Printed: 06/26/2025
Form Approved OMB
No. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 335803 | A. Building<br>B. Wing | 03/12/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Taconic Rehabilitation and Nursing at Ulster | One Wingate Way<br>Highland, NY 12528 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51214<br><br>Based on observations, interviews, and record review conducted during the recertification survey from 3/5/2025 to 3/12/2025, the facility did not ensure a resident was treated with respect and dignity and cared for in a manner that promoted maintenance or enhancement of their quality of life. This was evident for 1 of 1 residents (Resident #65) reviewed for Dignity. Specifically, Resident # 65 was observed ambulating wearing socks that were labeled with the resident's name on the top of the foot clearly visible to other residents, visitors and staff.<br><br>The findings are:<br><br>Resident #65 with diagnoses that included, but not limited to, Dementia, Anemia, and Hypertension.<br><br>The Facility Policy titled Dignity, Respect, and Privacy in Treatment and Care revised 10/2023 documented that the Resident is treated with consideration, respect, and full recognition of his/her dignity and individuality, including privacy in treatment and in care for his personal needs.<br><br>The Annual Minimum Data Set, dated dated dated [DATE] documented Resident #65 had severely impaired decision making, memory problem, and required maximal assistance for dressing and footwear.<br><br>The Care Plan titled Dressing, revised 1/1/2025, documented Resident #65 required maximal assist of 1 staff for dressing.<br><br>During observations on 03/05/25 at 10:04 AM, 03/06/25 at 11:13 AM, and 03/07/25 at 08:56 AM, Resident #65 was observed ambulating independently in the hallway, wearing socks labeled with their name clearly visible to other residents, staff, and visitors on the top of their foot.<br><br>During an interview on 03/10/25 at 2:42 PM, Licensed Practical Nurse Unit Manager #14 stated the labels on clothing were so items returned from the laundry went to the appropriate resident. They were not aware that labels on clothing with the resident's name should not be visible to others.<br><br>During an interview on 03/10/25 at 2:53 PM, the Social Worker stated they did not feel it was a problem having the name label visible to others on items of clothing.<br><br>(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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 03/10/25 at 3:25 PM, the Director of Nursing stated clothing labels should not be in a location visible to others, and it was a dignity issue. They contacted the unit and requested that Resident #65's socks be collected and relabeled so that the name label was not visible to others.<br><br>10 NYCRR 415.5(a) |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Reasonably accommodate the needs and preferences of each resident.<br><br>43478<br><br>Based on observations, record review and interviews conducted during the recertification survey from 3/5/25-3/12/25, the facility did not ensure that they were adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area for Resident #30 reviewed for Call Systems/Environment. Specifically, the call system unit at the bedside for Resident #30 was not accessible.<br><br>Findings include:<br><br>The facility's policy titled Call Light revised 10/24/22 documented all residents will be provided with a method to communicate requests and needs directly to a staff or a centralized work area from the bedside, bathroom, and bathing areas, and to always place the call light within the resident's reach.<br><br>The facility policy titled Fall Prevention revised July 2023 documented that all reasonable steps will be taken to keep the residents safe from falls and related injuries.<br><br>Resident #30 was admitted with diagnoses which included fracture of the right femur, cerebral infarct, and hemiplegia and hemiparesis affecting the left side. The 12/9/24 Minimum Data Set admission assessment documented the resident had intact cognition and required supervision with toileting hygiene, sit to stand and chair to bed and toilet transfers. Resident #30 had a fall in the past month, prior to admission, and a fracture related to a fall in the past 6 months prior to admission.<br><br>The 3/4/25 Quarterly Minimum Data Set (resident assessment) documented Resident #30 had moderately impaired cognition and required supervision with toileting hygiene and sit to stand and chair to bed transfers and toilet transfers.<br><br>The Nursing Falls Risk Data Collection Tools dated 12/3/24, 12/31/24, 1/26/25, 1/27/25, 1/30/25, 2/19/25 and the Falls Risk Tool dated 2/22/25 documented the resident was at risk for falls.<br><br>The 3/5/25 Care Plan for Activities of Daily Living documented Resident #30 required supervision with toileting and transfers and ambulation with rolling walker.<br><br>The 3/5/25 Care Plan for Falls documented Resident #30 was at risk for falls related to prior fall in the last 90 days prior to admission. Interventions included to remind to call for assistance.<br><br>The Kardex documented ambulation in room with supervision, fall injury alert-anticoagulant therapy use, remind to call for assistance.<br><br>(continued on next page) |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 03/05/25 at 01:02 PM, Resident #30 was observed in their wheelchair in their room. The call bell was observed out of the resident's reach and out of the resident's sight, lying on the stationary chair behind the resident in the corner of the room. When asked, how do you call for help, Resident #30 stated lately it has been difficult because I don't have a call bell. Resident #30 stated they have to yell for the nurse if they need something. Resident #30 additionally stated they take themself to the toilet by wheeling themself into the bathroom, hold onto the grab bar, and transfer themself.<br><br>On 03/05/25 at 01:25 PM, Resident #30 was observed sitting in their wheelchair, the call bell was still located out of the resident's reach and out of the resident's sight, on the stationary chair in the corner of the room.<br><br>On 03/05/25 at 01:54 PM Resident #30 was observed lying in bed awake. The call bell was observed on the stationary chair in the corner of the room. When asked, Resident #30 stated they did not know where their call bell was. Resident #30 looked around their room and stated they did not see the call bell. The surveyor gave the resident their call bell.<br><br>On 03/06/25 at 08:55 AM Resident #30 was not observed in their room. The call bell was observed on the stationary chair in the corner of the room.<br><br>On 03/06/25 at 10:55 AM and at 11:55 AM, Resident #30 was observed sleeping in bed, the call bell was observed on a stationary chair in the corner of the room, out of the resident's reach and out of the resident's sight.<br><br>On 03/06/25 at 12:22 PM, Resident #30 was observed sitting in their wheelchair in their room eating lunch. The call bell was observed out of sight and out of reach of the resident, lying on the stationary chair in the corner of the room.<br><br>On 03/07/25 at 12:30 PM during an interview, Licensed Practical Nurse Unit Manager #4 stated that all residents should have their call bell in reach at all times. They stated they are aware that Resident #30 had a fall prior to admission and is confused.<br><br>On 03/07/25 at 01:24 PM during an interview with the Director of Nursing, they stated the Certified Nurse Aides and any other staff should place all resident's call bells within resident's reach.<br><br>10NYCRR 415.29 |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>43478<br><br>Based on observation, record review, and interview during the recertification survey from 3/5/25-3/12/25, the facility did not ensure that the Comprehensive Care Plans were reviewed and revised in a timely manner for 1 (Resident #68) of 4 residents reviewed for pressure ulcers. Specifically, Resident #68's Skin Integrity at Risk Care Plan dated 11/15/24 and updated 2/12/25 documented to float Resident #68's heels, however it was not updated to include a new intervention when staff observed the resident moving their legs frequently when in bed.