/2023 Physician #23 order documented nothing by mouth. That order was discontinued on 12/14/2024.<br><br>A 12/13/2024 at 6:58 PM Registered Nurse #6 progress note documented the resident arrived via stretcher for admission, had a stroke with right sided facial droop and weakness, had a nothing by mouth diet order, and all by mouth medications were discontinued. Comfort measures were put in place with opioid pain medications (Morphine) and anti-anxiety medications (Lorazepam).<br><br>The 12/14/2024 Physician #23 order documented diet as tolerated with a stop date of 12/18/2024.<br><br>A 12/14/2024 at 2:45 PM Licensed Practical Nurse #20 progress note documented the resident's diet order was changed to as tolerated. Resident #146 was given mashed potatoes, pudding, and honey thickened juice. The feeding was discontinued due to the resident pocketing food and their inability to swallow.<br><br>A 12/15/2024 at 11:12 AM Registered Nurse #4 progress note documented Physician #23 met with the resident's family. The resident's medical conditions were discussed with the family. Recommendation was made for thickened water due to the resident pocketing food, and a trial feeding pending a speech evaluation scheduled for Tuesday (12/17/2024). The family agreed to pleasure feedings with attempts to give thickened water until the speech evaluation was completed.<br><br>A 12/16/2024 at 2:53 PM Registered Nurse Unit Manger #6 progress note documented they received a phone call from Physician #23 regarding the resident's nothing by mouth diet order. A new order for a speech evaluation was received.<br><br>A 12/16/2024 at 11:47 PM Registered Nurse #25 progress note documented the resident had honey thickened tomato soup, a Magic Cup (a protein rich ice cream), and honey thickened juice for dinner. The resident appeared to work hard to swallow.<br><br>A 12/17/2024 at 1:17 PM Registered Dietitian #10 progress note documented the resident was fed mashed potatoes and honey thickened liquids for lunch. The resident held food in their mouth and then swallowed. A speech evaluation was scheduled for 12/19/2024.<br><br>A 12/17/2024 at 3:50 PM Speech Language Pathologist #22's swallowing evaluation documented Resident #146 was seen for acute onset of dysphagia (difficulty swallowing) related to a stroke. The resident's current dietary intake was moderately thick (honey thick) and pureed consistencies. The resident's positioning was inadequate and led to decreased safety. The resident's overall assessment was moderately severe oropharyngeal dysphagia (impaired ability to swallow), and their risk was exacerbated due to poor clearance of materials via cough. Recommendations were to continue comfort care measures with continued attention to oral hygiene and frequent positioning and to allow oral intake for pleasure as awake status permits. A further decline in status was expected.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A 12/18/2024 at 1:40 PM Registered Dietitian #10 progress note documented they approached the resident's family representative regarding food allergies. The family representative expressed Resident #146 was not going to eat food and further discussion was not necessary.<br><br>The following observations of Resident #146 were made:<br><br>- on 12/16/2024 at 12:45 PM, Registered Nurse #6 was feeding the resident an undetermined soup and mashed potatoes.<br><br>- on 12/17/2024 at 12:17 PM, the resident was served a bowl of soup.<br><br>- on 12/17/2024 at 12:24 PM, Certified nurse aide #21 was assisting the resident at lunch and feeding them soup. The head of the resident's wheelchair was positioned at approximately 30 degrees.<br><br>During an interview on 12/17/2024 at 12:19 PM, Health Care Dining Attendant #19 stated they did not have a meal ticket for the resident and did not know what kind of diet the resident received.<br><br>During an interview on 12/17/2024 at 12:21 PM Licensed Practical Nurse #20 stated the resident came into the facility with a nothing by mouth diet order and the next day Physician #23 changed the diet to as tolerated. They stated the resident had not had a speech or swallowing evaluation. They did not know if the resident should be fed prior to the evaluation and was just following their supervisor's orders. They stated the family had initiated comfort care measures per the resident's Medical Orders for Life Sustaining Treatment form.<br><br>During an interview on 12/17/2024 at 12:27 PM Certified Nurse Aide #21 stated the resident was receiving a honey-thickened diet, it was not documented, and they knew how to feed a resident with a stroke based on their care instructions. They stated Resident #146's care instructions documented a house, regular consistency, thin liquid diet and that was not correct. The risk of a resident receiving an incorrect diet order could be pocketing the food and not swallowing it.