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	06/12/2024

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

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 48413 Based on observations, record review, and interviews during a recertification survey, the facility did not ensure that each resident was treated with respect and dignity and cared for in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. Specifically, dining meals were served with disposable utensils in 1 (fourth floor) of 4 dining rooms; and for 1 (Resident #150) out of 3 residents reviewed, the facility did not ensure the resident was treated in a dignified manner by ensuring resident was fully clothed in common areas. This is evidenced by: Fourth Floor Dining Room During an observation on 6/07/2024 at 12:15 PM, seven residents were given plastic utensils for their meal. During a record review, no comprehensive care plans included the usage of plastic utensils at meals. During an interview on 6/10/2024 at 3:05 PM, Licensed Practical Nurse #4 stated that plastic utensils may be used for safety reasons and should be in the comprehensive care plan. During an interview on 6/10/2024 at 3:35 PM, Registered Nurse #5 stated the use of plastic utensils should be in the comprehensive care plan for each resident that uses plastic utensils. Resident #150 Resident #150 was admitted to the facility with the diagnoses of multiple sclerosis (a condition that causes damage to our nerves), gastroesophageal reflux disease, and herpes viral infection. The Minimum Data Set (an assessment tool) dated 4/11/2024 documented Resident #150 was cognitively intact, usually understood and could usually understand others. During multiple observations on 6/04/2024 in the morning, Resident #150 was walking in the hallway with their pants falling down, exposing the incontinence brief. During observations, facility staff did not intervene. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Comprehensive Care Plan titled Activities of Daily Living Functional Status/Rehabilitation Potential dated 10/24/2023, Resident #150 was care planned for moderate/partial assistance for upper body and lower body dressing assistance. During an interview on 6/10/2024 at 11:25 AM, Certified Nurse Aide #6 stated if a resident was found to be clothed inappropriately, they would grab a hospital gown from the linen cart and place it on the resident. They would bring the resident back to their room to get appropriately dressed. During an interview on 6/10/2024 at 3:05 PM, Licensed Practical Nurse #4 stated the resident should not have been wearing those pants as they did not fit the resident appropriately. They stated residents should not have clothes on that did not fit appropriately. 10 New York Codes, Rules, and Regulations 415.5 (a)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 48615 Based on observation, record review, and interviews during a Recertification survey, the facility did not ensure residents were assessed by an interdisciplinary team to determine their ability to safely self-administer medication when clinically appropriate for 1 (Resident #91) of 1 resident reviewed for medication administration. Specifically, Resident #91 was observed self-administering medications in their room without being evaluated as to whether they could safely do so. This is evidenced by: The facility policy titled, Medication Administration and last revised 6/01/2024, documented medications should be administered in a safe and timely manner, and as prescribed. Medications would not be left at the resident's bedside. Residents may self-administer their own medications only if the Physician, in conjunction with the Interdisciplinary Care Planning Team, had determined that they have the capacity to do so safely. Resident #91 was admitted to the facility with diagnoses of sepsis due to methicillin resistant staphylococcus aureus (a type of staph infection that can be resistant to several antibiotics known also as MRSA), diabetes, and psoriasis (patches of abnormal skin). The Minimum Data Set (an assessment tool) dated 4/06/2024, documented the resident was cognitively intact, could be understood, and could understand others. During an observation on 6/06/2024 at 12:21 PM, Resident #91 was observed in their room applying betamethasone cream to their right lower extremity. Additionally, generic lubricant eye drops were observed in the resident's room. A Physician's Order dated 4/17/2024, documented the resident was to be administered betamethasone cream 0.05%, apply to psoriasis plaques/lesions twice a day. The order documented an end date of 5/17/2024. A Physician's Order dated 4/18/2024, documented the resident was to be administered Systane (lubricant eye drops) 0.4-0.3%, 1 drop each eye four times a day. The Medication Administration Record for May 2024 documented the betamethasone was administered twice daily from May 1, 2024, through May 17, 2024. There was no documentation of the medication being administered after May 17, 2024. The Medication Administration Record for June 2024 documented the Systane was administered as ordered from June 1, 2024, through June 12, 2024. Upon review of Resident #91's electronic medical record, there was no documented evidence that the resident was assessed to safely self-administer medications; there was no physician order or care plan in place for the resident to self-administer medications. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/06/2024 1:09 PM, Registered Nurse #4 stated there were no residents on their Unit who self-medicated. If a resident wished to self-medicate, the Physician would be notified and an assessment completed in the electronic medical record. 10 New York Codes, Rules, and Regulations 415.3 (e)(1)(vi)