<br><br>The findings are:<br><br>The facility policy titled Interdisciplinary Care Planning revised 4/15/2024 documented a comprehensive resident centered care plan is developed by the interdisciplinary team upon admission and reviewed/ updated on a regular basis throughout the residence length of stay. The comprehensive care plan is reviewed and updated with changes and minimally on a quarterly basis.<br><br>Resident #68 had diagnoses including protein calorie malnutrition, failure to thrive, and dementia. The 11/20/24 Quarterly Minimum Data Set Medicare 5-day assessment documented intact cognition. Resident #68 required maximum assistance with rolling in bed and had two unstageable pressure ulcers present on admission.<br><br>The 11/15/24 Skin Integrity at Risk Care Plan documented an intervention to float Resident #68's heels in bed.<br><br>The 2/4/25 Skin Integrity at Risk Care Plan documented intervention to float heels in bed.<br><br>The 2/15/25 Quarterly Minimum Data Set assessment documented intact cognition. Resident #68 required maximum assistance with rolling in bed, and one stage two pressure ulcer present on admission.<br><br>The Kardex (Certified Nurse Aide instructions) documented to float Resident #68's heels in bed.<br><br>On 03/05/25 at 10:37 AM, Resident #68 was observed sitting in their wheelchair wearing sneakers, with their right foot on the floor, although their wheelchair footrest was in place. Resident #68 stated their right heel is bruised and it feels better when they are wearing sneaker because the sneaker has padding. They stated their heel hurts at night when they move their foot. Resident #68 stated that nobody offered padded booties in bed.<br><br>On 03/06/25 at 09:06 AM, Resident #68 was observed in bed with their heels directly on the mattress, and no heel booties or pillow was observed to float their heels, and there was no air mattress in place.<br><br>On 03/07/25 at 10:45 AM, Resident #68 was observed lying in bed with their heels directly on the mattress, no air mattress was in place, no heel booties or pillow were observed to float their heels.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 03/07/25 at 11:00 AM during an interview, Licensed Practical Nurse #1 stated that Resident #68 moves in bed, and therefore pillows are not effective to float Resident #68's heels, but they never requested another intervention such as heel booties or another device for the resident. They stated they should have told the Nurse Manager.<br><br>On 03/07/25 at 04:10 PM during an interview, Licensed Practical Nurse Unit Manager stated that nursing staff who was aware that the pillow was not effective for floating the resident's heels should have reported the concern to them or therapy or any nursing management, so that a new intervention could have been implemented.<br><br>10 NYCRR415.11(c)(2)(i-iii) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>43478<br><br>Based on observations, record reviews and interviews during the recertification survey from 3/5/25 through 3/12/25, the facility did not ensure that a resident who was unable to carry out activities of daily living received the necessary services to maintain personal hygiene for 1 of 1 resident (Resident #29) reviewed for activities of daily living. Specifically, Resident #29 required staff assistance with personal hygiene was observed on three (3) occasions with long, stained fingernails.<br><br>Findings include:<br><br>The facility policy titled nail care revised October 2011 documented that routine nail care is to be done following baths and showers whenever possible.<br><br>The facility policy titled activities of daily living revised October 2023 documented that a resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living including hygiene bathing dressing grooming and oral care.<br><br>Resident #29 was admitted with diagnoses including heart failure, need for assistance with personal care, and dementia. The 1/5/25 Significant Change Minimum Data Set assessment documented Resident #29 had severely impaired cognition, required dependent assistance with showers.<br><br>The 1/2/25 Care Plan documented Resident #29 required maximal assistance with upper body bathing.<br><br>The Kardex documented showers on day shift Wednesdays & Saturdays, dependent with lower body, maximal assistance with upper body. There was no documented evidence regarding trimming or cleaning fingernails.<br><br>On 03/05/25 at 12:55 PM and on 03/06/25 08:55 AM, Resident #29 was observed with long fingernails with yellow-brown stains on them.<br><br>On 03/07/25 at 12:13 PM during an observation and interview, Certified Nurse Aide #7 observed Resident #29's fingernails. Certified Nurse Aide #7 stated they did not pay attention to resident's fingernails when they provided care. They stated they provided care to Resident #29 two days ago and did not notice Resident #29's long fingernails. They stated that fingernails should be clipped when they are long.<br><br>On 03/07/25 at 12:22 PM during an interview, Licensed Practical Nurse Unit Manager #4 stated the Certified Nurse Aides were responsible for cutting residents' fingernails unless the resident was diabetic. They stated the Certified Nurse Aide should have told the nurse if a resident's nails were long. When Licensed Practical Nurse Unit Manager #4 observed Resident #29's fingernails, they stated the resident's fingernails were long.<br><br>10 NYCRR 415.12 (a)(3) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>49364<br><br>Based on observation, record review, and interview conducted during the recertification survey from 3/5/2025 through 3/12/2025, the facility did not ensure residents received quality of care in accordance with professional standards of practice for one (1) of four (4) residents reviewed for accidents. Specifically, Resident #69 had a fall on 12/12/2024 at 4:00 AM, sustained a hematoma (bruise) to the face and complained of pain to their right lower back. Resident #69 was transferred from the floor to the wheelchair and then to the bed by Licensed Practical Nurse #10 and two Certified Nurse Aides (#8 and one unidentified). There was no documented evidence of an assessment by a qualified professional (Physician or Registered Nurse) prior to being transferred from the floor. Additionally, there was no documented assessment by a qualified professional from the time of the fall on 12/12/2024 at 4:00 AM until the resident was transferred to the hospital on 12/13/2024 at 8:32 AM. An X-ray was completed on 12/12/2024 at 6:30 PM which revealed an acute fracture of the trochanteric femur (area in the upper thigh). The hospital discharge summary dated 12/19/2024 documented the resident underwent an open reduction with internal fixation (surgical repair of broken bone) of the right hip on 12/14/2024. This resulted in actual harm to Resident #69 that was not immediate jeopardy.<br><br>Findings include:<br><br>The facility's policy titled Accident/Incident Investigation and Prevention revised 6/2023, documented the facility will provide an environment that is free from accident hazards over which the facility provides supervision and assistive devices to each resident to prevent avoidable accidents. All residents who have an accident/injury will be assessed by a Registered Nurse.<br><br>Resident #69 was admitted to the facility with diagnoses including seizure disorder, heart failure (the heart does not pump blood as well as it should), and traumatic brain injury. The 11/05/2024 Quarterly Minimum Data Set (resident assessment) documented the resident had moderately impaired cognition and required maximal assistance with lying to sitting in bed, was dependent with transfers, and was non-ambulatory.<br><br>The Care Plan for Falls dated 11/18/2024, documented interventions included to monitor for orthostatic hypotension (low blood pressure with positional changes), supervised area when out of bed, remind resident to call for assistance, and to prevent self-ambulation remove wheelchair from bedside while in bed.<br><br>The Certified Nurse Aide Care Instructions for Resident #69 on 12/12/2024, documented Resident #69 required maximum assist of two (2) people with transfers and toilet transfers, and dependent assist of two (2) people with toileting task, non-ambulatory in corridor and in room.<br><br>(continued on next page) |