<br><br>During an interview on 12/19/2024 at 8:50 AM, Registered Nurse #4 stated all residents required a physician order for their diets. An as tolerated diet was not sufficient, it did not specify what was allowed on the diet. They stated Resident #146 had not done well on their swallowing evaluation in the hospital and the family stated if the resident could not feed themself, they did not want staff to feed them. If staff were unsure how to feed the resident, they should not have fed them and should have called the physician for clarification. The resident should have remained on a nothing by mouth diet order until a swallowing evaluation was conducted. The resident was at risk for choking and aspiration without a proper diet consistency order.<br><br>During an interview on 12/19/2024 at 9:32 AM, Registered Dietitian #10 stated residents' diet orders would be on the hospital discharge summary. They relied on nursing to advise them what consistency food the resident could tolerate. Resident #146 had an as tolerated diet, and they did not know what that meant. Registered Dietitian #10 stated the resident had a severe stroke, could not make their needs known, and had been fed prior to a speech and swallowing evaluation. They stated they watched the resident eat and they held food in their mouth for a very long time. A house diet with regular consistency and thin liquids would not be appropriate for the resident.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 12/19/2024 at 10:17 AM, Registered Nurse Unit Manager #6 stated the resident came to the facility with a nothing by mouth diet order and it was changed to as tolerated. Feeding instructions for staff were not documented in the resident's electronic medical record. All residents should have a proper diet consistency order to prevent choking or aspiration. The resident's care instructions documented a house diet with regular consistency and thin liquids and that was not correct.<br><br>During an interview on 12/19/2024 at 10:50 AM, the Director of Nursing stated Resident #146 came to the facility with a nothing by mouth diet order and Physician #23 changed it to as tolerated. The diet order should have been more specific. A registered nurse could do an assessment for eating but they did not think a licensed practical nurse trialed the resident with food. They stated Licensed Practical Nurse #20 had fed the resident mashed potatoes and pudding but was unsure if it was a trial for feeding.<br><br>During an interview on 12/19/2024 at 11:47 AM, Speech Language Pathologist #22 they received Resident #146's order for an evaluation on 12/17/2024 and completed the evaluation. The resident had right sided weakness with facial droop and had failed the speech and swallowing evaluation due to severe weakness and inability to swallow. An as tolerated diet should have a consistency ordered and it was unsafe for staff to assist the resident with eating with their head at a 30-degree angle as it could increase their risk for choking and aspiration. They stated the resident's care instructions were incorrect in listing the resident's diet as a house diet, regular consistency, thin liquids. This could cause confusion as to how to assist the resident with eating.<br><br>During an interview on 12/19/2024 at 12:20 PM Physician #23, stated they visited Resident #146 on 12/14/2024 and the resident was alert. They changed the diet order from nothing by mouth to as tolerated. Nursing staff would know how to feed the resident from experience of feeding residents with dysphagia. They stated they did not think an as tolerated diet would need a consistency order as it was trial and error. Family agreed to pleasure feedings. Physician #23 did not think pleasure feedings required an order and nursing could trial the resident before a speech evaluation. They stated Speech Language Pathologist #22 was not available on the weekends and the resident would have been required to return to the hospital for a formal swallowing evaluation and the family opted out of sending them.<br><br>10NYCRR 415.12 (h) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>46276<br><br>Based on observations, record review, and interviews during the recertification survey conducted 12/16/2024-12/19/2024, the facility did not ensure residents received respiratory care consistent with professional standards of practice for 1 of 1 resident (Resident #7) reviewed. Specifically, Resident #7 had a physician order for oxygen at 2-3 liters per minute via nasal cannula to keep oxygen saturations (amount of oxygen in the blood stream) above 92%, the resident received continuous oxygen, oxygen saturation readings were consistently above 92% and taken while the resident was on oxygen.