STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335812	A. Building B. Wing	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hudson Park Rehabilitation and Nursing Center	325 Northern Boulevard Albany, NY 12204

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21414 Based on observation, interviews, and record review conducted during the abbreviated survey (NY00337430), the facility did not provide effective housekeeping and maintenance services on five (5) of 5 resident units. Specifically, the facility did not ensure that resident room, resident bathroom, common areas, and closets were clean; and furniture and walls were in good repair. This is evidenced by: The following observations were noted on 01/10/2024 from 9:50 AM through 3:30 PM and again on 04/03/2024 from 11:35 AM through 12:06 PM: Finding #1: Soiled Floors Floors were soiled in corners and next to walls in resident room #s 201, 203, 213, 217, 221, 227 bathroom, 304, 316, 317, 317 bathroom, 401, 402, 427, 523, and 525 (behind loose coving baseboard). Floors were soiled around wardrobes in resident room #s 407, 408, 409, 412, 418, 420, 421, and 422. The bathroom shower floor drains were soiled with a black buildup in resident room #s 505, 513, and 522. The bathroom floor in resident room [ROOM NUMBER] was soiled with a black mold-like substance. The door tracks for elevator #1 and elevator #2 were soiled with black particles. Finding #2: Heater/air conditioning units The heater/air conditioning units were soiled with dust, grime, beverage drips, or smudge marks in resident room #s 203, 304, 316, 317, 401, 402, 407, 412, 421, 427, 503, 505, 511, 512, 513, and 525, and the 5th floor dining room. Finding #3: Windows (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Windows were soiled with in resident room #s 206, 207, 211, 212, 213, 214, 215, 219, 304, 307, 308, 309, 312, 313, 314, 315, 316, 317, 401, 402, 405, 409, 410, 418, 420, 421, 422, 427, 503, 504, 511, 512, 513, 523, and 525; and in the corridors on the 2nd, 3rd, 4th, and 5th floors. Finding #4: Other environmental concerns The wall paneling was dusty in resident room #s 227, 403, and 500. The mop buckets and mop wringers in use on the 4th and 5th floors were heavily soiled with a black buildup. Record Review There is no documented evidence that facility staff are trained or expected to clean resident room floors in corners or next to walls, the heating/air conditioning units, wall paneling, around wardrobes, or windows. There is no documented evidence that facility staff are trained or expected to clean the floor drains in resident room showers that have a buildup of debris. There is no documented evidence that the facility requires elevator door tracks and mop buckets and wringers are to be kept clean. Interviews During an interview on 04/03/2024 at 1:46 PM, Interim Director of Housekeeping #1 stated that the facility had developed a schedule to deep clean all resident rooms, the maintenance department would be asked to move the wardrobes, cleaning the heating/air conditioning units and wall paneling would be added to the cleaning schedule, and a new housekeeping director had been hired starting work next week. Interim Director of Housekeeping #1 stated that the mop buckets and wringers would be cleaned by the end of the day today. During an interview on 04/03/2024 at 2:10 PM, Administrator #1 stated issues with environmental cleanliness including floors and windows have been identified; interdisciplinary rounding audits with housekeeping, maintenance, and someone from another department have begun; and though much improvement with the environment has been accomplished more needs to be done. 483.10(i)(2) 10 New York Codes, Rules, and Regulations 415.5(h)(4)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. 