STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335801	A. Building B. Wing	07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mvhs Rehabilitation and Nursing Center	1650 Champlin Avenue Utica, NY 13504

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews during the recertification survey conducted 7/16/2025-7/22/2025, the facility did not ensure a process was in place for residents to have their grievances addressed appropriately for all190 of 190 residents residing in the facility. Specifically, information on how to file a grievance and grievance forms were not available to the residents and the facility did not have a process for residents to file an anonymous grievance. Additionally, 8 of 8 anonymous residents present at the resident group meeting did not know where to obtain grievances forms or their right to file anonymously and did not know who the facility grievance officer was. Findings include:The facility policy Complaint Management, revised 11/18 documented Grievance Officer posters were located by the elevators stating the grievance officer's name and contact number. The procedure for any staff was to report any complaints to their immediate Supervisor. The Supervisor/Manager/Leadership would initiate the Complaint Form at the request of any resident, resident representative, interested family, visitor, or advocate. The form would be forwarded to the Social Work Director/Designee by the end of the shift for tracking and distribution for follow-up. The policy did not include information about the process for filing an anonymous grievance.During a resident group meeting on 7/17/2025 at 11:18 AM, 8 of 8 anonymous residents stated they did not know how to obtain grievance forms, how to file a grievance anonymously, or who the grievance official was. During an interview on 7/18/2025 at 8:50 AM, Receptionist #3 stated there were no grievance forms at the nurse's station on [NAME] North, or out and about for resident use. If there was a concern, the resident should go to the Unit Manager or Social Work for a grievance. They stated there used to be a drop box for suggestions on the first floor, but it was no longer there, and there was nothing like that on the second floor. During an interview on 7/18/2025 at 1:25 PM, Licensed Practical Nurse #4 stated they had not seen grievance forms for the residents to complete, nor had they seen a suggestion or grievance drop box for the residents. If the residents had a concern, they should go to the Unit Manager or Social Work. They stated the residents should have a grievance form and drop box for the forms.During an interview on 7/19/2025 at 10:47 AM, Certified Nurse Aide #17 stated if a resident had a concern, they should go to the Unit Manager. They knew there was a form for grievances but did not know where they were kept. During an interview and observation on 7/21/2025 at 9:25 AM, Receptionist #5 was seated at the main entrance lobby sign in desk. They stated the did not see anything about reporting concerns or grievance forms. If a family member or resident had a concern, they should call the Unit Manager for that unit or the Supervisor to assist the family/resident. There were no available grievance forms observed in the main lobby.During observations on 7/21/2025 between 9:31 AM and 9:35 AM, there were no grievance forms or drop boxes in the lobby between the [NAME] Units or the lobby between the [NAME] Units. During observations on 7/22/2025 between 1:23 PM and 1:29 PM, there was no grievance poster identifying the grievance official, grievance forms, or drop boxes located in the lobby between the [NAME] Units, the lobby between the [NAME] Units, or either elevator. During an interview on 7/22/2025 at 10:53 AM, Manager of Social Services #9 stated the process for filing a grievance was to let staff know. (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The residents should let the Unit Manager, Social Worker, or Nurse know and they would pass it along to the Unit Manager or Social Work would write the formal complaint. The facility had specific grievance forms, but they were not out for people to complete and could be found on the facility's intranet and unit filing cabinets. The facility did not have an anonymous grievance policy. They did not get anonymous grievances, but that was likely because there was no policy for it. They stated they were the grievance official but was not sure if the resident knew this. The sign listing the grievance official was either in the elevator or in the lobby off the elevator in the glass cabinet, but they were not sure if it was still posted. The residents should be able to file an anonymous grievance to voice concerns without worrying about retaliation. They should be able to file an anonymous complaint about someone