STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335794	A. Building B. Wing	12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oneida Center for Rehabilitation and Nursing	1445 Kemble Street Utica, NY 13501

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 48052 Based on observations, record review, and interviews during the recertification survey conducted 12/3/2024-12/10/2024, the facility did not ensure residents had the right to a dignified existence in a manner and an environment that promoted the maintenance or enhancement of quality of life for 4 of 5 residents (Residents #5, #58, #61, and #106) reviewed. Specifically, Resident #58 was not called by their preferred name and a certified nurse aide in the resident's room loudly communicated personal information to a nurse across the hall; Resident #61 was not provided with a toothbrush to complete oral care; and Residents #5 and #106 were transported backwards in their wheelchairs. Findings include: The facility policy, Resident Rights, revised 5/28/2024, documented all healthcare personnel were to treat the residents with kindness, respect, and dignity. All residents had the right to a dignified existence. Residents also had the right to participate in their care planning and treatment and self-determination. The facility policy, Quality of Life/Dignity, revised 5/28/2024, documented each resident was to be cared for in a manner that promoted and enhanced quality of life, dignity, respect, and individuality. Residents were to be treated with dignity and respect at all times. The residents were to be groomed as they wished to be groomed. The staff were to speak respectfully to residents, including addressing the resident by their name of choice and not labeling or referring to the resident by their room number, diagnosis, or care needs. Verbal staff-to-staff communication regarding residents were be conducted outside the hearing range of residents and the public. 1) Resident #58 had diagnoses including hypertension, chronic viral hepatitis C (a viral liver infection), and cerebral infarction (stroke). The 9/30/2024 Minimum Data Set assessment documented the resident had moderately impaired cognition and required substantial to maximum assistance for most activities of daily living. The Comprehensive Care Plan dated 1/25/2024 documented the resident preferred to dress comfortably and preferred to be called by their first name. Interventions included to assist the resident with their daily activities as needed and to respect and encourage the resident's preferences and choices. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 12/5/2024 at 12:04 PM, Certified Nurse Aide #34 stood at the resident's door and loudly called come on [resident's last name] three times without entering the resident's room. Certified Nurse Aide #34 loudly asked from the doorway why the resident slept so much and if the resident liked to sleep all day. During an observation on 12/6/2024 at 12:08 PM, Certified Nurse Aide #34 called to the resident by their last name loudly from the doorway to get up for lunch. Certified Nurse Aide #34 walked into the room and loudly stated come on and called the resident by their last name again. The resident stated they could not get up because they were having contractions. Certified Nurse Aide #34 stuck their head out of the resident's room and loudly called to Licensed Practical Nurse #30 who was behind the desk outside of the room, come get your resident they said they were having contractions. During an interview on 12/09/2024 at 2:10 PM, Resident #58 stated they preferred to be called by their first name. They stated it was annoying when the staff referred to them or called them by their last name. During an interview on 12/09/2024 at 2:18 PM, Certified Nurse Aide #34 stated it was not okay to yell a resident's personal information from the resident's room to the nurses' station. The nurse should be pulled aside and given the information. It was not dignified to yell to the resident from the doorway to get up for lunch. They should have asked the resident from inside their room. They stated they called Resident #58 by their last name because the resident was older than them so it would be weird to use their first name. Elders were to be respected and they looked at the residents like they were their grandparents. During an interview on 12/09/2024 at 1:43 PM, Corporate Resource Licensed Practical Nurse (acting Unit Manager) #4 stated staff should not have yelled resident personal information from a resident room to the nurse at the nurse's station. During a follow up interview on 12/10/2024 at 10:19 AM, they stated a resident should be called by their preferred name, especially if it was identified on their plan of care. It was important for residents to be treated with dignity and respect as everyone should be treated with dignity and respect. This was the resident's home. 2) Resident #61 had diagnoses including glaucoma (a chronic eye disease), drug induced movement disorder, and epilepsy (a seizure disorder). The 11/29/2024 Minimum Data Set documented the resident had intact cognition and required supervision for oral hygiene. The Kardex (care instructions) active as of 11/1/2024 documented supervision with oral hygiene, oral care with AM and PM care. The Comprehensive Care Plan created 6/7/2020 documented the resident required assistance with activities of daily living. Interventions included encourage resident to participate to the fullest extent possible with each interaction, and the resident required supervision or verbal cues with oral hygiene. During an observation and interview on 12/3/2024 Resident #61 stated they could not brush their teeth because they did not have a toothbrush and never had one. There was no toothbrush in the resident's bathroom. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 12/4/2024 at 2:04 PM there was no toothbrush located in the resident's room or bathroom. During an observation and interview on 12/6/2024 at 10:20 AM Certified Nurse Aide #31 looked for a toothbrush in the resident's room and could not find one. They stated the resident brushed their teeth when they were showered. The resident had refused their shower on 12/5/2024. During an interview on 12/10/2024 at 10:01 AM Corporate Resource Licensed Practical Nurse (Acting Unit Manager) #4 stated the resident often threw things away and may have thrown away their toothbrush. They stated it was important for residents to have their teeth brushed so their mouth did not feel horrible. Lack of mouth care was not dignified. 3) During an observation on 12/3/2024 at 11:04 PM Resident #5 was sitting in a Geri Chair (a specialized reclining wheelchair). An unidentified staff told the resident it was time to go to the bathroom and pulled the resident backward in their wheelchair down the hallway. During an observation on 12/4/2024 at 2:01 PM Resident #5 was sitting awake in their Geri chair. An unidentified staff gave the resident a drink and asked them if they were ready and pulled the resident down the hall backwards in their Geri chair. During an interview on 12/5/2024 at 10:01 AM Corporate Resource Licensed Practical Nurse (Acting Unit Manager) #4 stated residents should not be pulled backwards in their wheelchair. It was not dignified, and the resident would not be able to tell where they were going. During an observation on 12/6/2024 at 1:02 PM Resident #106 was transported to their room in their Geri chair by an unidentified staff and was pulled backwards down the hallway. 10 NYCRR 415.5(b)(1-3) 51469

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 51469 Based on observation, interview, and record review during the recertification survey conducted 12/3/2024-12/10/2024, the facility did not ensure each resident had the right to be fully informed in a language that they can understand for 1 of 1 resident (Resident #104) reviewed. Specifically, Resident #104's primary language was not English, and the resident was not fully informed of their health care status in a language they understood, and communication tools were not used by direct care staff to determine the resident's needs. Findings include: This facility policy, Translation services, revised 1/2020, documented that a language access program would ensure that individuals with limited English proficiency would have meaningful access to information and services provided by the facility. Resident #104 had diagnoses including perforation of intestine, anemia, and hearing loss. The 9/30/24 Minimum Data Set assessment documented the resident wanted or needed an interpreter to communicate with a doctor or health care staff, the resident had absence of spoken word, had adequate hearing, was rarely/never understood, sometimes understood others, and had severely impaired cognitive skills for daily decision making (the resident's cognition was unable to be assessed by an interview). The resident's 3/27/2024 Admission Record documented the resident's primary language was a language other than English. The Comprehensive Care Plan documented: - on 3/27/2024 the resident was at risk for actual impaired health literacy that was related to their nonverbal status. The resident would communicate barriers to health literacy with the interdisciplinary team through the next review period. Information would be adapted to accommodate the residents cognitive, perceptual, and behavioral disabilities. Assistance would be offered to the resident to identify any barriers to learning and the resident would be encouraged to ask questions. - on 3/29/2024 the resident was unable to make recreation and leisure preferences known. Their past hobbies and interests were unknown. The resident would be engaged in a variety of activities that were appropriate to the level of functioning and of benefit, such as audiobooks. The resident would partake in sensory cognitive stimulation such as music. Offer alternative setting and provide 1 to 1 bedside visits. Provide close supervision during activities. Provide assistance or special adaptive equipment as needed. Provide with diversional activity supplies during periods of increased confusion or agitation. Watch for signs of overstimulation or fatigue during periods of agitation or confusion. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- on 7/16/24 the resident had a decline in psychosocial well-being related to adjustment to nursing home placement and language difference. An interpreter would be utilized when necessary. The resident would demonstrate effective coping behavior through the next review. Support resident's familiar routines and encourage contact with resident's support system. The September 2024 activity attendance record documented the resident participated in Daily Chronicles every day In September 2024. This was the only activity marked as attended except for one arts and crafts activity. A 9/27/2024 at 10:30 AM Director of Nursing Interdisciplinary Team Meeting progress note documented nursing, social services, therapy, administration were in attendance. The resident was not appropriate to attend due to severe cognitive impairment. The resident did not have capacity for medical decisions. They attempted to reach family on multiple occasions, messages were left for call back with no response. The 11/26/2024 progress note by Nurse Practitioner #15 documented the resident was unable to answer many questions due to cognitive impairment. There was no documented evidence how it was determined the resident had severe cognitive impairment when they were unable to answer questions. There was no documented evidence the resident was assessed for communication needs and if a translation service was provided. Resident #104 was observed: - on 12/3/2024 at 9:30 AM sitting at the dining room table with other residents and staff members during an activity. Unidentified staff attempted to communicate by using facial expression, hand gestures, and English language. The resident did not appear to understand. - on 12/4/24 at 11:00 AM lying awake in bed with the television turned on with a show broadcasted in English. The resident was not engaged in watching the television. - on 12/6/24 11:09 AM at a table with other residents while the activities staff were making bracelets. The resident was not engaged in the activity. There was no communication with the resident. The staff asked the resident in English if they wanted a horse to color. The resident did not answer the question. - on 12/09/2024 at 10:40 AM given a fishing activity to do independently by Activity Assistant #33. There was a television with the volume elevated and a Bluetooth speaker with loud music on the activity cart in the same area. The combination of the television and the Bluetooth speaker made a very loud and chaotic environment. There was no observed communication between the resident and staff. During an interview on 12/09/24 at 11:01 AM, Activities Assistant # 33 stated the description of the activity titled daily chronicles was a printed paper with the daily menu on the front and a special event in history on the opposite side and was in English. They stated Resident #104 did not participate in daily chronicles because they would not understand it as it was in English. Activity Assistant #33 stated they mainly use hand gestures to communicate, because the resident did not know English. They stated they were not aware of any audio books in the resident's language. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/10/24 at 10:30 AM Activities Director # 32 stated communication with the resident was more nonverbal. The resident did not have any audio books available to them in their primary language. The Activity Director referenced the availability of a communication board that was present in the resident's room. The Activity Director stated it could be utilized with the resident to allow them to make their needs known. The resident's interests were unknown, and the family availability was limited as they would only visit during off hours. The Activity Director had not spoken to the family to determine specific activities the resident would enjoy. The residents main recorded activity attendance was reading the daily Chronicles. The Activity Director stated this was an error as the Chronicle was written in English, and this would not be an appropriate activity due to both the residents language barrier and their intellectual delay. During an interview and observation on 12/10/24 09:42 AM Licensed Practical Nurse #30 stated they were unaware of the existence or location of a communication board for the resident. Licensed Practical Nurse #30 inquired with several unidentified certified nurse aides in the immediate area who all stated they were not aware of a communication board to use with the resident. Licensed Practical Nurse #30 looked in the resident's room and confirmed there was no communication board for resident use. During an Interview on12/10/24 at 12:04 PM Licensed Practical Nurse Unit Manager #4 stated Resident #104 was developmentally delayed but the resident did have some ability to receptively communicate in their native language. They stated the resident was not completely deaf and had no specific tools to assist with communication. 10NYCRC483.10(c)(1)(4)(5)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48052 Based on observation, record review, and interview during the recertification survey conducted 12/3/2024 -12/10/2024, the facility did not ensure a safe, clean, comfortable, and homelike environment for 1 of 3 units (3rd Floor) reviewed. Specifically, the 3rd Floor had multiple unclean floors and walls, damaged walls, and unpleasant odors. Findings include: The undated facility procedure for Resident Room Cleaning documented the cleaning schedule should be reviewed before cleaning as well as the rotational cleaning schedule. Supplies should be gathered and the following cleaned: dust surfaces including bedside tables, dressers and overhead lights; empty trashcans from bathroom and living spaces and replace liners; clean bathrooms with disinfectant, cleaning from dirty to clean, flush toilet after cleaning; high and low dust surfaces in rooms including under the bed frames; sweep and mop living areas; clean and mop the hallway floors; and clean and dust the hall pictures and handrails outside of rooms. The facility policy, Maintenance Services, dated 8/2019 documented the maintenance department was responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. Functions of the maintenance department were to maintain the building in good repair and free from hazards, establish priorities in providing repair service, and provide routine scheduled maintenance to all areas. The following observations were made on the 3rd Floor: - on 12/3/2024 at 10:09 AM, room [ROOM NUMBER] had a strong urine odor in the bathroom. - on 12/3/2024 at 11:38 AM, the dining room had a strong urine odor. - on 12/3/2024 at 11:45 AM, the railing in the dining room next to room [ROOM NUMBER] had scrapes, and room [ROOM NUMBER]'s door was scraped and faded in color. - on 12/3/2024 at 1:14 PM, the dining room alcove wall had several scrapes. - on 12/3/2024 at 3:42 PM, the floors in room [ROOM NUMBER] A were unclean, the bathroom tiles were lifting and there was a sticky trap behind the bathroom door with unidentified bugs on it. - on 12/5/2024 at 9:09 AM, the hallway near the dining room had a strong urine odor. - on 12/5/2024 at 9:36 AM, the dining room alcove floor had 3 ripped and torn areas. - on 12/5/2024 at 12:54 PM, the kitchenette was unclean. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/9/2024 at 1:55 PM, Housekeeper #27 stated they worked 3 days and were off 2 days. The 3rd Floor was their assigned unit, and they were responsible for cleaning resident rooms, bathrooms, mopping floors, and cleaning shower rooms. They stated the 3rd Floor always smelled like urine and they did their best to clean up as needed. During an interview on 12/9/2024 at 2:07 PM Director of Maintenance #28 stated there was a book on each unit for work orders and staff also had access to a phone application to place work orders. If staff did not tell them a repair was needed, maintenance would do rounds to see if items needed repair or respond to resident requests. They recalled fixing room [ROOM NUMBER]'s tiles two years ago and stated it might have been a quick fix. They were not aware they needed to be fixed again. During an interview on 12/9/2024 at 2:20 PM Director of Housekeeping #29 stated the housekeeping staff was responsible for cleaning common areas, resident rooms, the dining room, high and low touch areas, common bathrooms, the nursing station, and kitchenettes. Staff should report and address any odors the minute they arrive on the unit. If work could not be completed, the housekeeping staff should tell them. The housekeeping staff was required to hand in daily cleaning checklist sheets at the end of the day. It was important to keep resident rooms clean because it was their home and for infection control reasons. 