35228 Based on record review and interviews during an abbreviated survey (NY00336807), the facility did not ensure each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used without adequate indications for its use for 1 (Resident #3) of 5 residents reviewed for unnecessary drugs. Specifically, Resident #3 was administered Resident #9's medication in error when the nurse became distracted. This is evidenced by: The Policy and Procedure titled, Medication Administration, revised 3/8/2024, documented medications shall be administered in a safe and timely manner, and in a way that ensured the resident's safety. Medications must be administered in accordance with the orders. Resident #3 The resident was admitted to the facility with diagnoses of diabetes, peripheral vascular disease (narrowed blood vessels reduce blood flow to the legs), and heart disease with heart failure. The Minimum Data Set (an assessment tool) dated 2/15/2024, documented the resident was cognitively intact, could be understood, and could understand others. The Medication Order Report dated 3/4/2024 - 4/4/2024 did not document any Medical Doctor orders for Xeljanz (used to treat rheumatoid arthritis, a disorder that causes warm, swollen, painful joints), Baclofen (a muscle relaxant), or Celexa (a medication to treat depression). A Nurse's Progress Note dated 3/21/2024 at 10:35 AM, documented the resident received another resident's (Resident #9) medications by mistake. The medications administered were Baclofen 5 milligrams, Celexa 40 milligrams, and Xeljanz 5 milligrams. Vital signs were within normal limits. An untimed Nurse Practitioner Encounter Note dated 3/21/2024, documented they were notified by Registered Nurse Unit Manager #3 that Resident #3 received Resident #9's medications in error. Resident #3 stated they felt fatigued but denied other symptoms. Registered Nurse Unit Manager #3 reviewed the medications with Resident #3 and explained the medications could make them feel fatigued. During an interview on 4/09/2024 at 11:12 AM, Registered Nurse Unit Manager #3 stated on 3/21/2024 Resident #3 was administered another resident's medications by Licensed Practical Nurse #8. The Nurse Practitioner was notified and Resident #3 was monitored. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/15/2024 at 2:10 PM, Licensed Practical Nurse #8 stated they had prepared Resident #9's medication and was getting ready to administer it to them when Resident #3 who was getting ready to leave the unit - approached them and asked if they could take their medication before they left. Licensed Practical Nurse #8 stated they started having a conversation with Resident #3 as they were dispensing their medication into the cup and then gave them to Resident #3. They stated when they went to give Resident #9 their medication, all that was on the medication cart was the cup of water they were going to give them with their medication; the medicine cup was gone. That was when Licensed Practical Nurse #8 realized what had happened. They stated they told the unit manager immediately and the Medical Provider was notified. Licensed Practical Nurse #8 took Resident #3's vital signs, which were within normal limits. Licensed Practical Nurse #8 stated the resident became sleepy and the Nurse Practitioner told Resident #3 and Licensed Practical Nurse #8 that it was an expected medication reaction. Licensed Practical Nurse #8 stated when Resident #3 returned to the unit, they rechecked their vital signs, and they were still within normal limits. They stated they gave report to the next shift regarding the incident. During an interview on 4/16/2024 at 10:25 AM, Director of Nursing #1 stated Licensed Practical Nurse #8 had Resident #9's medications ready to administer to them when Resident #3 approached the nurse and asked them to administer their medications because there were leaving the unit. Director of Nursing #1 stated that in being distracted, Licensed Practical Nurse #8 put Resident #3's medication in the same cup with Resident #9's and gave it to them. Director of Nursing #1 stated the Nurse Practitioner was notified, the resident was seen and monitored. There were no ill effects to Resident #3. 10 New York Codes, Rules, and Regulations 415.12(l)(1)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 35228 Based on record review and interviews during an abbreviated survey (NY00336807), the facility did not ensure its residents were free of any significant medication errors for 1 resident (Resident #2) of 5 residents reviewed for significant medication errors. Specifically, Licensed Practical Nurse #6 applied a 50 microgram Fentanyl transdermal patch (a strong narcotic pain medication that could be absorbed through the skin by applying a patch on the skin) on the resident's arm. The resident was prescribed a Fentanyl 12.5 microgram transdermal patch. This is evidenced by: The Policy and Procedure titled, Medication Administration, revised 3/08/2024, documented medications should be administered in a safe and timely manner, and in a way that ensured the resident's safety. Medications must be administered in accordance