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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. 21414 Based on observation, record review, and interviews conducted during the recertification and abbreviated (Case # NY00323716) survey, the facility did not provide effective housekeeping and maintenance services on 4 of 4 resident units, the basement, and the facility grounds. Specifically, floors, window blinds, tables, ceiling light covers, room signs, and facility grounds were not clean or maintained. This is evidenced by: During observations on 6/04/2024 from 10:19 AM through 11:00 AM, 6/05/2024 at 11:45 AM, 6/07/2024 from 10:01 AM through 3:07 PM, and 6/11/2024 from 9:33 AM through 10:33 AM: Finding #1 Floors 1) On the fourth floor, the corridor floor and door thresholds were soiled with dirt and were sticky, the walls and doors were soiled with scrape, scuff, and smudge marks, and dead flies were found in the corridor ceiling lights. 2) The basement floor and the floors in the mechanical rooms on the second floor, third floor, fourth floor, and fifth floor were heavily soiled with dust and dirt. Finding #2 Window Blinds, Light Covers, Room Number Signs 3) Window blinds were soiled with a buildup of oily dust in room #s 213, 221, 226, 301, 317, 326, 510, and 518. 4) The corridor call bell light covers were missing for resident room #s 402, 411, and 413. 5) Resident room #s 400, 401, 402, 403, and 405 were hand-written on the corridor wall; these rooms did not have room number signs as was typical for the other rooms on the unit. Finding #3 Tables and Facility Grounds 6) The underside of dining room tables was soiled with food particles and grime on the second floor, third floor, fourth floor, and fifth floor. 7) The grounds between the road and building were littered with paper waste, and the grounds behind the building were littered with paper waste, used surgical gloves, and plastic wrapping. The undated document titled, Enhanced Environmental Rounds, documented staff were to clean windows (including blinds), ensure all components of the call bell system (including call bell light covers) were functioning, and that trash was picked up around the facility grounds. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no documented evidence that the facility routinely checked the underside of the dining room tables for cleanliness and the basement and mechanical room floors for cleanliness. Interviews During an interview on 6/11/2024 at 11:49 AM, Regional Director of Environmental Services #1 stated that the floors, walls, and window blinds would be cleaned and checked for good repair; and a new audit would be developed for checking the underside of the dining room tables. During an interview on 6/11/2024 at 11:49 AM, Administrator #1 stated cleaning the basement floor and mechanical rooms would be added to the weekly rounding, the missing call bell light covers would be repaired, the facility had purchased and would install the new room number signs, and the housekeeping department would be assigned to keep the grounds free from litter. 10 New York Codes, Rules, and Regulations 415.5(h)(4)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 33538 Based on interviews and record review during the recertification survey, the facility did not thoroughly investigate or prevent further accidents for 1 (Resident #15) of 1 resident reviewed for accidents. Specifically, Resident #15 was found on the floor in their room on 6/01/2024 with a significant injury to their head. The facility did not thoroughly investigate the root cause to rule out abuse or neglect. This is evidenced by: Resident #15 was admitted to the facility with diagnoses of unspecified severity vascular dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life caused by decreased blood flow to the brain) without behavioral disturbance, chronic obstructive pulmonary disease (narrowing of airways in the lungs making it difficult to breathe), and Type 2 diabetes mellitus. The Minimum Data Set (an assessment tool) dated 4/15/2024 documented that the resident usually could be understood and could understand others. A Brief Interview of Mental Status indicated the resident had severe impairment in cognition for daily living decisions. The Policy and Procedures titled, Abuse Prevention and dated 9/2023, documented that all residents have the right to be free from verbal, sexual, physical, or mental abuse. The policy further documented that policy was to investigate all reported incidents, accidents, and resident complaints for potential abuse and crime. The Policy and Procedures titled, Incident Report and dated 3/2024, documented the facility was to document and investigate any accident or incident involving a resident. Comprehensive Care Plans for falls dated 7/01/2021 documented that the resident had been identified as a fall risk related to a decline in activities of daily living, acute illness, and medication use. Nursing progress notes dated 6/01/2024 documented resident was found on the floor in their room at approximately 6:30 AM. Resident #15 had a large hematoma on the left side of the head/eye area with swelling. The nursing supervisor notified the doctor and sent the resident out to the hospital for further evaluation at 7:43 AM. The incident and accident report dated 6/01/2024 at 7:00 AM documented the resident fell out of their wheelchair in the hallway. During an interview on 6/10/2024 at 3:05 PM, Licensed Practical Nurse #4 stated that the resident had a fall on 6/01/2024 in their room and was found on the floor. The nursing supervisor was called, resident was evaluated and sent to the hospital for further evaluation. They stated resident had no other issues since the fall. They stated that they did not know what the root cause of the incident was as they were unsure if an investigation was conducted. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/10/2024 at 3:35 PM, Registered Nurse #5 stated that any unwitnessed fall resulting in significant injuries should be investigated and a root cause analysis done. They stated they were unsure if an investigation was done on this incident. During an interview on 6/12/2024 at 9:45 AM, Director of Nursing #1 stated investigations of incidents should be started right away. They stated that every major incident along with injuries of unknown origin should be investigated. During an interview on 6/12/2024 at 10:00 AM, Administrator #1 stated that all incidents were to have a root cause investigation completed. They stated that all allegations of abuse, neglect, and injuries of unknown origin should be investigated. The facility investigation documentation was requested for record review, however, none was provided at the time of survey. New York Codes, Rules and Regulations 483.12(c)(2 - 4)