they did not feel comfortable talking to. The facility used to have a drop box, but when they painted it was taken down. They were not sure why it was not put back up. They stated the grievance forms were not available for residents to complete.10NYCRR 415.3(C)(1)(ii)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observations, record review, and interviews during the recertification survey conducted 7/16/2025-7/22/2025, the facility did not ensure each resident received and the facility provided food that accommodated allergies, intolerances and preferences for 12 of 18 residents (Resident #3, #17, #47, #56, #67, #86, #110, #117, #146, #150, #158 and #187) reviewed. Specifically, Residents #3, #17, #47, #56, #67, #86, #110, #117, #146, #150, #158 and #187 were not provided hot beverages as specified on their meal ticket. Findings include: The facility policy Preparing and Assisting Residents with Meals, revised 6/2025, documented the facility assured a mechanism to deliver food in a safe, accurate, effective and timely manner to residents with prescribed diets and it was the responsibility of the licensed nurse/certified nurse aide to check trays for any missing food items.During an observation of the breakfast meal service on 7/18/2025 at 9:25 AM, the following residents had hot beverages listed on their meal tickets and were not provided the hot beverages:Resident #3 coffee Resident #17 coffeeResident #47 coffeeResident #56 coffeeResident #86 coffeeResident #110 teaResident #117 coffeeResident #146 coffeeResident #158 coffeeResident #187 hot chocolateDuring an observation of the breakfast meal service on 7/21/2025 at 8:57 AM, the following residents had hot beverages listed on their meal tickets and were not provided the hot beverages:Resident #47 coffeeResident #67 hot chocolateResident #86 coffeeResident #110 teaResident #146 coffeeResident #150 hot chocolateResident #158 coffeeDuring an interview on 7/22/2025 at 12:43 PM the Clinical Nutrition Manager stated the resident's meal profile was based on the resident's preferences. They thought dietary staff provided the cold drinks, and nursing provided the hot drinks. All items listed on the ticket should be offered including hot cocoa, hot tea, and coffee. They tried to provide 75% of the resident's fluid needs at meals and hot beverages were part of that 75% calculation. If residents were not consistently receiving their hot liquids it could impact their hydration status.During an interview on 7/22/2025 at 12:52 PM, Certified Nurse Aide #13 stated pouring drinks was a shared responsibility between nursing and dietary. Dietary started pouring and nursing finished. If coffee was on the meal ticket, they always asked the resident because most did not want it. If a resident refused, they made a notation of an R (for refusal) next to that item and let the nurses know so changes could be made. During an interview on 7/22/2025 at 1:04 PM, Food Service Worker #14 stated they brought the meal tickets up from downstairs and set them on the dining tables. It was the responsibility of nursing to pour drinks, including hot beverages, but sometimes they did not do so. In those instances, they poured the drinks especially if the resident was asking for something to drink. During an interview and observation on 7/22/2025 at 9:19 AM Registered Nurse Unit Manager #15 stated pouring drinks, including hot beverages, was a combined effort between nursing and dietary but ultimately it was nursing's responsibility. Residents should get hot liquids if they wanted, and staff knew which residents wanted it. Items listed on meal tickets were based on resident preferences and meant the resident enjoyed those items. Everything on the meal ticket should be provided because that was part of their nutritional plan. During the interview Resident #86 said to Registered Nurse Unit Manager #15 they would like a cup of coffee with cream and sugar. The resident had hot coffee listed on their ticket, but it was not provided. 415.14(d)(4)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews during the recertification survey conducted 7/16/2025-7/22/2025, the facility did not store, prepare, distribute and serve food in accordance with professional standards for food service for one (1) of three (3) walk-in coolers (the meat and dairy cooler) in the main kitchen. Specifically, the meat and dairy walk-in cooler did not maintain food temperatures below 41 degrees Fahrenheit as required.Findings include: The United States Food and Drug Administration Food Code (current as of 1/8/2025) Section 3-501.12 Time/Temperature Control documented temperature control for food under refrigeration would maintain the food temperature at 41 degrees Fahrenheit or less. The National Food Safety Information Network Gateway