with the orders. The individual administering the medication must check the label 3 times to verify the right medication, right dosage, right time, and right route of administration before giving the medication. Resident #2 Resident #2 was admitted to the facility with diagnoses of lupus (an illness that occurs when the immune system attacks healthy tissues and organs), psoriatic arthritis (an inflammatory autoimmune condition that can affect both the joints and skin), and mild asthma. The Minimum Data Set (an assessment tool) dated 2/21/2024, documented the resident was cognitively intact, could be understood, and could understand others. Physician's Orders dated 3/22/2024, documented Fentanyl patch 12.5 micrograms, 1 patch transdermal every 72 hours. The Medication Administration Record dated March 2024 documented a Fentanyl patch was applied on 3/25/2024 by Licensed Practical Nurse #6. There was one removed and destroyed on 3/26/2024 by Licensed Practical Nurse #7. A Nurse's Progress Note dated 3/26/2024 at 2:05 AM, documented the resident seemed sleepy. The resident's blood pressure was 158/98, heart rate 98 and regular, respirations 20, and temperature 97.1 degrees Fahrenheit. The resident denied pain and discomfort. Lung sounds were clear. A Nurse's Progress Note dated 3/26/2024 at 12:22 PM, documented the resident received a 50-microgram patch accidentally for a short period of time. The patch was removed, and 12.5 microgram was applied as ordered. The Medical Doctor was aware. There were no adverse effects noted. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/03/2024 at 11:32 AM, Resident #2 stated on 3/25/2024, they had been given the wrong dose of Fentanyl. They stated Licensed Practical Nurse #6 applied a 50-microgram transdermal patch when they were prescribed a 12.5 microgram patch. They stated they started feeling a little funny, so they told the floor nurse (they did not know their name). The floor nurse confirmed to them that they received the wrong dose of Fentanyl, and called Registered Nurse Supervisor #2. Resident #2 stated Registered Nurse Supervisor #2 made a phone call and the correct dose of Fentanyl was then applied. During an interview on 4/09/2024 at 11:14 AM, Licensed Practical Nurse #6 stated they were floated to Resident #2's unit 3/25/2024 between 8:45 AM and 9:00 AM . They stated they had taken a Fentanyl patch from the medication room to lock in the locked box in their medication cart, and did not realize there were two residents on the unit using Fentanyl patches. When they took the patch out of the box, they did not notice a label. They stated there were 2 boxes of Fentanyl, 1 was already open and one was fully closed. Licensed Practical Nurse #6 stated it did not occur to them that the Fentanyl patches were for two different residents. They stated Resident #2 was leaving the unit for a time period and asked if they could wait to have their Fentanyl patch applied until after they returned. Licensed Practical Nurse #6 stated when the resident returned, they asked for their Fentanyl patch, and they applied it. Licensed Practical Nurse #6 stated they were re-educated to double check everything and always check the boxes of Fentanyl patches for labels. During an interview on 4/09/2024 at 11:12 AM, Registered Nurse Unit Manager #3 stated when they came in to work on 3/26/2024, they heard Resident #2 had a 50-microgram Fentanyl patch applied (was Resident #4's Fentanyl). They stated the patch was removed prior to their shift on 3/26/2024 and the correct dose applied (12.5 micrograms). During an interview on 4/15/2024 at 10:48 AM, Registered Nurse Supervisor #2 stated Resident #2 reported to them they had the wrong dose of Fentanyl applied. They stated Resident #2 had a 50-microgram patch applied to their arm instead of the 12.5 microgram patch that was ordered for them. They stated the 50-microgram Fentanyl patch was removed and they immediately called the Medical Doctor, who ordered to put the 12.5 microgram patch on the resident which was done. During an interview on 4/16/2024 at 10:25 AM, Director of Nursing #1 stated Licensed Practical Nurse #6 was sent to Resident #2's unit from another unit. The Licensed Practical Nurse grabbed Resident #4's fentanyl patch in error and applied it to Resident #2. It was the wrong dose. The resident was administered 50 micrograms, and the resident was prescribed 12.5 micrograms. 10 New York Codes, Rules, and Regulations 415.12(m)(2)