10 NYCRR 415.29(b)(j)(1)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 48052 48675 Based on observations, record review, and interviews during the recertification survey conducted 12/3/2024-12/10/2024, the facility did not develop and implement a comprehensive person-centered care plan that included measurable objectives to meet medical, nursing, and mental and psychosocial needs for 3 of 6 residents (Residents #58, #100, and #101) reviewed. Specifically, Resident #100 had a physician order to receive nothing by mouth and was care planned to be offered a bedtime snack; Resident #58 did not have a comprehensive care plan that addressed their diagnosis of liver disease, their care plan was not updated when their transfer status changed, and they did not have fall mats as planned; Resident #101 had physician orders for an antipsychotic medication and did not have a care plan to address the medication and non-pharmacological interventions. Findings include: The facility policy, Care Plans-Comprehensive, revised 8/2/2024 documented a comprehensive person-centered care plan that included measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs was developed and implemented for each resident. The interdisciplinary team reviewed and updated the care plan when there was a significant change in the resident's condition, when the desired outcome was not met, when the resident was readmitted from a hospital stay, and at least quarterly. 1) Resident #58 had diagnoses including chronic viral hepatitis C (an infection that affects the liver) and cerebral infarction (stroke). The 9/30/2024 Minimum Data Set assessment documented the resident had moderately impaired cognition, moderately severe depression, and required substantial to maximum assistance for most activities of daily living, including transfers. Fall Mats and Transfers: The Comprehensive Care Plan documented: - initiated 4/27/2021 the resident was at risk for falls/had an actual fall related to confusion, gait and balance problems, and a history of falls. Interventions included floor mats, ensure the resident had appropriate footwear, and be sure the call light was within reach. - initiated 10/27/2021 and revised 5/16/2024 the resident required assistance with activities of daily living related to confusion, impaired balance, limited mobility, and limited range of motion. Interventions included to encourage the resident to utilize the call bell for assistance, substantial assistance of 2 for transfers from bed to chair and from sitting to standing. The Kardex (care instructions) documented floor mats at the bedside as indicated, substantial assistance of 2 for transfers. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 8/7/2024 physical therapy discharge summary documented the resident required stand by assistance for transfers and bed mobility. There was no documented evidence the comprehensive care plan was updated to reflect the resident's change in transfer status. The following observations of the were made: - on 12/03/2024 at 12:08 PM, lying in bed with no fall mats. - on 12/05/2024 at 9:16 AM, in their room asleep with the bed slightly lowered with no fall mats. - on 12/06/2024 at 9:35 AM, in bed asleep with no fall mats. - on 12/09/2024 10:24 AM, asleep in bed with no fall mats. During an observation on 12/05/2024 at 12:04 PM Certified Nurse Aide #34 was at the resident's door and was loudly encouraging the resident to get up for lunch. Certified Nurse Aide #34 did not enter the resident's room. Certified Nurse Aide #34 encouraged the resident from the doorway, to transfer themself to their wheelchair from the edge of the bed. During an interview on 12/09/2024 at 10:39 AM, Certified Nurse Aide #35 stated they knew how to care for a resident by reading the Kardex at the kiosk. They checked the Kardex everyday because something could change every day. They stated Reside #58 required supervision for transfers but could transfer themself and often did without waiting for staff. They stated the resident was very adamant about not being touched. During an interview on 12/09/2024 at 1:43 PM, Corporate Resource Licensed Practical Nurse (acting Unit Manager) #4 stated the Director of Nursing, Assistant Director of Nursing, or the Minimum Data Set Coordinator were responsible for updating the care plans on the Third Floor as they were a licensed practical nurse and could not alter the care plans. They stated Resident #58 was supposed to have floor mats next to their bed. They stated they thought they saw them in the resident's room but the resident was up and down often so staff may not have put the mats down. They stated Resident #58 could transfer themself using the mobility bars on their bed. During an interview on 12/09/2024 at 2:18 PM, Certified Nurse Aide #34 stated they knew how to care for a resident by looking at their care plan. They stated Resident #58 required supervision for transfers and did not like to be touched. They stated if a resident was care planned to have two-person substantial assistance the staff should not be encouraging the resident to transfer themself. It was important to follow the care plan for the staff's and resident's safety. Liver disease: Physician orders documented: - 6/13/2024 30 milliliters of lactulose oral solution two times a day for elevated ammonia level (liver disease can cause elevated blood ammonia levels, elevated levels can cause multiple symptoms). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- on 10/16/2024 xifaxan (used to treat liver problems) oral tablet 550 milligrams one tablet by mouth two times a day for liver disease. An 11/18/2024 Physician #40 progress note documented the resident had increased ammonia levels related to chronic hepatitis C and alcohol abuse. The resident would need their ammonia levels checked periodically. There was no documented evidence of a comprehensive care plan that addressed the resident's liver disease or ammonia levels. 2) Resident #101 had diagnoses including bipolar disorder, major depressive disorder, and unspecified dementia. The 10/20/2024 Minimum Data Set assessment documented the resident had moderately impaired cognition, moderate depression, no behavioral symptoms, and was taking an antipsychotic. The 6/24/2024 physician order documented 2 milligrams of Rexulti (antipsychotic) once a day at bedtime for dementia with aggression. The 11/2024 Treatment Administration Record documented monitor resident behaviors (breaking furniture, hitting staff, throwing things) every shift. Record the number of episodes, record interventions by number (1 redirected, 2 one to one, 3 refer to nursing notes, 4 diversional activities, 5 assisted back to room, 6 toileted, 7 offered food/drink, 8 psychiatry/psychology consult, 9 changed position, 10 adjust room temperature, 11 backrub, 12 reapproached) with a start date of 3/6/2024. The resident did not have any documented behaviors in 11/2024. There was no documented evidence of a comprehensive care plan addressing aggressive behaviors, non-pharmacological interventions for aggression as documented on the Treatment Administration Record, or the use of an antipsychotic medication. The Kardex (care instructions) active as of 12/9/2024 documented distract resident from wandering by offering pleasant diversions and educate/encourage appropriate behavior. 3) Resident #100 had diagnoses including dysphagia (difficulty swallowing) and acute respiratory failure. The 10/4/2024 Minimum Data Set assessment documented the resident had severely impaired cognitive skills for daily decision making, was dependent for activities of daily living, did not have a swallowing disorder, had a feeding tube, and received 51% or more of calories through a tube feeding. The Comprehensive Care Plan initiated 5/1/2024 documented the resident had a nutritional problem related to dysphagia, and nothing by mouth with tube feeding. Interventions included nothing by mouth, review meal/fluid consumption records, offer snack every night at hour of sleep, and fluid intake every shift (do not include fluid with meals). The Kardex (care instructions) active as of 12/9/2024 documented to offer the resident an hour of sleep snack every evening. The November 2024 Documentation Survey Report (certified nurse aide documentation) documented hour of sleep snack every evening. The report was marked as NA (not applicable), was blank, or had incorrect documentation of resident accepting snack. The resident did not receive an hour of sleep snack. (continued on next page)

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Oneida Center for Rehabilitation and Nursing	1445 Kemble Street Utica, NY 13501