<br><br>Findings include:<br><br>The facility policy, Storage, Transportation and Administration of Oxygen, revised 8/2023, documented the administration of oxygen required a physician, physician assistant or nurse practitioner order. Such orders should contain the following: delivery method (nasal cannula, oxygen mask, variable flow mask, nonrebreather mask), liter flow or oxygen percentage, continuous, as needed, or use titrated to pulse oximetry. In cases where an order is given to titrate the liter flow based on pulse oximetry readings, the order must also include a maximum liter flow. Delivery method would not be changed without a physician order.<br><br>Resident # 7 had diagnoses of respiratory syncytial virus (RSV, a respiratory virus), asthma, and pneumonia. The 10/23/2024 admission Minimum Data Set assessment documented the resident had intact cognition, was independent for their activities of daily living, and used oxygen.<br><br>The Comprehensive Care Plan initiated 10/21/2024 documented the resident had shortness of breath related to asthma, pneumonia, and respiratory syncytial virus. Interventions included medications per physician orders, keep head of bed elevated as much as resident tolerated, assist with activities of daily living, maintain droplet precautions, and notify physician of any changes in condition. Oxygen therapy was not included on the Comprehensive Care Plan.<br><br>The 11/21/2024 Physician #12 order documented oxygen 2-3 liters per minute via nasal cannula as needed with goal oxygen saturation levels at or above 92%.<br><br>The resident was observed receiving oxygen by an oxygen concentrator at 2 liters per minute via a nasal cannula on 12/16/2024 at 10:44 AM, 12/17/2024 at 9:13 AM, 12/18/2024 at 8:35 AM, and 12/19/2024 at 8:35 AM.<br><br>Resident #7's oxygen saturation levels were documented as 92%-98% from 12/1/2024-12/19/2024.<br><br>During an interview on 12/19/2024 at 8:13 AM Certified Nurse Aide #13 stated the resident was admitted 3 months ago, had a respiratory virus, and was on oxygen. The resident had been off oxygen for a short period of time when they were first admitted but now used it all the time.<br><br>(continued on next page) |

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| Kendal at Ithaca | 2230 North Triphammer Road<br>Ithaca, NY 14850 |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 12/19/2024 at 8:37 AM, Registered Nurse # 4 stated Resident #7's oxygen order was as needed and their oxygen saturation levels were between 92% and 96%. They stated the oxygen saturation levels were taken while the resident was on oxygen, they wore it continuously, and did not think the resident had ever been trialed off oxygen. If a resident required oxygen continuously, the physician order should have been changed.<br><br>During an interview on 12/19/2024 at 10:31 AM, Registered Nurse Unit Manager #6 stated Resident #7 required oxygen and their physician order documented oxygen 2-3 liters per minute via nasal cannula as needed with goals to keep oxygen saturations above 92%. If a resident required continuous oxygen, the order should be changed. It was important for the resident to have the correct oxygen order, so they did not retain too much carbon dioxide.<br><br>During an interview on 12/19/2024 at 10:40 AM, the Director of Nursing stated a resident receiving oxygen required a physician order and should not be on oxygen continuously if the order documented as needed. Resident #7's order documented oxygen was as needed to keep their oxygen saturations above 92%. If they required it continuously, nursing should have called the physician to have the order changed. The risk of a Resident #7 receiving oxygen on a continuous basis with an as needed order could result in unnecessary use of the oxygen.<br><br>10 NYCRR 415.12(k)(6) |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.<br><br>48675<br><br>Based on observations, record review, and interviews during the recertification survey conducted 12/16/2024-12/19/2024, the facility did not to obtain informed consent (including risks and benefits) from the resident or the resident representative prior to the installation of bed rails (side rails) for 1 of 1 resident (Resident #6) reviewed. Specifically, there was no documented evidence informed consent was obtained for the placement of bilateral bed rails on Resident #6's bed.<br><br>Findings include:<br><br>The facility policy, Side Rails/Positioning Bars and Restraints, revised 12/5/2018, documented the use of side rails or positioning bars on beds would be permitted when the following conditions were met:<br><br>-The resident was evaluated to be appropriate for side rail or positioning bar use as indicated on the side rail/positioning bar evaluation form and would be reviewed at least quarterly by the interdisciplinary care plan team.<br><br>-The use of side rail or positioning bar would be included in the plan of care as a measure to enhance resident mobility, or for independent use of bed controls.<br><br>-An order would be obtained from the physician.