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F 0684

Level of Harm - Actual harm

Residents Affected - Few

Note: The nursing home is disputing this citation.

The facility's Witnessed Fall Incident Report dated 12/12/2024, completed by Licensed Practical Nurse Unit Manager #12 (who was not present at the time of fall) documented a fall at 4:00 AM. Certified Nurse Aide #8 called Licensed Practical Nurse #10 into the room. The resident was observed sitting on the bathroom floor in front of the sink, feet were straight out in front of the resident with their back against the wall. The resident had shoes on and was able to move all extremities. The resident had a hematoma to the face. The resident was oriented to person only, not situation, time or place. Neurological checks were not initiated. The resident complained of pain to the right side of lower back. Certified Nurse Aide #8 stated that they found the resident ambulating to the bathroom when they were doing rounds and went to assist the resident to the bathroom. The Certified Nurse Aide stated the resident became unsteady on their feet and the Certified Nurse Aide lowered the resident to the floor. The Primary Care Physician was made aware at 4:30 AM, and orders were received for acetaminophen (for pain) as needed, and x-ray of the lumbar spine and right hip.

Certified Nurse Aide #8's written statement dated 12/12/2024 documented the resident was last toileted at 3:30 AM, they observed the resident ambulating to the bathroom and assisted the resident to slide to the floor in the bathroom. The resident had complaints of pain, and they went to get help. The resident was safely seated on the floor, leaning against the wall when they left the room to get the nurse. When they returned, the resident was lying under the sink. They documented that the nurse and another unidentified Certified Nurse Aide assisted in lifting the resident from the floor to the bed.

Licensed Practical Nurse #10's written statement dated 12/12/2024 documented that Certified Nurse Aide #8 called them to Resident's #69 room, where they observed the resident in the bathroom with their back against the wall near the sink and their feet straight out in front of them. Licensed Practical Nurse #10 documented they asked the resident if they would like to go to the hospital and resident refused. The resident was transferred to the wheelchair with a two (2) person assist and then to the bed.

Licensed Practical Nurse #10's progress note dated 12/12/2024 at 6:45 AM documented at approximately 4:00 AM Certified Nurse Aide #8 called them to the resident's room. Resident #69 was observed sitting on the bathroom floor in front of the sink. Their feet were straight out in front of them with their back against the wall. They had shoes on and were able to move all extremities. They complained of pain to the right side of their lower back. Certified Nurse Aide #8 reported that they found the resident ambulating to the bathroom while doing rounds and assisted the resident the rest of the way to the bathroom. The resident became unsteady on their feet and the aide lowered them to the floor. The primary physician was called and ordered to give acetaminophen and get an X-ray. Order for x-ray of the lumbar spine and right hip placed. The resident representative was called, and message left.