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F 0657 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48413 Based on observations, record review, and interviews conducted during a recertification survey, the facility did not ensure Comprehensive Care Plans were reviewed and revised based on changing goals, preferences, and needs for 3 (Residents #15, 20, and 524) of 36 residents reviewed for care plans. Specifically, the comprehensive care plan was not revised (a) for Resident #15 after they had a fall with significant injuries on 6/04/2024; (b) for Resident #20 to address the resident's oxygen administration requirements, and (c) for Resident #524 after the resident sustained a wound. This is evidenced by: A review of policy and procedure titled, Comprehensive Person-Centered Care Plans and last revised in February 2024, documented an Interdisciplinary Team, which included the resident or representative, develop and implement a Comprehensive Care Plan for each resident. Each resident's Comprehensive Care Plan would be consistent with the resident's right to participate in developing and implementing their personalized Comprehensive Care Plan. The facility would inform the resident of their right to participate, or an explanation placed in their medical records determining that the resident or representative was not practicable. The care planning process would facilitate the involvement of the resident or representative. Resident #15 Resident #15 was admitted to the facility with diagnoses of unspecified severity vascular dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life caused by decreased blood flow to the brain) without behavioral disturbance, chronic obstructive pulmonary disease (narrowing of airways in the lungs making it difficult to breathe), and type 2 diabetes mellitus. The Minimum Data Set (an assessment tool) dated 4/15/2024 documented resident had severe cognitive impairment, usually could be understood, and could understand others. Comprehensive Care Plan for Falls was initiated on 11/2019 related to a decline in Activities of Daily Living, acute illnesses, and medications. Residents' short-term goal was to have no injuries related to falls through review dates. During a record review of nursing progress notes, it was documented that Resident #15 had several falls within the past several months, including on 4/06/2024, 4/10/2024, 4/11/2024, 6/04/2024, and 6/05/2024. Record review of the resident's care plan revealed the care plan was revised after a fall on 1/31/2024 to include a fall mat positioned to the left side of the bed when the resident was in their bed. There was no documented evidence that the care plan was revised after Resident #15 experienced a significant fall on 6/04/2024. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/10/2024 at 3:05 PM, Licensed Practical Nurse #4 stated Resident #15 had a significant fall on 6/01/2024 in their room and was found on the floor. The nursing supervisor was called, and the resident was evaluated and sent to the hospital for further evaluation. They stated resident had no other issues since the fall. They stated that they did not know the incident's root cause as they were unsure if an investigation was conducted. They stated that for any significant issue or changes in residents' condition, a care plan revision should have been completed with the interdisciplinary team. During an interview on 6/10/2024 at 3:35 PM, Registered Nurse #5 stated for any significant change, a care plan revision should be done-especially for a resident who has [NAME] frequent falls. They stated the resident would hardly fall during the day, withmost of the falls happening at night. They stated that they believed the resident fell because they were getting up to go the bathroom without assistance. They stated that the resident was care planned for falls by being monitored every two hours. When asked to locate the care plan modification for recent significant falls by being monitored every 2 hours, Registered Nurse #5 was not able to locate one, and identified a care plan intervention for monitoring every 2 hours for behavioral issues of the resident sleeping on the floor. 48615 Resident #20 Resident # 20 was admitted with diagnoses of Parkinson's Disease (a disorder that affects the nervous system and the parts of the body controlled by the nerves); diabetes mellitus, chronic obstructive pulmonary disease (a lung disease causing restricted airflow and breathing problems). The Minimum Data Set, dated dated dated [DATE] documented the resident was cognitively intact, could be understood, and coulde understand others. During an observation and interview on 6/04/2024 at 11:28 AM, Resident #20 was noted to have oxygen via nasal cannula set at 3 liters per minute. The resident stated they recently had an episode of pneumonia and asked for oxygen. They were given oxygen and since then self-applied oxygen as needed. Comprehensive Care Plan for Alteration in Respiratory Status dated 7/17/2023 and last revised 1/23/2024 documented the resident required oxygen, with interventions obtaining and documenting the resident's oxygen saturation as per physician orders. A Nursing Progress Note dated 4/16/2024 documented chest x-ray result that was taken on 4/15/2024 noted a left basilar pneumonia or effusion, which was relayed to Nurse Practitioner #1. The Medication and Treatment Administration Reports dated 03/20/2023 - 05/23/2024 had no orders for oxygen therapy. 