<br><br>-Side rails or positioning bars could be used at any time with staff present but returned to the original down position prior to leaving the room.<br><br>The policy did not document obtaining informed consent prior to the installation of side rails.<br><br>Resident #6 had diagnoses including difficulty in walking, age related osteoporosis (bones become weak and brittle), and muscle wasting and atrophy (shrinkage and loss of function). The 11/15/2024 Minimum Data Set assessment documented the resident had severe cognitive impairment, required substantial/maximal assistance with bed mobility and transfers, and did not use bed rails.<br><br>The Comprehensive Care Plan initiated 5/15/2023, documented the resident had impaired functional status on admission to the facility. Interventions included bilateral bedside positioning bars for bed mobility.<br><br>The 8/10/2023 Physician order documented positioning bars to bilateral sides of the bed for assistance with self-positioning.<br><br>The was no documented evidence informed consent for the use of bed rails was obtained or the risks and benefits were reviewed with the resident or resident representative prior to their placement.<br><br>(continued on next page) |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The 11/15/2024 positioning bar assessment completed by Registered Nurse Manager #6 and Director of Rehabilitation #16 documented bedside enabler bar (grab bar) usage was requested in order to facilitate positioning in bed.<br><br>During an observation on 11/16/2024 at 11:43 AM, Resident #6 had bilateral white enabler bars on their bed.<br><br>During an interview on 12/18/2024 at 3:56 PM, the Administrator stated they had never completed informed consents for enabler bars since they had worked at the facility. They had questioned it when they started but were told enabler bars were not technically side rails, so they did not need to obtain consents from resident or resident representative to use them.<br><br>During an interview on 12/19/2024 at 9:39 AM, Licensed Practical Nurse #15 stated bed rails required a physician order and assessments were done monthly by a registered nurse and the Director of Therapy to determine if the resident qualified for their use. They were unsure if consents were obtained from the resident or resident representative but thought it was important to get consent to make sure they knew the risks of using them.<br><br>During an interview on 12/18/2024 at 10:14 AM, Director of Rehabilitation #16 stated bed rails required a physician order and they completed quarterly bed rail assessments with Registered Nurse Manager #6. They educated the resident or resident representative while they were doing the bed rail assessment, and they would verbally agree to use them, but they did not obtain a signed consent. They stated it was important to obtain a signed consent to acknowledge the risks of using bed rails.<br><br>During an interview on 12/19/2024 at 10:48 AM, Registered Nurse Manager #6 stated they completed bed rail assessments quarterly with therapy to ensure residents were appropriately using them. Resident #6 had bilateral bed rails for positioning, and they had a physician order. They thought it was important to obtain signed consent forms from the resident or their family to show they knew the risks involved with bed rails and agreed with their use.<br><br>During an interview on 12/19/2024 at 11:08 AM, the Director of Nursing stated bed rails required a physician order and quarterly assessments were completed by nursing and therapy to ensure the resident was appropriate to use them. It was important to obtain a consent, so the resident knew the potential risks of using bed rails.<br><br>10NYCRR 415.12(h)(1)(2) |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.<br><br>50561<br><br>Based on record review and interviews during the recertification survey conducted 12/16/2024-12/19/2024, the facility did not ensure as needed orders for psychotropic drugs were limited to 14 days or had a prescribing provider order to extend beyond 14 days with documented rationale for 1 of 5 residents (Residents #26) reviewed. Specifically, Residents #26 had a physician order for lorazepam (a controlled antianxiety medication) as needed that was not re-evaluated for continued use after 14 days.<br><br>Findings include:<br><br>The facility policy, Psychotropic Medications, dated 12/16/2024, documented psychotropic medications would be used only when appropriate to treat a specific condition. Regular interdisciplinary reviews would be conducted to ensure the medication continued to be necessary, that the resident was receiving the appropriate dose, and that a gradual dose reduction was attempted when appropriate. The medications were also reviewed by the consultant pharmacists monthly for a possible reduction or other recommendations. Only medications in appropriate doses and duration which were clinically necessary to treat the residents' assessed condition or symptoms and maintain resident safety would be used. As needed orders for psychotropic medications would be limited to 14 days.