to Government Food Safety Information Guidelines documented cold food storage for eggs, luncheon meat, egg salad, tuna salad should be refrigerated at 40 degrees Fahrenheit or below.The undated facility document titled Hazard Analysis and Critical Control Points Weekly Refrigerator Temperature Log outlined procedures for monitoring refrigeration units used to store foods requiring time and temperature control for safety. It included critical limits indicating that refrigeration temperatures must be maintained at or below 40 degrees Fahrenheit during stable conditions. Staff should record temperatures once daily and initiate corrective actions if readings exceeded the threshold. Corrective measures included checking food temperatures, placing items on hold if necessary, and consulting the food safety manager for further evaluation. During a main kitchen observation with the Food Service Director on 7/17/2025 at 11:27 AM, the meat and dairy walk-in cooler's outside analog thermometer read 50.0 degrees Fahrenheit. The analog thermometer on the inside of the cooler read 39-40 degrees Fahrenheit. The temperatures of the food items in the cooler were measured using the New York State issued thermometer and included butter at 45.0 degrees Fahrenheit; pickles at 45.0 degrees Fahrenheit; feta cheese at 55 degrees Fahrenheit; bologna at 52.7 degrees Fahrenheit; and milk at 45 degrees Fahrenheit. The Food Service Director stated those foods should not have been out of temperature for more than 2 hours and the temperatures were not acceptable.During an interview on 7/17/2025 at 11:30 AM the Food Service Manager stated a temperature of 40 degrees Fahrenheit was considered acceptable for the cooler. Staff relied on the thermometer hanging inside the cooler to monitor temperatures, as the external thermometer was old and was not accurate. They stated internal food temperatures were only checked if there was a suspicion of a problem. Internal food temperature checks were not performed recently. They were not aware of the items in the cooler with elevated temperatures. They stated the temperatures were not acceptable. and acknowledged the staff would not have known the thermometer used to check temperatures had been inaccurate. On 7/17/2025 at 12:15 PM the food temperatures in the walk-in cooler were measured. - diced eggs - 37 degrees Fahrenheit - cottage cheese 52 degrees Fahrenheit (9 half gallons) - coleslaw dressing 50 degrees Fahrenheit (1 gallon opened) - provolone cheese 53 degrees Fahrenheit (6 pounds) - tzatziki 51 degrees Fahrenheit (1 quart) - sour cream 48 degrees Fahrenheit (3 half gallons) - liquid eggs 46-49 degrees Fahrenheit (7cases) - string cheese 48 degrees Fahrenheit 1(case) - ham 51-53 degrees Fahrenheit (5-10 pounds) - bologna 51 degrees Fahrenheit (2-10 pounds) During an interview on 7/17/2025 at 12:55 PM the Food Service Manager stated they were unaware how long the food in the walk-in cooler was out of temperature and they voluntarily discarded the items. They stated the vendor had been on-site for assessment of the coolers. During an observation with the Food Service Manager on 7/18/2025 at 1:00 PM the temperature of the walk-in cooler was re-checked using a bottle of water placed in the cooler on 7/17/2025.The water temperature measured 37.7 degrees Fahrenheit, and the comparison was made to the analog thermometer inside the walk-in cooler which measured 36.7 degrees Fahrenheit.During an interview on 7/22/2025 3:05 PM the Food Service Manager stated the temperatures for the walk-in coolers were monitored and documented once daily by the morning supervisor. The acceptable temperature range for the walk-in cooler was between 34 (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	degrees Fahrenheit and 40 degrees Fahrenheit, with 40 degrees Fahrenheit as the upper limit. If a cooler was found out of temperature, the product inside was removed and discarded. The Food Service Manager stated there was a verification check in place to ensure accuracy of the cooler thermometer. Potentially hazardous food left out of temperature could lead to foodborne illness if consumed. Maintenance of proper food storage temperatures was important for food safety. 10 NYCRR 415.14(h) _