The 12/12/2024 at 10:59 AM Physical Therapy note documented the resident presented with hip and facial bruising and was going to have an x-ray to check for fractures.

Licensed Practical Nurse Manager #12's note dated 12/12/2024 at 1:56 PM documented the resident had a hematoma on the lower left eyebrow, purpura/bruise like area on their right mid-back and complained of a lot of discomfort in their right groin and upper thigh area which was swollen. They encouraged the resident to go to the hospital to make sure the hip or pelvis was not broken but the resident declined and would wait for the portable x-ray.

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Licensed Practical Nurse Unit Manager #12's progress note dated 12/12/2024 at 2:21 PM documented Primary Physician #1 examined Resident #69, and the resident refused to go to the hospital. The resident was informed by the physician if the x-ray results showed a hip fracture, the resident would have to go to the hospital; the resident agreed to this.<br><br>There was no documented evidence Primary Physician #1 completed a medical evaluation of Resident #69 on 12/12/2024.<br><br>Licensed Practical Nurse #21's progress note dated 12/13/2024 at 12:21 AM documented an X-ray was done at 6:30 PM (12/12/2024) and the results were pending.<br><br>The x-ray report signed on 12/13/2024 at 7:44 AM, documented the resident had a fracture of the right femur (thigh bone).<br><br>Licensed Practical Nurse Manager #12's progress note dated 12/13/2024 at 8:32 AM documented the Primary Physician was made aware of the x-ray results and ordered to send the resident to the hospital.<br><br>Licensed Practical Nurse Unit Manager #12's progress note dated 12/13/2024 at 8:52 AM, documented the resident left the facility by ambulance.<br><br>The hospital discharge summary dated 12/19/2024 documented the resident underwent surgery for an open reduction with internal fixation of the right hip on 12/14/2024.<br><br>During a telephone interview on 3/11/2025 at 6:02 AM, Registered Nurse Supervisor #19 stated Resident #69 had frequent falls. They stated the process when a resident had a fall was that the staff would notify the Registered Nurse Unit Manager or the Registered Nurse Supervisor before transferring the resident from the floor. The Registered Nurse would assess the resident for injuries and document a risk assessment in the resident's electronic medical record.<br><br>During a telephone interview on 3/11/2025 at 8:10 AM, Licensed Practical Nurse #10 stated they transferred Resident #69 from the floor to the wheelchair with the assistance of two (2) Certified Nurse Aides (#8 and an unidentified) on 12/12/2024. They stated they called the resident's physician who gave an order to transfer the resident to the hospital, but the resident refused to go to the hospital. They stated they called Licensed Practical Nurse Supervisor #13's phone, and no one answered. Licensed Practical Nurse #10 did not answer when asked if a Registered Nurse needed to assess a resident prior to transferring the resident off the floor or after a fall.<br><br>During an interview on 3/11/2025 at 9:05 AM, the Director of Nursing stated that Licensed Practical Nurse #10 did not notify the Director of Nursing that Resident #69 had a fall. The Director of Nursing stated they were not made aware of the fall until 12/12/2024 when they came in to work. The Director of Nursing stated that Licensed Practical Nurse #10 did not report that they transferred the resident from the floor without a Registered Nurse assessment. The Director of Nursing stated Licensed Practical Nurse #10 should not have moved the resident from the floor without a Registered Nurse assessment. The Director of Nursing stated they reviewed the fall incident report and completed an investigation and stated that Licensed Practical Nurse Supervisor #13 re-educated Licensed Practical Nurse #10 on 12/12/2024.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 335803 | A. Building<br>B. Wing | 03/12/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Taconic Rehabilitation and Nursing at Ulster | One Wingate Way<br>Highland, NY 12528 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | During a telephone interview on 3/11/2025 at 12:21 PM, Primary Physician #1 stated they were familiar with Resident #69, but only vaguely remember the incident where they got a call from a nurse related to the resident's fall. They did not know whether the nurse that called was a Registered Nurse or a Licensed Practical Nurse. The Primary Physician stated they did not remember details of their assessment of Resident #69 after the fall incident on 12/12/2024. They stated when a resident had a fall it was their practice to send the resident to the emergency room for evaluation.<br><br>During a telephone interview on 3/11/2025 at 10:05 PM, Licensed Practical Nurse Supervisor #13 stated they were the assigned Supervisor for the night shift on 12/12/2024 and they were not made aware by Licensed Practical Nurse #10 that Resident #69 had a fall. Licensed Practical Nurse Supervisor #13 stated they were made aware of the fall at the end of the night shift by Licensed Practical Nurse Unit Manager #12. Licensed Practical Nurse Supervisor #13 stated they were trained to call the Director of Nursing when there were any falls or any emergency situations.<br><br>During a telephone interview on 3/12/2025 at 6:25 AM Certified Nurse Aide #8 stated they came to work at 11:00 PM on 12/11/2024 and were told by the nurse that Resident #69 had sustained a fall in the afternoon of 12/11/2024. They stated that on 12/12/2024, the resident had another fall at around 4:00 AM. They stated they called the nurse (Licensed Practical Nurse #10) but could not remember the name of the nurse. They stated the resident was on the floor in the bathroom and the nurse asked the resident if they were in pain, and resident stated they were in pain. Certified Nurse Aide # 8 stated they went to the other unit to get another Certified Nurse Aide, and then three staff (Certified Nurse Aide #8 and Licensed Practical Nurse #10 and another Certified Nurse Aide) manually transferred the resident from the floor to the wheelchair, and then from the wheelchair to bed.<br><br>During an interview on 3/12/2025 at 9:01 AM, the Director of Rehabilitation stated Resident #69 required two (2) staff assistance with toileting, transfers, and was non-ambulatory. They stated Resident #69 received Occupational Therapy and Physical Therapy from 8/14/2024 to 10/14/2024 when it was discontinued due to not making further progress.<br><br>NYCRR 415.12 |