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/9/2024 at 2:18 PM Certified Nurse Aide #34 stated the snack should not be on Resident #100's documentation and they frequently accidently marked it in the computer as given and would have to go back in and correct it. They stated they never gave the resident a snack and it needed to be removed from the system. During an interview on 12/09/2024 at 2:45 PM Minimum Data Set Coordinator #39 stated they, the Director of Nursing, and the Assistant Director of Nursing were responsible for updating the care plans for the two floors that had licensed practical nurses as Unit Managers. The care plans were updated as needed. They were unsure who was overall responsible for ensuring the care plans were up to date and accurate. Medications that were included on the care plan should include psychotropics. They stated if a resident was on Rexulti, they should have a care plan for antipsychotic medications. If a resident had liver disease and was on medication for it, they should have a care plan. Residents should have care plans for their current diagnoses, the medications they are on, and for other areas such as social work and activities. The care plan should tell you the picture of the person. The activities of daily living information on the care plan came from therapy assessments. If a resident was able to transfer at a higher level than what they were care planned for, the staff should let someone know. If a resident was documented as needing two person assistance, they should use two until the resident was assessed and the care plan updated. The certified nurse aides should not encourage a resident who was care planned for two-person assistance to transfer themself. That would not be following the care plan. If a resident's care plan included fall mats, they should have fall mats in place. It was important for the care plan to be up to date for the care of the resident. If the care plan was not up to date, mistakes could be made which could cause harm. During an interview on 12/09/2024 at 3:01 PM, the Director of Nursing stated they were responsible for ensuring care plans were up to date and accurate. They stated a resident who was on Rexulti should have a care plan for the grouping of the medication. If a resident received treatments and medications for liver disease, they should have a care plan. If a resident required two-person substantial assistance the certified nurse aides should not have encouraged the resident to transfer themself. It was important to follow the care plan to prevent injury. There was no formal way for the certified nurse aides to communicate items that were not up to date or changes needed to the resident's care plan. They should let the Nurse Manager know and if they were a licensed practical nurse, they should communicate it to the correct parties. It was important the care plan was up to date and accurate to give the resident the best treatment. During an interview on 12/10/2024 at 1:43 PM Corporate Resource Licensed Practical Nurse (acting Unit Manager) stated the certified nurse aides should not document on Resident #100's meal intakes and hour of sleep snacks. The program should not have generated that since the resident did not receive anything by mouth. The staff all knew the resident did not receive anything by mouth and would not offer a snack. 10NYCRR 415.11(c)(1)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 48675 Based on observations, record review, and interviews during the recertification survey conducted 12/3/2024-12/10/2024, the facility did not ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 of 4 residents (Resident #86) reviewed. Specifically, Resident #86 had unclean and untrimmed fingernails. Findings include: The facility policy, Activities of Daily Living Care and Support, revised 3/13/2024, documented activities of daily living care and support would be provided for residents who were unable to carry out activities or daily living independently. That included but was not limited to supervision and assistance with hygiene, mobility, elimination, dining, and communication. Nail care would be provided as needed for the resident and residents with certain medical conditions might require a licensed nurse to perform. Resident #86 had diagnoses including absence of left above the knee amputation and chronic obstructive pulmonary disease (lung disease). The 10/13/2024 Minimum Data Set assessment documented the resident was cognitively intact, did not reject care, and required supervision with eating, oral hygiene, upper body dressing, and personal hygiene. The Comprehensive Care Plan initiated 11/30/2022 documented the resident required assistance with activities of daily living. Interventions included to encourage the resident to participate to the fullest extent possible with each interaction and the resident required supervision, verbal cues or touching assistance with personal hygiene. The undated resident care instructions documented prevent resident from scratching, keep hands and body parts from excessive moisture, and keep fingernails short. During observations and interviews at the following times, Resident #86 had long, jagged nails with black/brown debris under them: - on 12/3/2024 at 1:20 PM. The resident stated staff did not offer or assist them with cutting their nails. - on 12/4/2024 at 9:11 AM. - on 12/5/2024 at 10:04 AM. - on 12/6/2024 at 10:30 AM. - on 12/9/2024 at 2:28 PM. The resident stated they asked the staff for nail clippers because the debris under their nails smelled bad and they were unsure what it was. They never received the nail clippers. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The December 2024 certified nurse aide documentation survey report documented the resident received care from 12/3/2024-12/9/2024 including personal hygiene. During an interview on 12/9/2024 at 2:32 PM, Certified Nurse Aide #17 stated they cared for Resident #86 last week and they were familiar with them. If they documented care was completed on a resident that meant all personal hygiene was done. Personal hygiene consisted of oral care, haircare, shaving, dressing, bathing, and nail care. Resident #86 required supervision and set up assistance with care and the only thing they refused was an occasional shower. They stated if the resident refused care they would reapproach them, document the refusal, and notify the nurse who would then write a progress note. They stated it was important to cut Resident #86's nails and make sure they were clean to prevent them from cutting themselves or getting an infection. During an interview on 12/10/2024 at 10:09 AM, Certified Nurse Aide #18 stated they cared for Resident #86 on 12/3/2024 and on 12/10/2024. When they documented care was completed it included dressing, nail care, haircare, mouth care, and a bed bath. If a resident refused care they would reapproach them, if they continued to refuse, they would document the refusal, and would notify the nurse. It was their responsibility to trim and clean nails unless the resident was a diabetic, then the nurse would complete it. They stated they should have been checking resident's nails and they did not notice if Resident #86's nails were unkept. It was important to keep Resident #86's nails clean and trimmed so they did not cut themself and develop an infection. During an interview on 12/10/2024 at 10:26 AM, Licensed Practical Nurse Unit Manager #19 stated when the certified nurse aides documented care was completed it meant they performed mouth care, bed bath, shaving, nail care, and dressed the resident. If a resident required supervision, it meant the staff member was present during care to ensure the resident was safe and assisted with setup and help as needed. If a resident refused care the certified nurse would reapproach the resident, if they continued to refuse, the certified nurse aide should document the refusal and notify them. They had not been notified of Resident #86 refusing care or they would have addressed it. They expected the certified nurse aides to offer nail care daily and it was important for nails to be short and clean to prevent cuts and infections. During an interview on 12/10/2024 at 10:51 AM, Licensed Practical Nurse #20 stated if the certified nurse aides documented the residents care was completed that meant they completed all their personal hygiene, and it was to be completed every shift. Personal hygiene consisted of toileting, shaving, nail care, and mouth care. The certified nurse aides were responsible for nail care unless the resident was a diabetic, then the nurse would complete it. They stated it was important to keep resident's nails short and clean for dignity reasons, to prevent them from cutting themselves, or getting an infection. During an interview on 12/10/2024 at 1:38 PM, the Director of Nursing stated certified nurse aides were expected to clean and trim resident's nails daily as needed. If they documented care was completed it meant all personal care. They stated it was important to keep Resident #86's nails clean and trimmed to prevent cuts and infections. 10NYCRR 415.12(a)(3)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 48052 Based on observations, record review, and interviews during the recertification survey conducted 12/3/2024-12/10/2024, the facility did not ensure ongoing provision of programs to support each resident in their choices of activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident for 2 of 5 residents (Residents #100 and #101) reviewed. Specifically, Resident #101 was not invited to or assisted to attend activities that were meaningful to them and met their interests and preferences; and Resident #100 was not provided with in-room stimulation that met their interests and preferences. Findings include: The facility policy, Activity Programs, revised 5/2019, documented the facility must provide an ongoing program to support residents in their choices of activities based on the comprehensive assessment, care plan, and preferences of each resident. The activity program consisted of individual, small, and large group activities that were designed to meet the needs and interests of each resident. The facility policy, Dementia Program, reviewed 6/1/2024, documented the facility would provide care to residents with dementia that was specialized, individualized, and person-centered. The facility provided residents who had diagnoses of dementia with person-centered activities designed to provide familiar routines and create social outlets. 