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on record review and interviews during the recertification survey conducted 7/16/2025-7/22/2025, the facility did not ensure residents were screened for serious mental disorders, intellectual disabilities, and related conditions prior to admission to the facility for 1 of 35 residents (Resident #8) reviewed. Specifically, there was no documented evidence Resident #8 had a Preadmission Screening and Resident Review Level I completed by a qualified screener prior to admission to the facility to determine if the resident had a mental disorder, intellectual disability, or a related condition.Findings include:The facility policy Pre admission Screening & Resident Review (PASRR), dated 11/16, documented the responsibility of Admissions was to ensure [Preadmission Screening and Resident Review] screen was present on all admissions as indicated and reviewed for completion. All resident entering the facility must have a Level I [Preadmission Screening & Resident Review] completed. If one had not been completed, the facility must complete one. The purpose of the policy was to ensure the identification and delivery of specialized developmental and mental health services to those that require them. The facility policy admission Policy, revised 2/2020, documented all admissions required a current [Patient Review Instrument] and screen (Preadmission Screening and Resident Review, DOH-695 Screen) completed by a qualified screener. Resident #8 had diagnoses including encounter for orthopedic after care and osteomyelitis (bone infection). The 12/8/2024 Minimum Data Set assessment documented the resident was admitted from an acute hospital, did not require a level II Preadmission Screen Resident Review, was cognitively intact, and required extensive assistance with most activities of daily living. There was no documented evidence Resident #8 had a Level I Pre admission Screen and Resident Review completed prior to admission to the facility as required. During an interview on 7/22/2025 at 10:53 AM, Manager of Social Service #9 stated they typically audited charts for the Preadmission Screening and Resident Review form but did not complete those audits due to increased job duties. They often had to go into the hospital computer system to search for the forms. The form typically did not make it into the facility chart system for review until two to three days after admission. They stated the form should be reviewed prior to admission, as it was important to know what services a resident required, and the facility could meet those needs. They were not sure why some residents had the screening forms and others did not. The admission information came from the Admissions Coordinator, and it was the responsibility of the Manager of Social Services to review Preadmission Screening and Resident Review form. During an interview on 7/22/2025 at 11:58 AM, Admissions Coordinator #23 stated they used the hospital computer system to obtain records when residents were admitted from the partnering facility. If the resident came from another hospital everything was faxed with the initial referral. They printed the admission information from the hospital computer system and provided it to the Unit Manager where the resident would live. They used the hospital computer system to search for Resident #8. Admissions Coordinator #23 printed 2 separate documents from the hospital computer system that were labelled Patient Review Instrument and Screen. Neither file included the Preadmission Screening and Resident Review, DOH-695 screen form. They stated they just printed what was labelled. If that was not the required item, they might not be providing the unit with the correct information. The Unit Manager or the registered nurse on the unit reviewed the packet they made from the hospital documents the day of admission. They stated they were not sure where to find the document in the facility record, or what the Preadmission Screening and Resident Review, DOH-695 screen form looked like. During an interview on 7/22/2025 at 12:36 PM, the Director of Nursing stated they did not have the Preadmission Screening and Resident Review, DOH-695 form for Resident #8. The screening was supposed to be reviewed before the resident was accepted for admission. They reviewed the screening and would send an email to the unit with the things needed to be in place before the resident arrived. The screen was important to know what services residents needed and to ensure the facility could provide those services. During a follow up interview on 7/22/2025 at 1:50 PM, Manager (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of Social Services #9 stated the facility did not have the Preadmission Screening and Resident Review form on file for Residents #8. They should receive a form with every admission, as not everyone in the building had access to the hospital computer system. They did not recall reviewing a Preadmission Screening and Resident Review form for Resident #8. 