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| NAME OF PROVIDER OR SUPPLIER Taconic Rehabilitation and Nursing at Ulster | | STREET ADDRESS, CITY, STATE, ZIP CODE One Wingate Way Highland, NY 12528 | |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43478<br><br>Based on observation, record review, and interview during the recertification survey and abbreviated surveys (NY00347643) from 3/5/25-3/12/25, the facility did not ensure residents at risk for pressure ulcers and residents who had pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote wound healing, and prevent new ulcers from developing for 2 of 4 residents (Residents #68 and #352) reviewed for Pressure Ulcers. Specifically, 1) Resident #68's feet were not floated in bed as ordered and there was no documented evidence that wound care treatments were administered 10 of 48 times in February and 4 of 18 times in March, and 2) for Resident #352, there was no documented evidence that wound care treatments were administered five (5) times in May and June 2024 for their Stage 3 pressure ulcers to their coccyx, and left lateral ankle, and Stage 4 pressure ulcer to their left dorsal foot.<br><br>The findings are:<br><br>The 6/23 facility policy titled Documentation of Pressure Ulcer and Chronic Wounds documented pressure ulcers and chronic wounds are monitored closely to monitor effectiveness of treatment and change in risk factors, all pressure ulcers and chronic wound dressings will be inspected daily, pressure, stasis, and or chronic wounds will be monitored daily with documentation.<br><br>1) Resident #68 had diagnoses including protein calorie malnutrition, failure to thrive, and dementia. The 11/20/24 Quarterly Minimum Data Set Medicare 5-day assessment documented intact cognition. Resident #68 required maximum assistance with rolling in bed and had two unstageable pressure ulcers present on admission.<br><br>The 11/13/24 Hospital Nursing Wound Summary documented follow-up evaluation for two left lateral heel deep tissue injuries approximately 0.5-centimeter X 1.5 centimeter deep, maroon in color, diffuse wound edges, bilateral heels red and slow to blanch. Area cleaned, skin prep applied, and area offloaded with pillow. Dayshift nurse informed. General Care Instructions to continue implementation of the pressure injury prevention bundle. Mattress type recommended-pressure redistribution bed/mattress, schedule regular repositioning and turning.<br><br>The 11/15/24 Skin Integrity at Risk Care Plan documented intervention to float Resident #68's heels in bed.<br><br>The 1/15/25 Skin Risk Data Collection Tool documented an unstageable pressure injury to the bottom of right foot. It was not open and there was no drainage. Care Planning interventions included to float heels when in bed.<br><br>The 2/4/25 Skin Integrity at Risk Care Plan documented intervention to float heels in bed.<br><br>The 2/12/25 Physician's Orders documented to apply Skin Prep to heels as prophylaxis every shift.<br><br>The 2/15/25 Quarterly Minimum Data Set assessment documented intact cognition. Resident #68 required maximum assistance with rolling in bed, and one Stage 2 pressure ulcer present on admission.<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Taconic Rehabilitation and Nursing at Ulster | One Wingate Way<br>Highland, NY 12528 |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The Kardex (Certified Nurse Aide instructions) documented to float Resident #68's heels in bed.<br><br>The February 2025 Treatment Administration Record documented no evidence that skin prep was administered as ordered 10 of 48 times (2/14, 2/18, 2/24, and 2/25 on the evening shift, 2/15 and 2/23 on the day shift, and 2/16, 2/21, 2/22, and 2/24 on the night shift).<br><br>The March 2025 Treatment Administration Record documented no evidence that skin prep was administered 4 of 18 times between 3/1/25 and 3/6/25 (3/2 on the evening shift, 3/3 on the day shift, and 3/2 and 3/6 on the night shift).<br><br>On 3/05/25 at 10:37 AM, Resident #68 was observed sitting in their wheelchair wearing sneakers, with their right foot on the floor, although their wheelchair footrest was in place. Resident #68 stated their right heel was bruised and it felt better when they were wearing sneaker because the sneaker had padding. They stated their heel hurts at night when they move their foot. Resident #68 stated that nobody offered padded booties in bed.<br><br>On 3/06/25 at 9:06 AM, Resident #68 was observed in bed with their heels directly on the mattress, and no heel booties or pillow was observed to float their heels, and there was no air mattress in place.<br><br>On 3/07/25 at 10:45 AM, Resident #68 was observed lying in bed with their heels directly on the mattress, no air mattress was in place, no heel booties or pillow were observed to float their heels.<br><br>On 3/07/25 at 10:47 AM during an interview, Certified Nurse Aide #3 stated they were responsible for Resident #68 and did not know much about Resident #68's left foot. They stated they did not get report about any specifics on Resident #68's positioning or floating their heels. Certified Nurse Aide #3 stated they looked at the Kardex before providing cares to Resident #68, and did not notice anything about positioning or floating their heels. When they reviewed the Kardex during the interview, they stated they should have put a pillow under Resident #68's calves.<br><br>On 3/07/25 at 10:54 AM during an interview, Licensed Practical Nurse #2 stated they were responsible for Resident #68. They stated they were aware of the order to apply skin prep to Resident #68's bilateral heels and Resident #68's heels should be floated in bed.<br><br>On 3/07/25 at 11:15 AM during an interview, the Assistant Director of Nursing stated they did weekly wound care rounds with the wound care physician. The Assistant Director of Nursing reviewed the resident's care plan and stated the Certified Nurse Aide should have checked the Kardex and floated Resident #68's heels.<br><br>On 3/07/25 at 11:08 AM during an interview, Licensed Practical Nurse #1 stated they were responsible to apply the Skin Prep to Resident #68's heels on 2/15/25. They stated they believed they applied the treatment but forgot to sign and should have signed.<br><br>On 03/07/25 at 1:27 PM during an interview with the Director of Nursing regarding administration omissions, they stated the nurses were responsible for administering treatments as ordered by the provider and for signing the administration records after completion.<br><br>51214<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER Taconic Rehabilitation and Nursing at Ulster | | STREET ADDRESS, CITY, STATE, ZIP CODE One Wingate Way Highland, NY 12528 | |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2. Resident #352 had diagnoses including Chronic Vascular Disorders of the Intestine, Peripheral Vascular Disease, and Peripheral Neuropathy.<br><br>The Care Plan titled At Risk for Impaired Skin Integrity dated 2/14/24 documented the resident was at risk for impaired skin related to neuropathy and anemia. Interventions included to apply moisture barrier following incontinence care and as needed, turn and reposition every 2 hours and as needed, and skin and feet check with daily care, document weekly on shower day.<br><br>The Admission 5 Day Minimum Data Set, dated dated dated [DATE] documented intact cognition, maximum assistance with most activities of daily living, at risk for pressure ulcers, and no ulcers present.<br><br>The Medical Provider Note dated 4/14/24 documented a new Stage 1 to the coccyx.<br><br>The Physician's Order dated 4/14/24 documented to cleanse coccyx with normal saline, pat dry, apply hydrogel to wound bed, and cover with border gauze.<br><br>The Physician's Order dated 4/18/24 documented an air mattress.<br><br>The Wound Care Note dated 4/23/24 documented:<br><br>- a coccyx Stage 3 pressure injury measuring 4.5-centimeter x 3.5 centimeter x 0.1 centimeter,<br><br>- a deep tissue injury to the right heel measuring 0.5-centimeter x 2.0 centimeter x unable to measure depth,<br><br>- a deep tissue injury left lateral foot measuring 0.5 centimeter x 1.0 centimeter x unable to measure depth,<br><br>- a deep tissue injury left lateral ankle measuring 5.6 centimeter x 1.4 centimeter x unable to measure depth.<br><br>The Physician's Order dated 4/24/24 documented to apply Santyl Ointment topically every day shift for wound care. To cleanse the wound at coccyx with wound cleanser and pat dry, apply a thin layer of Santyl and cover with dry protective dressing.<br><br>The Care Plan titled Impaired Skin Integrity revised 4/26/24 documented resident with impaired skin integrity related to dehydration, impaired mobility, poor nutrition, pressure ulcer. Interventions included administer treatment per physician's order, provide adequate calories and protein for healing, measure and evaluate wound at least weekly, offload heels.<br><br>The Significant Change in Status Minimum Data Set, dated dated dated [DATE] documented intact cognition, maximum assistance to dependent on assistance for Activities of Daily Living, at risk for pressure ulcers, two Stage 3 pressure ulcers and one deep tissue injury/unstageable.<br><br>The Physician's Order dated 5/7/24 documented Santyl Ointment for wound care; to cleanse left ankle with wound cleanser spray and apply Santyl to open area only, cover with Xeroform to open area and dry protective dressing.