47140 Resident #524 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #524 was admitted to the facility with diagnoses that included insomnia (difficulty sleeping), depression, and acute respiratory failure. The Minimum Data Set (an assessment tool) dated 5/14/2024 documented resident had severe cognitive impairment, could sometimes be understood, and could sometimes understand others. A Nursing Progress Note dated 5/22/2024 documented Resident #524 had been found on the ground near the nurse's station. Upon assessment, the resident had a lacerated wound noted on the right leg shin area with a measurement of 1.4 centimeters by 0.6 centimeters. A steri strip (thin adhesive bandages that help close shallow cuts or wounds) was applied to the affected area and covered with an opti foam patch (wound dressing). The resident's family and physician were documented to have been notified. During an observation on 6/05/2024 at 11:22 AM, Resident #524 was seated in a wheelchair by the second-floor nurse's station with an uncovered wound on their right shin, which was approximately 3 inches long and half an inch wide. The wound had reddened edges and was without weeping or active bleeding. A review of Resident #524's Care Plan revealed the care plan was updated on 6/05/2024 (14 days after the injury was first observed) to include the resident had an actual impairment of skin integrity as evidenced by a skin tear to their right shin; interventions included that nursing staff should follow the facility's skin tear protocol, treatment was to be done as per physician orders and the resident was to be seen on weekly rounds by the Wound Nurse and measurements obtained. An Occupational Therapy/Physical Therapy assessment was to be completed per the physician's order to evaluate positioning devices and/or therapy needs to promote wound healing. During an interview on 6/05/2024 at 11:35 AM, Registered Nurse #1 stated that Resident #524 had a recent fall, during which they obtained the injury to their right shin. They stated the wound should be cleansed and covered, and the dressing changed every three days. During an interview on 6/11/2024 at 3:10 PM, Wound Nurse #1 stated that typically when they would initially assess a new wound was when they would update the resident's care plan with interventions. They stated they were first notified of Resident #524's wound to their right shin on 5/29/2024 (7 days after it was first observed/documented). During an interview on 6/12/2024 at 10:01 AM, Director of Nursing #1 stated that when a wound/laceration was identified, the physician should be notified, the wound should be evaluated by the wound nurse, treatment orders obtained, and the resident's care plan should be updated with treatment orders/any new interventions. They stated after the wound was identified, it should be monitored and tracked to determine if it is healing/worsening. 10 New York Codes of Rules and Regulations 415.11(c)(2)(ii)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48413 Based on observations, record review, and interviews during a recertification survey, the facility did not ensure that it provided an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community for 2 of 4 resident units reviewed for activities. Specifically, residents on 2 of 4 resident units were not provided with activities that met the residents' preferences and cognitive abilities. This is evidenced by: The Policy and Procedure titled Activities dated 2/14/2024 stated the facility would provide activities, social events, and schedules that were compatible with the resident's interests, physical and mental assessment, and overall plan of care. The Policy and Procedure stated activities were offered 7 days a week. Resident #15 Resident #15 was admitted to the facility with the diagnoses of vascular dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life caused by decreased blood flow to the brain), schizoaffective disorder (a mental health disorder that is marked by a combination of schizophrenia symptoms, such as hallucinations or delusions, and mood disorder symptoms, such as depression or mania), and major depressive disorder. The Minimum Data Set (an assessment tool) dated 4/15/2024 documented the resident has severe cognitive impairment, was usually understood and could usually understand others. The resident resided on a primarily dementia care unit. During an observation on 6/05/2024 at 11:56 AM, no activities were observed for the unit. Comprehensive Care Plan titled, Activities and dated 12/02/2019, documented Resident #15 enjoyed reading and viewing pictures in a magazine, enjoyed music, and needed encouragement and assistance as needed. As documented in the Comprehensive Care Plan, the resident was to be offered one on one visits at least three times a week, assistance to activities was to be offered as well as in room activities of interest when the resident did not prefer group activities. A document titled Daily Activity Tracking Form dated 4/15/2024 documented the resident received a coloring activity. During an interview on 6/07/2024 at 12:51 PM, Activities Director #1 stated they assessed the residents for likes and dislikes and would reach out to family to see what the preferences were if the resident was unable to state. Most dementia residents would receive one on one visits and sensory activities like coloring. They stated they would do the one-on-one visits themselves. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/10/2024 at 10:43 AM, Resident Aide #1 stated they had been employed at the facility for 3 weeks. They stated they had only seen anyone from the activities department on the floor once or twice since they started at the facility. During an interview on 6/10/2024 at 11:25 AM, Certified Nurse Aide #6 stated there were not a lot of activities for the residents and the residents were given 'toddler' games if they were becoming agitated. They stated they had not seen anyone from the activities department on the floor often but recently had been coming up occasionally with activities such as coloring, balloons, and things like that. During an interview on 6/10/2024 at 3:05 PM, Licensed Practical Nurse #4 stated they would try to do activities with the residents but was not able to too often due to nursing and care duties. During an interview on 6/10/2024 at 3:35 PM, Registered Nurse #5 stated recreation individuals would sometimes come up and sit with residents but would not stay very long or try to interact with them. They believed more activities would be helpful with cognition on the unit as that unit was primarily a dementia unit. 48615 Resident #91 Resident #91 was admitted to the facility with diagnoses of sepsis due to methicillin resistant staphylococcus aureus, anxiety disorder, and type 2 diabetes. The Minimum Data Set, dated dated dated [DATE] documented the resident was cognitively intact, could understand, and be understood by others. A document titled Daily Activity Tracking Form dated 5/01/2024 documented the resident received a