10NYCRR 415.11(3)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews during the recertification survey conducted 7/16/2025 -7/22/2025 the facility did not ensure sufficient nursing staff to provide nursing care to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being for 8 of 8 anonymous residents who expressed concerns regarding the lack of sufficient staffing and 2 of 2 residents (Residents #56 and #135) who experienced prolonged wait time for care. Specifically, during a confidential group meeting (resident council) 8 anonymous residents stated the facility was frequently short staffed and there were often only two certified nurse aides assigned to a unit; and Residents #56 and #135 had prolonged call bell response times. Findings include:The Facility Assessment, last reviewed 6/26/2025, documented the facility was licensed for a total of 202 beds. The number/average or range of long stay residents dependent with activities of daily living was 40-60. The staffing plan documented there would be 5-10 licensed nurses providing direct care during both the week and weekend day, evening, and night shifts; 8-20 nurse aides during both the week and weekend day and evening shifts; and 5-8 nurse aides during the week and weekend night shift. That staffing plan was an estimated range used for staffing consideration; individual extenuating circumstances such as a residents needing 1:1, this would be reviewed and determined how to add the additional staff. The facility policy Resident's/Patient's Rights and Responsibilities, revised 2/2017, documented the residents had the right to receive services in the facility with reasonable accommodation of individual needs and preferences, except with the health or safety of the individual would be endangered.Facility actual staffing documented the following nursing schedule for the [NAME] unit with a census of 39 residents (one resident required one-to-one supervision):On Thursday 7/17/2025 evening shift: 1 licensed practical nurse3 certified nurse aides from 3:00 PM-11:00 PM 4 certified nurse aides from 4:30 PM-11:00 PM 1 certified nurse aide from 7:00 PM-11:00 PM 1 unit service aide from 3:00 PM-7:00 PMOn Friday, 7/18/2025 7:00 AM-3:00 PM day shift:1 Unit Manager2 licensed nurses (one marked as late)4 certified nurse aides (one to go to [NAME] North unit) and1 unit service aide.On Saturday 7/19/2025 7:00 AM-3:00 PM day shift:1 Unit Manager1 licensed nurse3 certified nurse aides1 unit service aideOn Sunday, 7/20/2025 7:00 AM-3:00 PM day shift:1 licensed nurse2 certified nurse aides from 7:00 AM-10:00 AM3 certified nurse aides from 10:00 AM-11:00 AM4 certified nurse aides from 11:00 AM-2:00 PM 3 certified nurse aides from 2:00 PM-3:00 PM 1 unit service aideOn Sunday, 7/20/2025 3:00 PM- 11:00 PM evening shift:1 licensed nurse3 certified nurse aides from 3:00 PM -5:30 PM 4 certified nurse aides from 5:30 PM-11:00 PMOn Monday 7/21/2025 7:00 AM-3:00 PM day shift:1 Unit Manager1 licensed nurse2 certified nurse aides from 7:00 AM-10:30 AM3 certified nurse aides from10:30 AM-2:00 PM2 certified nurse aides from 2:00 PM-3:00 PMThe facility staffing sheets did not reflect a resident assigned one-to-one supervision. During an interview on 7/16/2025 at 11:02 AM, Resident #148 stated they felt the facility was short staffed. There were usually only 2 staff members on the 7:00 AM-3:00 PM shift, particularly on the weekends. Most every day they waited at least an hour to use the bathroom and if their bell was not answered timely, they were incontinent. They had accidents and they soaked through their clothes because staff did not get to them in time. There were a lot of residents who required assistance of 2 for transfers and a resident who was on one-to-one supervision because they fell a lot. They stated there was not enough staff to go around.During an observation on 7/16/2025 at 1:17 PM, Resident #135 was arguing with their family member regarding not getting help. The family member stated they should call for staff again. At 1:49 PM the Administrator entered the resident's room. The resident told the Administrator staff told them they were not able to assist them at that moment and would be with them when they were available. They also stated their call bell was never answered timely. The Administrator explained the staff were busy and would answer as soon as they could. The (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator stated they would stay with the resident until staff came back. After waiting, staff did not come back, the Administrator looked out into the hall, went back into the room and said staff must still be busy. The Administrator waited, talked with the resident, then went back out in the hall, where no staff was observed. They asked the resident to put their light on again. A certified nurse aide was summoned by the Administrator and the Administrator exited the room at 2:25 PM. During an interview on 7/22/2025 at 11:16 AM, Resident #135 stated sometimes it was hard to wait for the staff to come put them to bed. They did not like to wait and got frustrated easily.During a resident