1) Resident #101 had diagnoses including bipolar disorder, major depressive disorder, and unspecified dementia. The 10/20/2024 Minimum Data Set assessment documented the resident had moderately impaired cognition, had moderate depression, had no behaviors, and required set up assistance for all activities of daily living. The 1/18/2024 Admission Minimum Data Set assessment documented the resident it was very important to listen to music, to be around animals, to keep up with the news, to do things with groups of people, to do their favorite activities, and somewhat important to have books, magazines, and newspapers to read. The Comprehensive Care Plan dated 1/19/2024 documented the resident was able to make their recreation and leisure preferences known. The resident's interests included bingo, crafts, and word search puzzles. Interventions included to assist the resident to find programs of interest; introduce the resident to peers with similar interests; introduce distracting stimuli such as music, conversation, and touch; invite and escort the resident to activities of choice and interest; provide the resident with any assistance or special adaptive equipment as needed; provide the resident with independent leisure supplies; and provide a monthly calendar/daily schedule of events. The Comprehensive Care Plan dated 2/13/2024 documented the resident displayed or reported mood symptoms related to major depressive disorder, feeling down or depressed, having little energy, feeling bad about themselves, and had trouble concentrating. Interventions included to encourage participation in activities of interest, provide the opportunity for the resident to express themselves, provide support and reassurance, and psychiatric/psychology visits as needed. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 10/15/2024 Director of Activities #32 Activity Assessment documented the resident liked socializing with their peers in the common area and the activity room. The resident was always willing to lend a helping hand to other residents. They enjoyed crafts, music programs, social hours, bingo, table games, and special events. The activity staff would encourage the resident to participate in activities that met the resident's interest. The resident's Kardex (care instructions) documented to invite/escort the resident to activities of choice and interest and provide/offer technology device. Resident #101's December 2024 activities log documented: - on 12/1/2024 to 12/4/2024 the resident had no activities marked as attended or refused except for the daily chronicle - on 12/5/2024 the only activity marked as complete other than the daily chronical was the coffee/tea/snack cart - on 12/7/2024, the resident was marked as unavailable for bingo, coffee/tea/snack, and music listening. - on 12/8/2024, the resident was marked as unavailable for a movie and religious/spiritual activity. The following observations of activities on Unit 3 were made: - on 12/03/2024 at 11:38 AM, Activities Aide #42 was at a table with six residents, including resident #101. There was a box of beads directly in front of the activities aide. The activities aide was threading beads and not engaging with the residents or giving them items make. The residents at the table did not have items in front of them. - on 12/03/2024 at 12:23 PM, the large activity calendar on the wall in the dining room documented most of the scheduled activities were conducted in the activity room. - on 12/05/2024 at 9:33 AM Corporate Resource Licensed Practical Nurse (acting Unit Manager) #4 asked the Activities Aide #42 about doing nails for the residents at 10:00 AM and Activities Aide #42 agreed. At 9:53 AM Activities aide #42 was on the unit with varied items on their cart and was set up in the dining area. They did not invite residents to join in the music, coloring, or making bracelets. Resident #101 was not in the dining area. Nail painting did not occur at 10:00 AM. At 11:07 AM, a cookie activity was taking place in the atrium of the building. No residents from 3rd floor were invited due to current isolation of the unit. At 1:52 PM, Corporate Resource Licensed Practical Nurse (acting Unit Manager) #4 stated staff was supposed to bring up cookies from the cookie activity but that did not occur. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- on 12/06/2024 at 9:50 AM, Activities Aide #33 was engaging residents as they came into the dining area and inviting them to join the activity. They did not go from room to room to invite residents to the activity. At 10:10 AM, Resident #101 came into the dining area and asked about the pictures that were scheduled. Activities Aide #33 stated they were not doing pictures at this time, but they were going to do Christmas pictures downstairs with a backdrop, trees, and headbands. Resident #101 was not taken downstairs for Christmas pictures. - on 12/10/24 at 9:40 AM no activities were happening on the floor. There were 4 residents at the tables in the dining area with nothing in front of them and 5 residents in the alcove off the dining room with the TV on. During an interview on 12/03/2024 at 1:13 PM Resident #101 stated they liked to do crafts and to attend activities. They stated staff did not always come get them for activities. 2) Resident #100 had diagnoses including altered mental status, severe protein-calorie malnutrition, and cerebral edema. The 11/4/2024 Minimum Data Set assessment documented the resident had severely impaired cognition for daily decisions and was dependent for activities of daily living. The 5/10/2024 Admission Minimum Data Set Assessment did have the section Preferences for Customary Routine and Activities completed. The Comprehensive Care Plan initiated 5/2/2024 documented the resident was unable to make recreation and leisure preferences known, social history was provided by the resident's representative. Past hobbies and interests included listening to county music, and watching police shows on TV. Interventions included escort the resident to activities of benefit, introduce distracting stimuli (music, conversation, touch), offer alternative setting, provide 1:1 bedside visits, provide close supervision during activity, and provide diversional activities/supplies during periods of increased confusion/agitation, and review prior interest/preferences with family/friends. The 10/30/2024 Director of Activities #32 Activity Assessment documented the resident was unable to respond. They preferred independent pursuits, one to one in both their room and on the unit, required invitations and transport to/from activities, and had personal music equipment. The resident participated independently in music appreciation, sensory stimulation, and social events. The resident's November 2024 Activity log documented the resident refused one to one visits 17 of 30 days; was unavailable for one to one visits 8 of 30 days; and had eye movement, eye fluttering, and facial movement during one to one visits 5 of 30 days. The resident's December 2024 Activity Log documented: - on 12/6/2024 the resident was unavailable for social hour and a special event. - on 12/7/2024 the resident refused bingo, a movie, and listening to music, and coffee/tea hour/snack cart. - on 12/8/2024 the resident was unavailable for a movie and religious/spiritual activity. There was no one to one documented from 12/1/2024-12/9/2024. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/4/2024 at 9:00 AM the resident's significant other stated the resident was always in bed. The resident was unable to move, talk, or eat. They rarely saw staff interact with the resident. The TV was on as background noise, but the resident did not really watch it. Resident #100 was observed: - on 12/5/2024 at 9:52 AM in their room reclined in their wheelchair, positioned in front of the TV, the TV was not on. At 12:10 PM in their room asleep with the TV on. At 2:12 PM in their room asleep. - on 12/6/2024 at 9:37 AM lying in bed with no music or TV. AT 10:39 AM sitting in their room in their wheelchair, positioned perpendicular to the TV. There was a Western playing on the TV. - on 12/9/2024 at 10:19 AM asleep in bed. There was no TV or radio playing. - on 12/10/2024 at 9:37 AM up in wheelchair with the TV playing a Western. During an interview on 12/09/24 at 1:15 PM, Activities Aide #42 stated they only substituted on the Third Floor for if the normal activities aide was not there. They stated when the unit was not isolated, they usually brought residents down to activities and the normal assigned activities aide stayed on the unit. They stated since the residents could not come down to the scheduled activities they did jewelry with them, brought music and snacks, and the residents also liked to color. Cookies, snacks, drinks, jewelry, and coloring were normally what they did when they were assigned to the unit. They stated they usually did the bracelets for the residents because the pieces were too small, so they had the residents tell them what they wanted, and they would make it for the resident. They believed there was a special calendar for the Third Floor, but they did not know where it was. They recorded attendance on paper in a binder in the activity room. They stated Resident #100 usually just watched TV. They did see the resident at many activities, but the resident listened to music and watched a lot of TV. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/09/2024 at 1:27 PM, the Activities Director stated they had one activities aide normally assigned to the Third Floor unit, but most of their staff was part time, so it was hard to find coverage. They tried to make sure there was someone on the unit in the morning and about two to three times a week they did not have anyone on the Third Floor in the afternoon. They stated they did not have structured activities on the Third Floor unit as the residents did not seem to like it. It was a lot easier to just fill up a cart with different things for the residents and let them choose. They invited residents who could attend structured activities down to the main floors for activities. With the third floor on isolation for the week, they sent some items, like the foam gingerbread houses, up to the Third Floor to be completed. They stated the activities staff was supposed to go around to the rooms on the floors and invite residents to attend activities. It was important to provide activities for all interests because residents had different interests. There was a big age, mental ability, and physical ability range in the facility, so they tried to have activities that were from different areas. During a follow up interview on 12/10/2024 at 9:15 AM, the Activities Director stated the activities log should have been marked if a resident was invited and refused. They stated many of residents were interested in beading/bracelet making, but the staff should not just be doing it for the residents. They should assist the residents if needed but just making a bracelet for the residents was not an activity for the residents. They stated Resident #101 was almost always down in activities if the unit was not on isolation. They stated Resident #101 had been a little lost the last week as they could not come down to activities and they want to be active. They stated they did not set any activities or any plans in place for Resident #101 to supplement not being able to go to activities while the unit was on isolation. They stated activity aides would offer Resident #100 soft music or aromatherapy. They can tell the resident got agitated by the look on their face. It was difficult to find activities Resident #100 would tolerate. Sometimes they leave the Chronicle with Resident #100 and have someone read it to them. 10NYCRR 415.5(f)(1) 51469

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 48052 Based on observations, record review, and interviews during the recertification survey conducted 12/3/2024-12/10/2024, the facility did not ensure a resident who was fed by enteral means (tube feeding, delivery of nutrition directly to the stomach or small intestine) received the appropriate treatment and services to prevent complications of enteral feeding for 1 of 2 residents (Resident #100) reviewed. Specifically, Resident #100's tube feeding water flushes were not administered as ordered and the tube feeding was observed unlabeled. Findings include: Resident #100 had diagnoses including unspecified protein-calorie malnutrition and dysphagia (difficulty swallowing). The 11/4/2024 Minimum Data Set Assessment documented the resident had severely impaired cognition, was totally dependent for eating, did not have signs and symptoms of a swallowing disorder, weighed 126 pounds, did not have weight loss, and received nutrition through a feeding tube. The 5/1/2024 comprehensive care plan documented the resident required tube feeding related to dysphagia. Interventions were discussed with family/caregivers/resident concerns regarding tube feeding, advantages, disadvantages and complications from tube feeding, administer tube feeding per Registered Dietitian recommendations and physician orders, Jevity 1.5 via PEG tube at 70 milliliters per hour starting at 8:00 PM for a total volume of 1400 milliliters. Auto flushes at 40 milliliters per hour starting at 8:00 PM with a total volume of 800 milliliters, check for tube placement prior to administration, keep head of bed elevated at 30 degrees during administration, listen to lung sounds as needed and monitor/document/report to physician signs of aspiration, tube dislodgement, fever, shortness of breath, abnormal lung sounds, tube dysfunction or malfunction, abnormal lab values, abdominal pain, distention, nausea/vomiting or dehydration. The 10/29/2024 PM physician order documented Jevity 1.5 via enteral tube at a rate of 70 milliliters per hour to begin at 8:00 PM for a total volume of 1400 milliliters to be delivered (20 hours total run time). The 12/2024 Medication Administration record documented: - Jevity 1.5 via enteral tube at a rate of 70 milliliters/hour to begin at 8:00 PM for a total volume of 1400 milliliters to be delivered. Stop tube feed when total volume of 1400 milliliters is infused. Verify with pump setting the total volume has been delivered. Document total volume infused (PM shift, total volume should be delivered by around 4:00 PM). The time for administration was documented as 2:30 PM. - Auto flush water via enteral tube at a rate of 50 milliliters per hour, verify infusion every shift. Keep head of bed elevated at least 30 degrees during administration. Stop auto flush when volume of 1000 milliliters is delivered. Verify pump setting that volume has been delivered. The order had a start date of 11/22/204. (continued on next page)

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Oneida Center for Rehabilitation and Nursing	1445 Kemble Street Utica, NY 13501

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The auto flush water at a rate of 50 milliliters per hour was signed as administered at 8:00 PM from 12/1/024-12/9/2024. During an observation on 12/3/2024 at 12:00 PM, Resident #100's enteral tube feeding nutrition bottle and auto flush water bag was not labeled or dated. The Medication Administration record documented Licensed Practical Nurse #45 administered the tube feeding on 12/2/2024 at 8:00 PM. During an observation on 12/9/2024 at 10:19 AM, the Resident's enteral tube feeding auto flush was set to 40 milliliters per hour on the pump. The Medication Administration record documented 12/8/2024 at 8:00 PM medication administration record documented the enteral tube feed order was signed by Licensed Practical Nurse # 37 for auto flush of 50 milliliters per hour as administered. During an interview on 12/6/2024 at 2:39 PM Registered Dietitian #37 stated they determined the flow rate on Resident #100's enteral tube feeding based on their calorie and protein needs and the auto flush rates for hydration. They were not aware the resident's auto flush setting was changed to 40 milliliters per hour and expected to be notified if there was a change. It was important for Resident #100's auto flush rate to run at the required amount for hydration due to the resident's nothing by mouth status. During an interview on 12/9/2024 at 11:20 AM Licensed Practical Nurse #38 stated they knew what medications or treatments a resident had by checking their medication and treatment administration records. They were responsible for checking the resident's enteral feeding to ensure the rate was correct and the nutritional content was being administered. They administered the resident's medications and refilled their auto flush bag when they came on shift and did not notice the flow rate of the auto flush bag. It was important for Resident #100's enteral feedings were administered correctly so the resident received adequate hydration. Licensed Practical Nurse #38 stated they did not observe the auto flush water flow rate on the pump when they administered the resident's medications. During an interview on 12/9/2024 at 1:43 PM, Registered Nurse Unit Manager #4 stated the registered dietitian was responsible for enteral feeding orders and nursing checked the medication administration records and followed up to ensure the resident was receiving the correct amount and flow rate. Nursing should check to ensure the pump was functioning properly and if there was an issue they should report it. Resident #100's enteral tube feeding pump was not checked to ensure the proper amount had been administered. It was important for the resident to receive the correct flow rate to ensure they received proper hydration. During an interview on 12/9/2024 at 3:01 PM, the Director of Nursing stated nursing was responsible for checking a resident's enteral tube feeding to ensure that the proper rate and flow were set correctly, and the resident's tube was not leaking. If there were problems with a resident's enteral tube feeding, they expected nursing to notify the dietitian and medical as the incorrect flow rate could affect the resident's total 24-hour fluid intake. They stated if nursing did not know how to correct the problem, they should get a manager to assist them. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/10/2024 at 12:05 PM, Nurse Practitioner #15 stated Resident #100's enteral tube feeding flow rates were determined by Registered Dietitian #37 and they followed the recommendations. They would expect to be notified if the resident's flow rate was incorrect. They stated it was important for the resident's enteral tube feeding orders to be followed because they determined what the resident needed for nutrition and hydration. 10 NYCRR 415.12(g)(2)