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The Physician's Order dated 5/7/24 documented Xeroform Oil Emulsion 2x 2 External Pad apply to Coccyx topically in the evening for wound care. To cleanse coccyx with wound cleanser, apply Xeroform and cover with dry protective dressing.<br><br>The Physician's Order dated 5/7/24 documented Xeroform Oil Emulsion 2x 2 External Pad apply to left ankle topically in the evening for wound care.<br><br>The Treatment and Medication Administration Records for May 2024 had no documented evidence that the treatment to the coccyx was completed on 5/2, 5/6, 5/7, and 5/9/24; and no evidence it was completed for the left ankle on 5/9/24.<br><br>The Physician Order dated 6/19/24 documented Santyl Ointment to apply topically every evening shift for wound care cleanse left dorsal foot with NS or wound cleanser.<br><br>The Medication and Treatment Administration Records for June 2025 had no documented evidence that the treatments to the left ankle and left dorsal foot were completed on 6/21/24.<br><br>During an Interview on 3/12/25 at 10:10 AM, Licensed Practical Nurse Unit Manager #14 stated the treatments for Resident #352's wound care were not signed on 5/2, 5/6, 5/7, 5/9, and 6/21 and the nurse failed to document a reason why. They stated that if the nurse did not complete the treatment, there should be documentation why the treatment was not done.<br><br>During an interview on 03/12/25 at 10:40 AM, the Director of Nursing stated if the nurse did not sign for a treatment or medication on the administration records, that would mean the treatment or medication was not administered. They stated the nurse should have documented the reason the treatment was not done on the Medication or Treatment Administration records and/or in a progress note.<br><br>10 NYCRR 415.12 |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51214<br><br>Based on observation, interview, and record review conducted during the recertification survey from [DATE]-[DATE], the facility did not ensure drugs and biologicals were maintained in accordance with currently accepted professional standards for expiration dates and storage. Specifically, 1) one (1) of two (2) medication rooms examined for medication storage, had a box of expired Jevity 1.5 feeding that was stored and being used; and expired nicotine patches were stored in 1 of 3 medication carts examined for medication storage. 2) Resident #60 was found with physician ordered Isosorbide, Amlodipine, Carvedilol (blood pressure pills), Sertraline (anti-depressant), Aspirin, Apixaban (blood thinner), Folic Acid (supplement), Levetiracetam (seizure medicine), Docusate (stool softener), and Omeprazole (anti-acid) in their room on their bedside table.<br><br>The findings are:<br><br>The facility policy titled Medication/Treatment Labeling and Storage revised ,d+[DATE], documented medications/treatments are stored under proper conditions of sanitation, temperature, light, moisture and ventilation. There is no documentation specific to expiration dates in the policy.<br><br>1. During an observation of the Medication Room on the First Floor Unit on [DATE] at 11:00 AM, an open box containing six bottles of Jevity 1.5 Cal with an expiration date of February 1, 2025 was found.<br><br>During an observation on [DATE] at 11:25 AM with Licensed Practical Nurse #2, a nearly empty bottle of Jevity 1.5 Cal was observed in Resident #90's room hanging, but not running or being administered to resident at that time. A handwritten date of [DATE] was written on the bottle. The bottle had an expiration of February 1, 2025.<br><br>During an interview on [DATE] at 11:33 AM, Licensed Practical Nurse #2 stated that the Jevity 1.5 Cal hanging in Resident #90's room was stopped by them that morning as their feeding was hung in the evening and taken down in the morning at 10 AM. They stated the Jevity 1.5 Cal used did have an expiration date of [DATE] and should not have been hung since it was expired.<br><br>During an observation on the First Floor Unit on [DATE] at 11:40 AM with Licensed Practical Nurse #1, seven Nicotine Patches with an expiration date of ,d+[DATE] were loose in the top drawer of the medication cart with no resident label. Licensed Practical Nurse #1 was interviewed during the observation and stated the patches were house stock so that was why there was no label. They stated the patches should not have been in the cart since they were expired.<br><br>During an interview on [DATE] at 3:57 PM, Licensed Practical Nurse Unit Manager #4 stated that the medication nurse hanging a tube feeding should check the expiration date prior to hanging it. They stated all nurses should check the contents of the medication room for any expired items. Medication nurses should be checking, and are responsible for, the contents of their medication carts. They should dispose of any expired items and let the Unit Manager know.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2. Resident #60 was admitted to the facility with diagnoses including Hypertension, Epilepsy, Atrial Fibrillation, and Folate Deficiency Anemia. The [DATE] admission Minimum Data Set assessment documented intact cognition, and required set-up and clean-up assistance with eating.<br><br>The Physician Orders and February 2025 Medication Administration Record documented morning medications included Isosorbide 30 mg for Hypertension, Carvedilol 12.5 mg for Hypertension, Sertraline 50 mg for depression, Amlodipine 5 mg for Hypertension, Aspirin 81 mg tablet for prophylactic, Docusate 1 tablet for constipation, Apixaban 5 mg for Atrial Fibrillation, Folic Acid 1000 mcg for supplement, Levetiracetam 1000 mg for seizure, and Omeprazole 20 mg for Gastro-esophageal disease.<br><br>The [DATE] Care Plan had no documented evidence Resident #60 could self-administer medications.<br><br>On [DATE] at 10:15 AM during an observation, Registered Nurse Unit Manager #6 entered Resident #60's room and left a cup of medication at bed table and instructed Resident #60 to not take the medications until they returned with water.<br><br>On [DATE] at 10:26 AM, during an observation Resident #60's medications were still sitting on bedside table.<br><br>On [DATE] at 10:28 AM during an interview, Registered Nurse Unit Manager #6 stated the medications left at bedside were Isosorbide, Carvedilol, Sertraline, Amlodipine, Aspirin, Docusate, Apixaban, Folic acid, Keppra, and Omeprazole. Registered Nurse Unit Manager #6 stated Resident #60 was alert and would wait for them to bring water to take the medication. Registered Nurse Unit Manager #6 stated they should have left the medications locked in the medication cart while getting water for the resident. Registered Nurse Unit Manager #6 stated this was not normal practice or facility policy.<br><br>10 NYCRR 415.18(e) (,d+[DATE])<br><br>51902 |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>51902<br><br>Based on observation and interview conducted during the recertification survey from 3/5/25 to 3/12/25, the facility did not ensure food was distributed and served in accordance with professional standards for food service safety. Specifically, nursing staff did not perform proper hand hygiene while serving beverages at lunch meal.<br><br>The findings are:<br><br>The facility policy last revised 11/2019, Dining Room Service documented dining room meal service is provided in a clean, comfortable and orderly atmosphere.<br><br>On 3/5/25 at 12:28 PM in the main dining room, the Assistant Director of Nursing was observed serving beverages to multiple residents wearing disposable gloves and not changing gloves between service. The Assistant Director of Nursing touched the beverage cart handle, proceeded to pick up a resident's glass, touched the carafe/pitcher handle and replaced the glass for resident use. The Assistant Director of Nursing did not change their disposable gloves before moving to serve the next resident. This was observed multiple times until the Regional Director of Nursing was observed speaking to the Assistant Director of Nursing, upon which the Assistant Director of Nursing removed the disposable gloves. The Assistant Director of Nursing continued to serve residents without using hand sanitizer or washing their hands between serving residents. The Assistant Director of Nursing touched their own face with their bare hand while taking a beverage order at a table and proceeded to serve Resident #93 hot cocoa in a cup at a separate table. Resident #93 touched the cup to take a drink. The Assistant Director of Nursing touched a resident's walker with their bare hands to move it for a resident and continued to serve a beverage to that resident. After all beverages were served and beverage cart was put away, Assistant Director of Nursing used hand sanitizer.<br><br>On 3/5/25 at 1:15 PM during an interview with the Assistant Director of Nursing, they stated they wore disposable gloves because they were worried the ice scoop would fall into the ice bin during service and bare hands would contaminate the ice. The Assistant Director of Nursing stated the Regional Director of Nursing asked why gloves were being used, and stated gloves were not needed. The Assistant Director of Nursing stated the disposable gloves were to protect the residents. The Assistant Director of Nursing stated they should have used the sink to wash hands, but the sink was out of soap. The surveyor confirmed no soap at sink. The Assistant Director of Nursing stated if they had no soap and no disposable gloves, they should have used hand sanitizer, which was used after beverage service.<br><br>10 NYCRR 415.14(h) |