group meeting on 7/17/2025 at 11:18 AM, 8 of 8 anonymous residents stated the facility was frequently short staffed. It was most noticeable during mealtimes and when the certified nurse aides had to help with the residents on one-to-one supervision. Each unit had approximately 36-38 residents and only 2 certified nurse aides. One resident stated that the facility did not provide extra staff to assist with wandering residents and used the staff who were already scheduled. There was no one left on the unit to help the cognitively intact residents with their needs.During an interview on 7/17/2025 at 3:13 PM, Certified Nurse Aide #24 stated they were supposed to have 4 certified nurse aides but there were only 2. There was one nurse, and a unit service aide from 3:00 PM- 7:00 PM. At 7:00 PM one aide would have to take over the one-to-one resident supervision. If they did not get the additional 2 certified nurse aides, they did not know what they would do.During an interview on 7/18/2025 at 9:53 AM, Licensed Practical Nurse #25 stated they were down to 2 certified nurse aides and a unit service aide. Certified Nurse Aide #26 wanted to switch to another floor and walked off the unit. During an observation on 7/18/2025 at 8:33 AM, the call bell monitor documented Resident #56's call bell was on for 30 minutes. Staff were bringing residents into the dining room. The call bell was answered at 8:43 AM after 41 minutes. During an observation and interview on 7/21/2025 at 9:10 AM, the call bell monitor documented Resident #148's call bell light was on for 78 minutes. The resident stated they rang to use the bathroom, but they had been incontinent while waiting. They waited an hour and a half and was dry when they put their light on. They held it for about 20-30 minutes before they were incontinent.During an interview on 7/21/2025 at 9:21 AM, Licensed Practical Nurse #25 stated they had 3 aides but were down to 2 because Certified Nurse Aide #26 just left the unit and had no idea why. They had 2 nurses, but the rehab unit took second nurse these at 7:20 AM because that unit had to have more staff.During an observation on 7/21/2025 at 9:37 AM the call bell monitor showed Resident #56's call light was on for 33 minutes. It was answered at 9:39 AM after 35 minutes. During an interview on 7/21/2025 at 9:53 AM, Resident #56 stated they rang because they needed assistance with their electric wheelchair. Their call bell was sometimes not answered for hours, especially on the weekends because there was not enough help.During an interview on 7/21/2025 at 10:36AM, Certified Nurse Aide #27 stated they did not have enough staff to meet the resident's needs. Their unit had about 18 residents who required the use of a lift and 2 staff for transfers, a lot of behaviors, and a resident who was on one-to-one supervision. That day the unit was scheduled for 3 aides, but because there was not a unit service aide there were only 2 aides for the floor. Right now, there were residents still in bed who were not repositioned or bathed. Resident #3 was in a hospital gown at the nurses' station and did not have their shower. They were responsible for 13 residents if there were 3 aides. They worked many times with just 2 aides and one nurse especially on the weekends. Short staffing resulted in delays in providing toileting/incontinency care, showering, and answering call bells. Resident #148 was able to use their call bell and make their needs known and might be dry if their bell was answered in a timely manner. The resident was not dry that morning. The resident's call was on for over 90 minutes because they could not leave the dining room to answer it.During an interview on 7/21/2025 at 2:37 PM, Licensed Practical Nurse #29 stated current staffing levels were not desirable. On evenings there was usually 1 nurse and 3 or 4 aides: but more commonly 3. They had always had 3 plus someone to do the 1:1. They noticed call bell response times were long when there were only 3 aides.During an interview on 7/22/2025 at 10:39 AM, Staffing Coordinator #28 stated staffing numbers were determined by Administration. All units in the facility (continued on next page)

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	335801	A. Building B. Wing	07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mvhs Rehabilitation and Nursing Center	1650 Champlin Avenue Utica, NY 13504