<br><br>Resident #26 had diagnoses including dementia with severe agitation. The 4/25/2024 Minimum Data Set assessment documented the resident had severely impaired cognition, was short tempered and easily annoyed, had physical behavioral symptoms directed towards others (hitting, kicking, pushing), had verbal behavioral symptoms directed towards others (threatening, screaming, cursing), and received antianxiety medication.<br><br>The Comprehensive Care Plan documented:<br><br>-initiated on 4/23/2022, the resident had socially inappropriate/disruptive behavioral symptoms as evidenced by spitting, striking out, scratching staff with care and showering, wandering into other rooms, and was difficult to redirect. Interventions included maintain a calm, slow and understandable approach, assess whether the behaviors danger the resident or others, avoid over-stimulation, and to administer medications as ordered.<br><br>-initiated on 1/24/2023, the resident received antianxiety medication related to dementia with behavioral disturbances. The resident received lorazepam (an antianxiety medication) routinely in the AM, at 6:30 PM, and had a weekly as needed dose for their shower. Interventions included pharmacy consultant review every quarter and as needed.<br><br>The 1/22/2024 physician order documented lorazepam 0.5 milligram once per week as needed for unspecified dementia with behavioral disturbances.<br><br>(continued on next page) |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The November and December 2024 Medication Administration Records documented lorazepam 0.5 milligrams by mouth once per week as needed prior to showers for dementia with behavioral disturbances. The resident received 0.5 milligrams of lorazepam as needed:<br><br>-on 11/4/2024 at 8:55 AM and 11/25/2024 at 9:16 AM.<br><br>-on 12/2/2024 at 8:25 AM and 12/9/2024 at 7:50 AM.<br><br>There was no documented evidence the use of the as needed lorazepam was re-assessed every 14 days.<br><br>There was no documented evidence of a pharmacy review regarding need for re-assessment of use of medication.<br><br>During an interview on 12/18/2024 at 1:20 PM, Registered Nurse #4 stated residents could only have an as needed order for antianxiety medications if they already had a routine order in place. The as needed order had to be reviewed and renewed by the physician every 60 days during their routine visits. Resident #26 had an as needed order for lorazepam for their shower and they did not always receive it. The most recent order was written on 1/22/2024 and since there was no end date it would just continue.<br><br>During an interview on 12/18/2024 at 1:59 PM, Registered Nurse Manager #6 stated as needed antianxiety medication orders were only good for 14 days then the physician had to renew it. There was no formal process for a renewal, but they had an interdisciplinary team meeting every 14 days and the physician would attend and discuss the orders with the nurses. Resident #26 had a twice a day routine order for lorazepam and a once a week as needed order on their shower day. The original order was written on 1/22/2024, it did not appear to have been renewed, and it should have been renewed every 14 days. They stated it was important to review and renew a psychotropic medication because they needed to be monitored closely to make sure the medication was still appropriate, and the resident was not a fall risk as the medication could cause sedation.<br><br>During an interview on 12/18/2024 at 2:34 PM, the Director of Nursing stated as needed medication orders were only good for 14 days. They had no process for tracking order renewals, but they did have a gradual dose reduction meeting with the pharmacist every quarter. Resident #26 had a weekly as needed order for lorazepam to be given before their shower. The most current lorazepam order was written on 1/22/2024 and it had not been renewed since then. It was important to renew the resident's order to avoid unnecessary medications and overmedicating which could lead to increased confusion and falls.<br><br>10 NYCRR 415.12(l)(2) |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46276<br><br>Based on observations and interviews during the recertification survey conducted 12/16/2024-12/19/2024, the facility did not ensure each resident received food and drink that was palatable, attractive, and at a safe and appetizing temperature for 1 of 2 meal trays (the 12/18/2024 [NAME] Unit lunch) reviewed. Specifically, the grilled salmon grain bowl and French fries were not served at palatable temperatures and lacked taste.<br><br>Findings include:<br><br>During an anonymous Resident Council meeting on 12/16/2024 at 2:03 PM, one resident stated the food was cold.<br><br>During an interview on 12/16/2024 at 10:58 AM, Resident #18 stated the food temperatures were cold and the food did not taste good.