new monthly calendar. During an interview on 6/07/2024 at 11:11 AM, Resident #91 stated they did not attend activities because they were not interested. They stated they were unaware of a recent ice cream social and would have attended it if they had known about it. During an interview 6/10/2024 at 3:05 PM, Licensed Practical Nurse #6 stated the activities department would occasionally come to the floor and provide activities but usually the residents would go down to activity room for the events. During an interview on 6/07/2024 at 12:51 PM, Activities Director #1 stated activities should be documented in the Activity Tracking in the electronic medical record. They stated the residents had to let the activities department know if they want to attend an activity. They were unable to state how residents who required assistance with transfers or mobility would attend activities. They stated that at this time, only Catholic religious services were available to residents. 10 New York Codes, Rules and Regulations 415.5(f)(1)h

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47140 Based on observations, record review, and interviews during a Recertification Survey, the facility did not provide needed care and services that were resident centered and in accordance with professional standards of practice to meet each resident's physical, mental, and psychosocial needs for 1 (Resident #524) of 34 residents reviewed. Specifically, Resident #524 fell on [DATE] and sustained a wound; the wound was not tracked, monitored or treated as the resident's wound was observed to be uncovered and larger than it was initially assessed to be at the time of the fall. This is evidenced by: Cross referenced to F657: Care Plan Timing and Revision The Policy and Procedure titled, Incident Report, Residents and last revised 03/05/2024, documented any bruises, cuts, lacerations, etc. sustained during a fall must have a size and description documented by the nurse and nursing staff should continue to monitor for any changes, injury, or effects of the incident. Resident #524 Resident #524 admitted to facility with diagnosis which included insomnia, depression and acute respiratory failure. The Minimum Data Set (as assessment tool) dated 5/14/2024 documented the resident could sometimes be understood and could sometimes understand others with cognitive impairment for decisions of daily living. During an observation on 6/05/2024 at 11:22 AM, Resident #524 was seated in a wheelchair by second floor nurse's station with an uncovered wound on their right shin, which appeared to be approximately 7.62 centimeters long and 1.27 centimeters wide. The wound had thickened, reddened edges without weeping or bleeding. A Nursing Progress Note dated 5/22/2024, written by Registered Nurse #2, documented Resident #584 had been found on the ground near the nurse's station. Upon assessment, the resident had a lacerated wound noted on their right leg shin area with a measurement of 1.4 centimeters by 0.6 centimeters. A steri strip (thin adhesive bandages that help close shallow cuts or wounds) was applied on the affected area and covered with an optifoam patch (wound dressing). The resident's family and physician were documented to have been notified. Review of the Treatment Administration Record revealed that Resident #524 had a standing (on-going) physician order with a start date of 4/25/2024 to treat any skin tears as needed by cleansing the wound, covering with an optifoam wound dressing and changing the dressing every three days. Review of the record revealed nursing staff did not sign off that wound care and dressing changes were completed from 5/22/2024 to 6/05/2024. During an interview on 06/05/2024 at 11:35 AM, Registered Nurse #1 stated that Resident #524 had a recent fall, during which they obtained the injury to their right shin. They stated that the wounds should be cleansed, covered, and dressing changed every three days. They stated Resident #524 had a behavior of picking at their skin and removing wound dressings. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Registered Nurse assessment dated [DATE] at 12:50 PM, written by Registered Nurse #1, documented Resident #524's continued to be unchanged in size and that the resident continued to pull off the dressing and picks at the wound. The wound edges were thickened, rolled under and appear irritated by the frequent picking. The wound was dry with no drainage or odor. Treatment was updated to have wound dressing changed every 3 days, with kerlix (wound dressing) added to deter the resident from removing their dressing and picking the wound. A Treatment Order was entered for Resident #524 on 06/05/2024 (14 days after the injury was first observed) for the wound to be cleansed and optifoam wound dressing to be applied and secured with kerlix (wound dressing) every three days and as needed. A Wound assessment dated [DATE] at 2:40 PM, completed by Wound Nurse #1, documented the resident was seen for assessment of a skin tear to the resident's right shin. The wound was documented to be 4 centimeters long by 0.9 centimeters wide. The wound was documented with partial thickness. The measurement revealed that the wound had more than doubled in length from when it was first assessed to be 1.4 centimeters long at the time of the fall. The wound was photographed during the assessment. Review of Resident #524's Care Plan, revealed the care plan was updated on 6/05/2024 (14 days after the injury was first observed) to include that the resident had an actual impairment of skin integrity as evidenced by a skin tear to their right shin. Interventions included nursing staff should follow the facility's skin tear protocol, treatment were to be completed per physician orders and the resident was to be seen on weekly rounds by the Wound Nurse and measurements obtained. An Occupational Therapy/Physical Therapy assessment was to be completed per physician order to evaluate positioning devices and/or therapy needs to promote wound healing. During an observation on 6/07/2024 at 9:40 AM, Registered Nurse #1 took measurements for Resident #524's wound and reported that the wound was 3.8 centimeters long by 0.8 centimeters wide with a depth of 0.1 centimeters. The wound appeared to be improved from