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had a staffing goal of 2 nurses and 3 certified nurse aides. They did not participate in the Facility Assessment and did not review it. 8 certified nurse aides were not enough to cover the building for the day or evening shift. The minimum to schedule was 1 nurse and 3 certified nurse aides per unit, there were 5 units, which meant the minimum should be 15. If a unit had a resident that required one on one supervision they could use a unit service aide, but they could only sit or walk with the resident they could not help with care of the resident. They were able to schedule for 4 certified nurse aides, per unit for the first and second shifts. On average they had 2 certified nurse aides call out per day shift, and 1 on evenings. The weekends had higher call out rates. The agency staff tended to call out more. A large percentage of the certified nurse aides were agency staff from 4 different agencies. If they were directed to staff extra, they could, but they did not over staff the schedule. If the staffing numbers fell below the minimum, they would try to call people in to work. During an interview on 7/22/2025 at 10:54 AM, Registered Nurse Unit Manager #15 stated a reasonable call bell response time was 5-10 minutes. Some residents had complained about response times. Full day shift staff should be 2 licensed nurses 4 certified nurse aides and on evenings 1 nurse and 4 aides. Sometimes they had a unit service aide. Their unit had about 15 residents who required a mechanical lift. When they had 2 nurses, they were able to help the aides otherwise they did not have time to help. They did not usually staff a full day with just 2 aides. When short staffed, toileting and showers were delayed as they had to concentrate on getting residents up and feeding them first. 78 minutes was not an appropriate call bell response time, but Resident #148 knew it was breakfast time, knew what was going on at that time, and should wait. Resident #148 rang to be changed because they were incontinent. It was their right to use the bathroom whenever they needed to. Call bells should be answered timely to promote continency, to avoid self-toileting, and prevent urinary tract infections.During an interview on 7/22/2025 at 1:14PM, Licensed Practical Nurse #25 stated 50% of the time they were short staffed, and they considered 3 aides short staffed. They were the only nurse that day, and when that happened, they were unable to help with transfers and meals. They were unable to get the medications passed on time, and they did not get a lunch break. During the week it was harder to be short because there was more going on. They did not get any help from ancillary departments. When they were short staffed there were longer wait times for the residents and the aides were overwhelmed and frustrated. They stated they were asked a couple times a week to pick up extra shifts. Call bell response times should be 5-7 minutes; 78 minutes was excessive. Residents complained about the call bell response times. It was important to answer call bells in a timely manner because someone could be having a medical emergency or could have fallen. During a follow up interview on 7/22/2025 at 2:37 PM, Registered Nurse Unit Manager #15 stated the minimum staff for the unit was 1 nurse and 3 certified nurse aides, for 40 residents. The unit had approximately 20 residents that required a mechanical lift and a higher number of residents with mental health and behaviors than other units. The unit did not always have enough staff to care for the residents. They helped and assisted residents to the bathroom, but they had a workload of their own to cover. There should be enough staff to cover the resident needs. The ideal staffing was 2 nurses and 5 certified nurse aides, due to special needs and one on one supervision requirements. The residents knew when they were short staffed and noticed the bustle of the staff to get things done. On 7/21/2025, the unit had 1 nurse and 3 certified nurse aides. At the start of the day, 1 certified nurse aide walked out, and there was 1 resident that required one to one supervision. That left the unit with 1 nurse and 1 aide for approximately 40 residents. Staff could get frustrated, and they tried to jump in to help and allow staff to get a break off the unit when emotions got high. 415.(a)(1)(i-iii)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, record review, and interviews during the recertification survey conducted 7/16/2025-7/22/2025, the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for one (1) of seven (7) residents (Resident #91) reviewed. Specifically, Resident #91 was on enteric pathogen precautions for active clostridium difficile (a contagious bacteria causing inflammation of the colon). Housekeeper #7 entered and cleaned the room without wearing required personal protective equipment, and Certified Nurse Aide #9 entered the room and delivered a meal tray without wearing required personal protective equipment.Findings include: The facility policy Standard, Transmission, and Enhanced Barrier Based Precautions, created 7/2/2025, documented enteric pathogen precautions were used