<br><br>During an observation on 12/18/2024 at 12:07 PM on the [NAME] Unit, Resident #7's lunch tray was served, and a replacement was given. The main entree was a grilled salmon grain bowl (cold plate). Temperatures were measured on the original lunch tray as follows, the salmon was 52 degrees Fahrenheit and was dry and overcooked, the rice medley was 60 degrees Fahrenheit, and the French fries were 65 degrees Fahrenheit. The food was not seasoned and was not palatable.<br><br>During an interview on 12/18/2024 at 12:12 PM, Health Care Dining Attendant #17 stated upon hire they received education regarding proper food temperatures and how to take them. They stated when Resident #7's food arrived from the kitchen, they took the temperature, and it was 42 degrees Fahrenheit. Cold plate food should be below 40 degrees Fahrenheit. They did not know if Resident #7s plate had sat out. They stated they made up the room trays when needed and did not let them sit for long periods of time.<br><br>During an interview on 12/19/2024 at 9:44 AM, the Director of Dining and Nutritional Services stated lunch tray items were prepared in the main kitchen and brought up to the units via a hot box. Cold food plates were prepared in the main kitchen at 10:00 AM and they assumed they were brought up to the Units by 11:00 AM. They stated warm food items such as French fries should be 140 degrees Fahrenheit or higher and placed on a separate plate from the cold plate. The salmon and rice should have been below 40 degrees Fahrenheit. It was important to maintain proper food temperatures to prevent food borne illnesses.<br><br>10NYCRR 415.14(d)(1)(2)<br><br>50561 |

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| F 0806<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.<br><br>50561<br><br>Based on observations, record review, and interviews during the recertification survey conducted 12/16/2024-12/19/2024, the facility did not ensure each resident received and the facility provided food that accommodated resident allergies, intolerances, and preferences for 3 of 7 residents (Residents #8, #25, and #37) reviewed. Specifically, Resident #8 did not receive yogurt and a banana for lunch as specified on their menu and Residents #25 and #37 were not offered desserts as specified on their menus.<br><br>Findings include:<br><br>The facility policy, Meal Round Policy, dated 2/1/2023, documented the facility ensured all residents had access to nutritious, high-quality meals that met their individual dietary needs and preferences. Residents were encouraged to inform the dining team of any specific needs or preferences that may affect their meal choices.<br><br>The facility policy, Meal Attendance, Nutritional Preferences and Nutritional Intake, dated 9/11/2024, documented as part of the admission process, social work, dining, and nursing staff would gather and document resident food preferences and dietary restrictions or therapeutic diets or ethnic and religious food preferences in the individualized service plan and physician orders. Dining staff would ensure staff were aware of any special accommodations.<br><br>1) Resident #8 had diagnoses including dementia. The 3/13/2024 Minimum Data Set assessment documented the resident was cognitively intact and was independent with eating.<br><br>The 3/15/2021 physician order documented a house diet, normal consistency, and thin liquids.<br><br>During an observation and interview on 12/16/2024 at 1:09 PM, Resident #8's lunch meal ticket documented yogurt and a banana at breakfast and lunch. The resident did not have either item on their tray. The resident stated they only received the yogurt and banana during the breakfast meal.<br><br>During an observation and interview on 12/17/2024 at 12:35 PM, Resident #8's lunch meal did not include yogurt, or a banana as documented on their meal ticket. The resident stated they would have eaten them if they had received them.<br><br>During an observation on 12/18/24 at 12:11 PM, Resident #8's lunch meal did not include yogurt, or a banana as documented on their meal ticket.<br><br>2) Resident #25 had diagnoses including mitral valve insufficiency (a disorder of a heart valve) and disorder of the kidney and ureter (tube that goes from the kidney to the bladder). The 11/14/2024 Minimum Data Set assessment documented the resident had moderately impaired cognition and was independent with eating.<br><br>(continued on next page) |