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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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>41666<br><br>Based on observation, record review and interview conducted during a recertification survey from 3/5/25 to 3/12/25, the facility did not ensure infection control prevention practices were maintained to prevent the development and transmission of communicable diseases and infection for all residents. Specifically, 1) the facility did not provide documentation of screening, administration, or declination and education provided for 2 of 10 staff (Certified Nurse Aide #15 and Laundry Aide #16) reviewed for pneumococcal vaccination; 2) there was no evidence that a Water Management Plan was reviewed and updated, if needed, annually to prevent and control Legionella; and 3) a Licensed Practical Nurse was observed putting an unsanitized blood pressure cuff into the medication cart before properly cleaning it.<br><br>The findings are:<br><br>The facility policy titled Pneumococcal Vaccination Program for employees dated 10/24 documented control of pneumococcal disease is increasingly important due to high morbidity rates. The pneumococcal vaccine will be offered to all employees.<br><br>During the recertification survey the facility was asked to provide documentation that pneumococcal vaccination was offered, education was provided, and staff had the opportunity to consent or decline the vaccine for Certified Nurse Aid #15 and Laundry Aide #16, but none was provided.<br><br>1.During an interview on 3/12/25 at 10:59 AM, Licensed Practical Nurse #17 stated they were responsible for collecting data for employee immunization status which included eligibility, education and administration of vaccines. They stated they did not have completed forms for Certified Nurse Aide #15 and Laundry Aide #16 which verified they were eligible, educated and consented to or declined the pneumococcal vaccination.<br><br>During an interview on 03/12/25 at 10:29 AM, the Director of Nursing stated the Infection Preventionist was new, and they had delegated the vaccines task to the Licensed Practical Nurse #17. Licensed Practical Nurse #17 was responsible for ensuring forms were signed by the employee as proof that education was provided. The Director of Nursing stated they would make sure vaccines were offered and declinations were on file for staff and was not sure why this happened.<br><br>2., The facility's Legionella binder was reviewed with the Director of Maintenance and the Regional Director of Maintenance.<br><br>The Water Management Plan was undated, and there was no documented evidence as to when it was completed, reviewed, or updated.<br><br>On 03/05/25 at 3:45 PM, the Director of Maintenance stated they did not realize the Water Management Plan was undated.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335803 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/12/2025 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Taconic Rehabilitation and Nursing at Ulster | One Wingate Way<br>Highland, NY 12528 |