when it was initially observed on 6/05/2024. A Wound assessment dated [DATE] at 8:13 AM completed by Wound Nurse #1, documented the wound was identified on 6/05/2024, however, a note added to the bottom the assessment documented that the assessment was a late entry and was actually completed on 5/29/2024 (12 days prior). The assessment documented the wound was 3 centimeters long by 0.5 centimeters wide. The wound was not photographed during the assessment, and it was documented that this was due to the resident being restless at the time. During an interview on 6/11/2024 12:50 PM, Registered Nurse #2 stated they were working on another unit when they were called to come assess Resident #524 on 5/22/2024. They stated the resident was on the floor near the nurse's station and upon assessment, had sustained a wound to their right shin. They stated when they first observed the wound, it appeared to be a laceration (a deep cut or tear of the flesh). They stated they used the side of a piece of gauze to measure the size of the wound and relayed the measurements to the on-call physician. They stated they had not been trained in obtaining wound measurements. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/11/2024 at 3:10 PM, Wound Nurse #1 stated Resident #524's wound had worsened since they had initially assessed the wound. They stated they were initially informed of the wound on 5/29/2024 but that they did not enter the assessment in the system until 6/11/2024. They stated the had seen the resident again on 6/05/2024 for follow-up and the wound was larger. They stated the resident would pick at their skin/wound. They stated typically when they would initially assess a new wound was when they would update the resident's care plan with interventions. They stated it was important to track and monitor wounds for changes and signs of infection. During an interview on 6/12/2024 at 10:01 AM, Director of Nursing #1 stated wounds should be documented timely, accurately and tracked for any changes. They stated they believed Wound Nurse #1 was first notified of Resident #524's wound and completed an assessment on 5/29/2024, however, they did not enter their assessment into the system until 6/11/2024. They stated sometimes nursing staff would forget to chart their assessments right away. They stated the facility would enter standing orders for treatment of skin tears. They stated when a new wound was identified, treatment orders should be obtained, the Wound Nurse should be notified, and the resident's care plan should be updated. They stated the Wound Nurse should obtain initial measurements in order to track the wound. 10 New York Codes, Rules, and Regulations 415.12

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. 48615 Based on observation, interview, and record review conducted during a Recertification survey, the facility did not ensure that residents received proper treatment and assistive device to maintain hearing abilities for 1 (Resident #58) of 4 residents reviewed. Specifically, Resident #58 did not receive assistance with replacement of broken hearing aids and did not receive follow up Audiologist (a healthcare professional that manages hearing loss and balance disorders) visits for maintenance of hearing aids as recommended. This is evidenced by: Resident #58 was admitted with diagnosis of Unspecified osteoarthritis (degeneration of bone causing pain and stiffness), Impacted cerumen (ear wax), bilateral; Chronic obstructive pulmonary disease, unspecified (a condition involving constriction of the airways and difficulty or discomfort in breathing). The Minimum Data Set of 3/28/2024, documented resident was cognitively intact, could be understood, and understand others. During an observation and interview on 6/04/2024 at 1:50 PM, Resident #58 was noted to be very hard of hearing. Resident #58 requested writer stand within 1 inch of their ear to hold conversation. Resident stated they were hard of hearing, and they do not have a hearing aid. No other hearing adaptive devices were observed for this resident. Comprehensive Care Plan Titled Alteration in Sensory Perception dated 12/11/2023 documented resident had a hearing deficit. Both ears, considered deaf. Long Term Goal: Resident would maintain adequate communication daily through next review of 7/28/2024. Intervention include Speak slightly louder and towards left ear. Resident lost hearing aide. Schedule hearing consultant and see if it could be replaced. During an interview on 6/11/2024 at 12:17 PM, Unit Manager, Registered Nurse #4 sated Resident #58's hearing aid had been broken several times as Resident likes to disassemble their hearing aid. Resident had not had a functioning hearing aid since 12/11/2023. An in-house audiology exam was scheduled for 5/13/2024, although, the visit or consultation was not documented. Unit Manager, Registered Nurse #4 stated they would follow up on audiology consult and obtaining a new hearing aid. During an interview on 06/11/2024 at 12:15 PM, Certified Nurse Aide #5 stated Resident #58 was extremely hard of hearing. They stated they do not attempt to assist Resident #58 because Resident #58 refuses care and yelled at staff a lot. During an interview on 06/11/2024 at 12:55 PM, Director of Nursing #1 stated residents were followed up every six months for audiology maintenance and as needed. Review of Treatment Administration Record dated 12/11/2023, documented appointment for audiology hearing aids as needed. There was no documented audiology or hearing consults for Resident #58 after order date. 10 New York Codes, Rules, and Regulations: 415.12(3)(b)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47140 Based on observations, record review, and interviews during the Recertification Survey, the facility did not ensure that residents who required respiratory care were provided such care in a manner consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident goals and preferences for 2 (Resident #20 and 98) of 3 residents reviewed. Specifically, Resident #s 20 and 98 oxygen therapy were not administered as ordered by the physician. This is evidenced by: The Policy and Procedure titled Oxygen Administration, last revised on 4/09/2024, documented the purpose of the procedure was to provide