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F 0700 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48895 Based on observations, record review, and interviews during the recertification survey conducted 12/3/2024 through 12/10/2024, the facility did not provide on-going assessment and did not obtain informed consent prior to the installation of bed rails (side rails) for 1 of 2 residents (Resident #68) reviewed. Specifically, Resident #68 had bed rails on both sides of the bed and did have informed consent for the placement of bed rails and was not regularly assessed to ensure the bed rails remained appropriate. Findings include: The 9/2019 facility policy, Side Rails, documented that each resident would be assessed for functional status on admission, readmission, quarterly, any significant change, and as needed. Side rails would only be used by a resident to assist with his or her bed mobility. The Rehabilitation Department might be asked to also evaluate the resident's need for side rails as determined by the Interdisciplinary Team. The staff should obtain consent for the use of side rails/enabler from the resident prior to their use. Resident's that require the use of side rails would obtain a physician order indicating that side rails were used to assist with bed mobility. Resident #68 had diagnoses including acute dyskinesia (movement disorder) and adult failure to thrive. The 11/6/2024 Minimum Data Set assessment documented the resident was cognitively intact, required supervision for bed mobility, partial assistance for transfers, and did not use bed rails. The 7/16/2024 Quarterly Restraint/Side Rail Assessment completed by Registered Nurse #26 documented the resident had a potential restraint of a side rail or enabler bar. The side rail was being used for safety, and resident weakness and leaning forward. The side rail would assist the resident turning side to side, holding self to one side of the bed, moving up and down in bed, supporting balance while transferring, and provide security to the resident. The side rail would help avoid rolling out of bed, would obstruct the resident's view, and would impede freedom of movement. The determination was full side rails were recommended at all times. The risks and benefits of side rails were discussed with the resident, the decision was made as a result of a discussion with therapy. A consent for side rail and a physician order for the side rails was obtained, the care plan was updated, and the certified nurse aide tasks documented. The 7/16/2024 Comprehensive Care Plan documented the resident used enablers (devices attached to the bed to provide a hand hold for getting in and out of bed) for increased independence and mobility related to impaired bed mobility. Interventions included offering resident assistance with position changing and bed mobility often during the shift and orient the resident to call light and safety measures. The care plan did not include the use of full side rails as documented in the 7/16/2024 Quarterly Restraint/Side Rail Assessment. There was no documented evidence of a physician order for the use of side rails. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 11/19/2024 Quarterly Restraint/[NAME] ail Assessment completed by Registered Nurse Unit Manager #23 documented the resident did have side rail or enabler bars as potential restraints. The section side rail assessment and determination was blank. During observations on 12/10/2024 at 9:47 AM and 1:54 PM, Resident #68 had brown half side rails (not enabler bars) on both sides of the bed. The rails started at the top of the mattress and extended down to where the movable portion of the bed met the stationary portion of the mattress, approximately half the length of the mattress. During an interview on 12/10/2024 at 9:50 AM, Licensed Practical Nurse #25 stated they were not sure how frequently bed rails were assessed, the Unit Manager was responsible for those assessments. They were not sure if the certified nurse aides were required to document on the use of the bed rails. Bed rails required a physician order for use, or they would be considered a restraint. Resident #68 did not have an order for bed rails. During an interview on 12/10/2024 at 10:02 AM, Certified Nurse Aide #22 stated that Resident #68 had bed rails in place. There was no required documentation for Certified Nurse Aides, and it was not included on the resident's care instructions. It was important for bed rails to be on the care instructions so they could ensure safety of the resident. If a resident stated they were interested in getting bed rails they would notify Physical Therapy and the Nurse Supervisor, who would work through the process with the resident. During an interview on 12/10/2024 at 10:18 AM, Registered Nurse Unit Manager #23 stated they were not sure how frequently bed rail assessments needed to be completed, they would have to check the policy. Nursing and Therapy were responsible for completing the bed rail assessment. If the bed rail impeded view or restricted movement of the resident it would not be put on the bed. The bed rails required a signed consent form, and they were responsible for completing that. Bed rails should be included on the care plan, and if they were on the care plan they should be included on the care instructions with a location for certified nurse aides to document on. They stated their electronic medical record had the ability to do that with a check box. They stated they were responsible for updating the care instructions and the required documentation for the certified nurse aides. They completed a quarterly assessment on 11/19/2024. The assessment documented no restraints, but should have documented the enabler bar, which would have opened the rest of the assessment for the resident. It was important to have on-going monitoring because they could have a change in condition, or not use the enabler bars correctly. During an interview on 12/10/2024 at 1:34 PM Director of Rehabilitation #24 stated that therapy made the initial recommendation for side rails, but nursing assessed the residents quarterly for side rails. The on-going assessments, care plan, orders, care instructions, were the responsibility of nursing. They ensured the resident could safety use enabler bars but would never make a recommendation for full or hospital style bed rails. The Director of Rehabilitation reviewed the residents therapy notes and recommendation. They stated therapy did not assess or recommend any type of enabler bars for Resident #68, but nursing could add them without a therapy recommendation. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/10/2024 at 1:53 PM, the Director of Nursing stated bed rail assessments were done quarterly, however, they were decreasing the number of bed rails in the facility. The Unit Manager was responsible for the assessments and therapy was also involved. If the bed rail was documented as restricting movement, it would be a restraint. A signed consent form should be completed for a resident with bed rails. The bed rails should be on the care instructions for the resident, and the Unit Manager was responsible for updating that. Resident #68 had enabler bars and did not have an order for them. They stated side rails and enablers bars were different. Side rails required a physician order, but enabler bars did not. Nursing should not be putting side rails or enablers bars in place without a recommendation from therapy. They were not sure if 11/19/2024 side rail assessment was completed or fully done, but they should be done quarterly. It was important to have the assessment completed for safety risks and appropriateness of the bed rail/enablers bar. The on-going monitoring was important because if the resident did not need them, they could be removed, and if they had a decline in condition the bed rails could assist with mobility and independence. During an interview on 12/10/2024 at 2:08 PM, Licensed Practical Nurse Assistant Unit Manager #21 stated Resident #68 had enabler bars on their bed. Nursing would not put bed rails/enabler bars in place without therapy recommendations. They stated some of the beds were old and they were just there, versus the newer beds where the bed rails could go on and off more easily. They were not sure what type of bed Resident #68 had. Electronic mail received 12/10/2024 at 2:46 PM from the facility Administrator documented they did not have documented informed consent for Resident #68's bed rails. 10NYCRR 415.12(h)(1)(2)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48675 Based on observations, record review, and interviews during the recertification survey conducted [DATE] - [DATE], the facility did not ensure food was stored, prepared, distributed, and served in accordance with professional standards for food service safety in the facility's main kitchen. Specifically, the main kitchen had unclean surfaces and expired food items. Findings include: The facility policy, Food Storage, revised [DATE], documented sufficient storage facilities would be provided to keep foods safe, wholesome, and appetizing. Food would be stored at appropriate temperatures and by methods designed to prevent contamination or cross contamination: -All stock would be rotated with each new order received. Rotating stock was essential to assure the freshness and highest quality of all foods. -All freezer units would be kept clean and in good working condition. The facility Sanitation Policy, last reviewed ,d+[DATE], documented the food service area would be maintained in a clean and sanitary manner. Food service staff would be trained to maintain cleanliness throughout their work areas during all tasks and the Food Service Manager was responsible for scheduling staff for regular cleaning of the kitchen. The following observations were made in the coolers/freezers in the main kitchen: - on [DATE] at 11:17 AM, the fruit/cheese cooler floor was wet and slippery. - on [DATE] at 11:19 AM, the freezer had small chunks of ice scattered on the floor, a large block of ice on the left side of the compressor, and icicles on the ceiling were slowly dripping water onto the floor towards the back of the freezer. - on [DATE] at 10:50 AM, there was an unknown brown sticky liquid substance covering the floor to the entrance of the freezer. The freezer had small chunks of ice scattered on the floor, there was a large block of ice on the left side of the compressor, and icicles on the ceiling were dripping water onto a closed cardboard box on top of a milk crate. The following observations were made in the dry storage room in the main kitchen: - on [DATE] at 11:10 AM, there were eight 32-ounce bags of powdered sugar that expired on ,d+[DATE]. - on [DATE] at 11:12 AM, there was a box containing twelve bags of 32-ounce powdered sugar that expired on ,d+[DATE], and a box containing twelve bags of 32-ounce powdered sugar that expired on ,d+[DATE]. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 12:20 PM, Food Service Director #12 stated the kitchen was cleaned daily, every staff member was responsible for picking up and cleaning their area throughout their shift, and they had deep cleaning staff who also cleaned the kitchen throughout their shift. The freezer and coolers were cleaned, mopped, and swept daily. The freezer had not been defrosted in the 3 months they had worked at the facility. They stated the freezer should not have any ice buildup inside or on the compressor because it could cause a safety issue for slipping, an infection control issue if the food went bad, and the compressor could stop working properly. They rotated the food items in the dry storage room a few times each week and on truck delivery day to make sure food was sitting too long and expiring. They stated they looked at the expiration date on all food items before serving them to the residents. It was important not to serve expired food to prevent illness or food poisoning. During an interview on [DATE] at 12:29 PM, Kitchen Supervisor #13 stated they supervised all kitchen staff, made sure food was prepped properly, and assisted with scheduling. The kitchen was cleaned twice a day, each staff member was responsible for cleaning their own area, and they also had deep cleaning staff who were responsible for cleaning the ovens, walls, fryers, and assisted with stocking food on delivery days. The coolers and freezer were cleaned daily but sometimes when they were short staffed it did not get done. The freezer was defrosted every few months but there was no set schedule. There should not be any ice buildup inside the freezer because it could cause it to break or affect the temperatures. They noticed ice buildup by the compressor. They thought icicles could have developed inside the freezer if the door was not latched properly causing it to warm up inside. This could cause the food temperatures to rise, and it could become a safety or tripping hazard. They stated the dry food items were rotated a few times a week and they also checked for expired food. It was important not to have expired food items to reduce the risk of residents getting sick if the food was served to them. 10NYCRR 415.14(h)

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48052 Based on record review and interviews during the recertification and abbreviated (NY00326659) surveys conducted on 12/3/2024-12/10/2024, the facility did not provide specific services outside the facility when the facility did not employ a qualified professional to furnish the specific service for 1 of 2 residents (Resident #100) reviewed. Specifically, Resident #100 was referred to neurosurgery and pulmonology (lung specialist) and the facility did not follow up on these referrals in a timely manner. Findings include: The facility policy, Physicians-Consultations, revised 8/2019, documented the facility would ensure all residents received medical care in a timely manner. The attending physician would indicate the appropriate time frame within which the specialist would see the resident. A follow-up appointment was to be done within the time frame requested by the consultant and approved by the attending physician. The attending physician would consider the appropriateness of the consultant's recommendation and the provider approved orders based on consult recommendations if they were appropriate. Resident #100 had diagnoses including pulmonary toxoplasmosis (a serious lung infection), acute respiratory failure, and cerebral edema (swelling of the brain). The 11/4/2024 Minimum Data Set assessment documented the resident had severely impaired cognitive skills for daily decision making, was dependent for activities of daily living, had an active infection of pneumonia, and was on an antibiotic. The 5/1/2024 Comprehensive Care Plan documented the resident had an alteration in their respiratory system. Interventions included to use the incentive spirometry as ordered. The 9/17/2024 consult from an outside brain and spine clinic documented there was a concern for worsening hydrocephalus (spinal fluid buildup in the ventricles of the brain). The plan was to repeat magnetic resonance imaging of the brain to monitor; also concern for pneumonia given new productive cough. The plan was to refer the resident to neurosurgery clinic for a higher level of care as the resident was not an optimal surgical candidate. The consult was illegibly signed by a facility nurse. The medical provider review by the facility was blank and the section to check if new orders were obtained was not checked. The 9/18/2024 Nurse Practitioner #15 progress note documented the resident had a diagnosis of cerebral edema and went to a neurologist appointment. The neurologist felt the resident needed a higher level of care, a repeat magnetic resonance imaging and a referral was made by that office. The 9/20/2024 Nurse Practitioner #15 progress note documented resident was seen by the spine and brain clinic who recommended a referral to neurosurgery for monitoring of the resident's hydrocephalus. The resident was hospitalized [DATE]-[DATE] for bacterial pneumonia. (continued on next page)

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 10/2/2024 hospital discharge summary documented the resident was to have outpatient follow ups with pulmonology in one week, neurology in 1 week, and neurosurgery in 1 week. The After Visit Summary Instructions documented follow up with pulmonology in 1 week, neurology in 1 week, and neurosurgery in 1 week. There was a handwritten note documenting all orders in, a smiley face, and me. A 10/2/2024 at 9:11 PM Licensed Practical Nurse #41 progress note, cosigned by Registered Nurse Supervisor #43 documented the resident was readmitted to the facility from the hospital. There was no documented evidence of follow up on the discharge recommendations for pulmonology and neurosurgery. There was no documented evidence the facility scheduled follow up appointments with pulmonology or neurosurgery as recommended. During an interview on 12//4/2024 at 9:02 AM, Resident #100's significant other stated they had issues getting in touch with staff in charge of transportation. They stated the resident missed appointments with their brain and spine doctor as well as a follow up on a magnetic resonance imaging. They stated the resident had fluid on the brain and was supposed to have follow ups. During an interview on 12/06/2024 at 1:16 PM, Medical Records Staff #16 stated they took care of the transportation for resident appointments. They stated they worked with the Nurse Managers to schedule appointments as well. They were mainly responsible for reaching out to the outside providers to schedule appointments, however if a Nurse Manager scheduled an appointment, there was a form they filled out for transportation to be scheduled. They stated they were unaware the resident had a referral pending for neurosurgery and had not been followed up. They stated they were aware of the pulmonology referral from the resident's hospitalization on [DATE]. They attempted to get an appointment scheduled but was having trouble with the office accepting the appointment. They faxed the discharge summary to the office about a week after the resident had returned from the hospital in 10/2024 but they had not followed up since. They stated their procedure was to inform the Nurse Managers if they had issues with scheduling resident appointments. They did let the Nurse Manager know they had trouble scheduling the appointment. During an interview on 12/06/2024 at 1:28 PM, Corporate Resource Nurse (acting Unit Manager) #4 stated there had been a lot of turn over for Nurse Managers on the third floor. They stated they were unaware of the referral for neurosurgery for a higher level of care but that it was normally the spine and brain clinic that would make the referral. They had not heard anything about the referral. They stated they were unaware of there being difficulties with scheduling the resident's pulmonology appointment. They would have advised Medical Records staff #16 to try another office. During an interview on 12/09/2024 at 3:01 PM, the Director of Nursing stated they expected an outside consult would be followed up in the time frame directed by the office. They stated if a consult had been ordered or referred on 9/17/2024, the facility should have followed up on the referral by now. If there was an issue with scheduling a follow up, they expected the Nurse Managers and the medical providers be made aware. 10NYCRR 415.26(e)