to prevent the spread of organisms (including clostridium difficile) through contact with resident or residents' environments. Red signage stating Enteric Pathogen Precaution would be placed on the outside of the resident room with a caddy on the outside of the resident door containing the necessary personal protective equipment. Residents on precaution for clostridium difficile required hand washing with soap and water prior to exiting the room. All precautions remained in place unless directed by the Infection Prevention Department.The Facility Policy Daily Cleaning of Posted Isolation Rooms-Contact Precaution C-Diff, updated 3/19/2024, documented cleaning personal must wear personal protective equipment listed on the door and use Defender (a sporicidal disinfectant and cleaner) chemical to clean the room. Resident #91 had diagnoses including clostridium difficile. The 6/20/2025 annual Minimum Data Set assessment documented the resident had moderate cognitive impairment and was always incontinent of bowel.The Comprehensive Care Plan initiated 12/23/2024 and revised 6/26/2025 documented the resident had a history of clostridium difficile. Interventions included contact isolation. The 7/14/2025 Physician #16 progress note documented Resident #91 had active diarrhea and clostridium difficile was likely recurring. The smell and characteristic of the stool, with the resident's abdominal discomfort, indicated high probability of recurrence. The plan included testing for clostridium difficile and the resident was started on oral vancomycin (antibiotic). During an observation on 7/17/2025 at 8:57 AM a sign was located outside Resident #91's door documenting Enteric Pathogen Precautions. Staff should wash hands and put on gloves and a gown before entering the room and discard them before exiting the room. Hands should be washed with soap and water when exiting the room. A personal protective equipment caddy was hanging on the door to the room.During an observation and interview on 7/18/2025 at 8:37 AM, Housekeeper #7 entered Resident 91's room without putting on a gown and proceeded to clean the room. Housekeeper #7 exited the room without changing their gloves and entered the shower room next door. Housekeeper #1 stated they wiped down every surface and cleaned Resident #91's room thoroughly. They stated they used a spray bottle of disinfectant and showed the surveyor the bottle. The disinfectant would not kill clostridium difficile spores. During a follow up interview on 7/18/2025 at 2:55 PM, Housekeeper #7 stated they usually wore gowns in a room with enteric pathogen precautions but forgot to today. They stated they went in the shower room to get the garbage and removed their gloves at that point. They stated they washed their hands in the sink in the janitor room. The janitor room sink was observed and was a chemical sink connected to different chemicals, and not a handwashing sink.During an interview on 7/18/2025 at 3:00 PM, Housekeeping Supervisor #8 stated rooms with enteric pathogen precautions were cleaned with a special mop bucket kept in the dirty utility room containing the Defender chemical, which killed clostridium difficile. They stated this was required to be used when cleaning Resident #91's room.During an observation on 7/21/2025 at 12:13 PM, Certified Nursing Aide #9 entered Resident #91's room and delivered the resident's lunch tray without putting on a gown, gloves, or performing hand hygiene. They exited the room without performing hand hygiene and proceeded to pass other trays to resident rooms. During an interview on 7/22/2025 at 10:45 AM, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered Nurse/ Infection Preventionist #10 stated the enteric pathogen precautions sign in a shared room meant all staff who entered the infected side of the room should wash their hands and put on the personal protective equipment including a gown and gloves. When they left the room, staff should remove the gown and gloves using the proper technique, throw them in the designated receptacle, and wash their hands with soap and water in the room before leaving. They stated this process was used for any reason, including passing meal trays.During an interview on 7/22/2025 at 11:45 AM, Certified Nursing Aide #9 stated the enteric pathogen precautions sign was for the resident, to prevent getting them from getting sick. They stated gown and gloves were only required for hands on care.During an interview on 7/22/2025 at 11:50 AM Registered Nurse Unit Manager #11 stated the enteric pathogen precautions sign means contact precaution and staff should wash their hands and wear a gown and gloves when performing direct care. Precautions were only needed if staff touched the resident and not needed for food delivery.10 NYCRR 415.19(a)(b)