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| F 0806<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an observation on 12/16/2024 at 12:15 PM, the resident's lunch meal menu documented tomato basil soup, grilled cheese sandwich, two cups of orange juice, and fresh fruit for dessert. The fresh fruit was missing from the resident's tray and was not offered prior to them leaving the dining area.<br><br>During an observation on 12/18/2024 at 12:42 PM, the resident left the dining room and was not offered a dessert.<br><br>During an interview on 12/18/2024 at 12:44 PM, Health Care Dining Attendant # 8 stated Resident #25 did not get their fruit for dessert at lunch that day and often left the dining area before they received their dessert.<br><br>3) Resident #37 had diagnoses including fracture of the left forearm and essential hypertension (high blood pressure). The 7/10/2024 Minimum Data Set assessment documented the resident had moderately impaired cognition and was independent with eating after set-up assistance.<br><br>The 8/7/2024 physician order documented a house diet, regular consistency, and thin liquids.<br><br>During an observation on 12/17/2024 at 12:26 PM, Resident #37's lunch meal ticket documented a salted peanut butter bar. The resident was removed from the dining area and was not offered a salted peanut butter bar.<br><br>During an observation on 12/18/2024 at 12:58 PM, Resident #37's lunch meal ticket documented carrot cake. The resident was removed from the dining area and did not receive their dessert.<br><br>During an interview on 12/16/2024 at 12:56 PM Health Care Dining Attendant #14 stated residents filled out menus the day before the meal was served. The resident menus were looked at and plates were made based on the menu choices. Desserts were served when residents were finished eating. Some residents had their dessert choices circled, and the dining staff chose dessert for other residents who were unable to choose. Menus Health Care Dining Attendant #14 stated it was their responsibility to serve everyone dessert and they were not aware of any residents who refused dessert. If dessert was on the menu, it should be offered. Resident #25 circled fresh fruit on their menu, and it was not offered. They stated it was important residents received foods they liked.<br><br>During an interview on 12/18/2024 at 12:21 PM, Health Care Dining Attendant #8 stated they checked the menus to make sure items selected match what was served. Stickers on the bottom of the menus guided how big the portions were listed allergies. They were generated by the dietitian. Extra food or preferences would be placed on the trays. Health Care Dining Attendant #8 stated it was their responsibility to check the tickets to ensure residents received foods per their preference. They were not aware Resident #8 had a banana and yogurt for the lunch meal. They stated whoever delivered their tray should check to make sure all food items were on the tray. At 12:44 PM, Health Care Dining Attendant # 8 stated residents were asked and offered desserts that were available. There were a variety of desserts such as ice cream, puddings, applesauce, and fresh fruit. It was their responsibility to ensure residents received the dessert they requested. Desserts were not served until the resident's plates were cleared. They were asked by their supervisor not to place desserts out early due to the restaurant style dining experience. It was important for residents to receive what they asked for and if there were multiple missed desserts, they should notify management.<br><br>(continued on next page) |

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| F 0806<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 12/18/2024 at 12:35 PM, Certified Nurse Aide #9 stated when they delivered food, they read the meal ticket and ensured what was served to the resident matched the ticket. They were familiar with the stickers at the bottom of the meal ticket and stated they reviewed them. They stated Resident #8's meal ticket listed a yogurt and banana for the lunch meal and was missed. It was important for residents to receive their food items because they were part of their nutritional plan.<br><br>During an interview on 12/18/2024 at 2:13 PM, Registered Nurse Unit Manager #6 stated they expected all food items on the meal ticket to match the actual foods served. Staff should check the meal tickets for accuracy and special instructions. Desserts were a joint effort between dietary and nursing staff. The dietary staff-initiated desserts, but nursing should catch errors. If a resident was not receiving dessert before they left the dining area staff should have been aware and offered it sooner.<br><br>During an interview on 12/19/2024 at 10:56 AM, the Director of Dining and Nutritional Services stated dining attendants were responsible for all items on the meal tickets including desserts. Residents should be offered dessert even if it was not circled. Staff were familiar with residents and knew their preferences. Residents filled out their dessert menus and put thought into their choice. Desserts could be offered at any time and dining staff were responsible to ensure residents received them. If the items were on the resident's meal ticket, they should receive them.<br><br>10NYCRR 415.4(d)(4) |