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

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|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 3. During an observation of the medication pass on the second-floor unit that started at 8:58 AM on 3/10/25, Licensed Practical Nurse #18 obtained a blood pressure reading for Resident #40 prior to administering their medications. They used a wrist cuff to obtain the reading. After obtaining the blood pressure, they returned the wrist cuff back into the medication cart without sanitizing the cuff. When asked about the sanitization of the cuff, Licensed Practical Nurse #18 stated it should have been wiped after use.<br><br>During an interview on 3/10/25 at 11:03 AM, the Director of Nursing stated that all shared equipment should be sanitized between each use. They stated that staff may use either alcohol wipes or the sanitizing wipes with a purple top to sanitize the cuff.<br><br>10NYCRR 415.19 (a)(1-3)<br><br>43478<br><br>51214 |

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|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Taconic Rehabilitation and Nursing at Ulster | | STREET ADDRESS, CITY, STATE, ZIP CODE One Wingate Way Highland, NY 12528 | |

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

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|---|---|
| F 0887<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.<br><br>41666<br><br>Based on observation, record review and interview conducted during the recertification survey from 3/5/25 to 3/12/25, the facility did not ensure infection control prevention practices were maintained to prevent the development and transmission of communicable diseases and infection for all residents. Specifically, the facility did not provide documentation of screening, administration or declination and education provided for 2 of 10 staff (Certified Nurse Aide #15 and Laundry Aide #16), reviewed for COVID-19 vaccinations.<br><br>The findings are:<br><br>The facility COVID-19 policy dated 10/30/24 documented the facility will ensure that all employees and contracted staff will be screened prior to offering the vaccination and prior to immunization, medical precautions and contraindications necessary for determining whether they are appropriate candidates for vaccination at any given time.<br><br>Documentation will be maintained to reflect that the required education was provided and whether the resident and staff member received the vaccine.<br><br>During the recertification survey, the facility was asked to provide documentation that COVID-19 vaccination was offered, education was provided, and staff had the opportunity to consent or decline the vaccine for Certified Nurse Aide #15 and Laundry Aide #16, but none was provided.<br><br>During an interview on 3/12/25 at 10:59 AM with Licensed Practical Nurse #17, they stated they were responsible for collecting data for employee immunization status which included eligibility, education and administration of vaccines. They did not have a completed form for Certified Nurse Aide #15 and Laundry Aide #16 which verified they were eligible, educated and consented to or declined the vaccination. Licensed Practical Nurse # 17 stated they did not know the COVID-19 vaccine needed to be offered to staff.<br><br>During an interview with the Director of Nursing on 03/12/25 at 10:29 AM they stated the Infection Preventionist was new and they delegated the vaccines to the Licensed Practical Nurse #17 to ensure forms were signed by the employee as proof education was provided. The Director of Nursing stated they were not sure why this happened.<br><br>10NYCRR 415.19 (a)(1-3) |