guidelines for safe oxygen administration. The procedure included that nursing staff should first verify the physician order for oxygen and then adjust the flow of oxygen as prescribed. Resident #20 Resident # 20 was admitted with diagnoses of Parkinson ' s Disease (disorder that affects the nervous system and the parts of the body controlled by the nerves); diabetes mellitus (a disease in which the body does not control the amount of glucose (a type of sugar) in the blood). chronic obstructive pulmonary disease (a lung disease causing restricted airflow and breathing problems). The Minimum Data Set (an assessment tool) dated 3/29/2024, documented resident was cognitively intact, could be understood and could understand others. During an observation and interview on 6/04/24 at 11:28 AM, Resident #20 was noted to have oxygen via nasal canula set at 3 liters per minute. Resident #20 stated they recently had pneumonia and asked for oxygen. They were given oxygen and since then applied oxygen as needed. Nursing Progress Note dated 4/16/2024, documented Chest X-ray result taken on 4/15/2024, showed left basilar pneumonia or effusion, was relayed to Nurse Practitioner #1. Ordered to start Azithromycin 500milligram tablet today, then 250 milligram tablets tomorrow until 4/21/24. Comprehensive Care Plan Titled Alteration in Respiratory status requiring oxygen, dated 7/17/2023, last revised 1/23/2024, Intervention include obtain and document oxygen saturation as per physician orders. The Medication and Treatment Administration Reports dated 3/20/2023 - 5/23/2024 had no orders for oxygen therapy. 48615 Resident #98 Resident #98 was admitted to facility with diagnoses which included chronic obstructive pulmonary disease, acute pulmonary edema and glaucoma. The Minimum Data Set, dated dated dated [DATE] documented the resident was cognitively intact, could be understood and could understand others. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Comprehensive Care Plan, Titled at Risk for Compromised Respiratory status dated 4/04/2024, documented the resident was at risk for compromised respiratory status related to diagnoses of chronic obstructive pulmonary disease, pulmonary edema and recent intubation. Interventions included resident to receive oxygen therapy as ordered at a flow rate of 4 liter per minute. A Physician Order dated 4/02/2024 documented 4 liters per minute of continuous oxygen flow. During an observation on 6/04/24 at 12:29 PM, Resident #98 was seated in the dining room on the second floor. The resident had oxygen via nasal cannula with a portable oxygen contractor which was set to a liter flow of 2 liters per minute. During an observation and interview on 6/05/24 at 9:13 AM Resident #98 was lying in their bed receiving oxygen therapy via nasal cannula with the concentrator set to a liter flow of 3 liters per minute. During an interview on 6/07/2024 at 11:52 AM, Licensed Practical Nurse #2 stated only nurses could adjust the liter flow on oxygen concentrators. They stated that all residents who required oxygen therapy should have a physician order which indicated how much oxygen the resident should be administered, how it should be delivered (nasal cannula versus face mask) and how often (continuously or as needed). They stated that oxygen therapy was considered to be the same as administering a medication and should always be administered as indicated by the physician order. They stated that if a resident did not receive enough oxygen, they could potentially have increased confusion or become lightheaded. During an interview on 6/11/2024 at approximately 2:00 PM, Registered Nurse #1 stated that the adjustment of liter flow on an oxygen concentrator needed to be completed by a nurse. They stated that each resident that required supplemental oxygen should have a physician order which indicated a prescribed liter flow per minute. They stated that some risks existed for residents who received too much or too little oxygen. During an interview on 6/12/2024 at 10:01 AM, Director of Nursing #1 stated that all residents who required oxygen therapy should have physician order which indicated the amount of oxygen the resident required to maintain oxygen levels. They stated that nurses should check the physician order to ensure that oxygen was administered correctly. They stated that some residents had physician orders to titrate (determine and adjust the needed concentration) of oxygen when within certain parameters of oxygen saturation. Director of Nursing #1 reviewed Resident #98 ' s physician orders and noted that Resident #98 did not have an order to titrate oxygen. 10 New York Codes, Rules, and Regulations 415.12 (k)(6)

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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. 21414 Based on observation, record review, and staff interview during a Recertification Survey, the facility did not store, prepare, distribute, and serve food in accordance with professional standards for food service safety in the main kitchen and 4 of 4 kitchenettes. Specifically, the automatic dishwashing machine was not functioning properly, and areas of the main kitchen and unit kitchenettes were not clean. This is evidenced by: During observations of the main kitchen on 6/04/2024 at 9:06 AM, the following were observed: Food contact equipment was being washed in the automatic dishwashing machine and the final rinse temperature was 150 degrees Fahrenheit; the information plate on the dishwashing machine stated that the final rinse is to be 180 degrees Fahrenheit. The can opener holders, knife rack, kitchen floor in corners and along the wall, dry storage area wall behind the air handler and floor, locker room floor, and mop buckets were soiled with food particles, dirt, or grime. During observations on 6/04/2024 at 9:52 AM, the following were observed: The refrigerator, microwave oven, and cabinets in the second-floor kitchenette were soiled with food spills or food particles. The refrigerator, microwave oven, and drawers in the third-floor kitchenette were soiled with food spills or food particles. The refrigerator, drawers, and sink in the fourth-floor kitchenette were soiled with food particles or a black build-up. The drawers, freezer door gasket, and waste receptacle in the fifth-floor kitchenette were soiled with food particles or grime. The undated document titled Dishwasher Procedure documented that dietary staff were trained to monitor the automatic dishwashing machine final rinse temperature for 180 degrees Fahrenheit. During an interview on 6/04/2024 at 10:05 AM, Interim Food Service Director #1 stated that they would contact the maintenance department to have the dishwashing machine checked, and the can opener holders, knife rack, floors, and items found in the kitchenettes would be cleaned. During an interview on 6/07/2024 at 12:54 PM, Regional Food Service Director #1 stated that the booster heater servicing the dishwashing machine required a minor repair and was now functioning properly. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/07/2024 at 12:56 PM, Administrator #1 stated that a log would be created to ensure the main kitchen and kitchenettes were kept clean, and kitchen staff would receive education on how to check the dishwashing machine for proper functioning and sanitizing. 10 New York Codes, Rules, and Regulations 415.14(h) Chapter 1 State Sanitary Code Subpart 14

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 48615 Based on observations, record review, and interviews during a Recertification Survey, the facility did not maintain an infection control program designed to provide a safe, sanitary, and comfortable environment to help prevent the possible development and transmission of communicable infections for 2 of 4 care units. Specifically, the facility did not ensure staff appropriately used and discarded personal protective equipment. This is evidenced by: The Policy and Procedure titled, Infection Prevention and Control Policy last reviewed 5/2024, documented, An Infection Control Program is established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infections. Important facets of infection prevention include educating staff and ensuring they adhere to proper technique and procedures. The Policy and Procedure titled, Personal Protective Equipment last revised 3/15/2023, documented, Training in the proper donning, use, and disposal od personal protective equipment is provided upon orientation and at regular intervals. According to the Centers for Disease Control and Prevention's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, last reviewed found online at https://www.cdc.gov/infectioncontrol/guidelines/core-practices/index.html, core practices should include development of processes to ensure that all healthcare personnel understood and were competent to adhere to infection prevention requirements as they performed their roles and responsibilities. Healthcare personnel were required to perform hand hygiene in accordance with Centers for Disease Control and Prevention recommendations. Staff should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: Immediately before touching a patient, before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices, before moving from work on a soiled body site to a clean body site on the same patient, after touching a patient or the patient's immediate environment, after contact with blood, body fluids or contaminated surfaces and immediately after glove removal. Personal protective equipment should be removed and discarded upon completing a task before leaving the patient's room or care area. Healthcare personnel should not use the same gown or pair of gloves for care of more than one patient and disposable gloves should be removed and discarded upon completion of a task or when soiled during the process of care. Healthcare facility was to ensure that healthcare personnel have immediate access to and were trained and able to select, put on, remove, and dispose of personal protective in a manner that protects themselves, the patient, and others. During an observation on 6/04/2024 at 11:35 AM, a Resident Assistant walked out of a resident's room on Unit 2 (Resident ' s room was identified by signage as being under Enhanced Barrier Precautions) wearing blue gloves, touched a clean linen cart in the hallway, walked down the hall and into two other resident rooms, went to another clean linen cart at the other end of the hallway, and back into the original resident ' s room with the gloves still on. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 6/04/2024 at 11:43 AM, a Resident Assistant walked up from a resident's room to the nursing station on Unit 2 and removed blue gloves but did not wash hands or use hand sanitizer. During an observation on 6/04/2024 at 1:00 PM, in a resident's room on Unit 2 (identified by signage as being under Enhanced Barrier Precautions), there were three used surgical gloves balled up on a small dresser in the room. During an observation and interview on 6/06/2024 10:27 AM, soiled gloves and a plastic bag were on the floor in a resident ' s room on Unit 5. Certified Nurse Aide #3 stated they left bag and gloves on floor because there are no bins for waste. Certified Nurse Aide #3 was later observed exiting the room with the plastic bags filled with soiled contents, brought them to dirty room, and did not wash or sanitize hands after handling the soiled bags. During an observation and interview on 6/06/2024 10:37 AM, Certified Nurse Aide #4 exited a resident ' s room on Unit 5 with two plastic bags of soiled contents, entered and exited dirty utility room without washing or sanitizing hands, then entered another resident's room that was identified by signage as being under Contact Precautions). Certified Nurse's Aide #4 did not don (put on) protective gown or gloves prior to entering the room. Certified Nurse Aide #4 stated the room was under contact precautions, and that they went into the room to assist, and should have gowned up. 10 New York Codes, Rules, and Regulations 415.19 (a) (1-3)

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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 0924 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Put firmly secured handrails on each side of hallways. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21414 Based on observation and interviews during a Recertification Survey, handrails were not maintained on 2 of 4 resident units. Specifically, handrails were not firmly secured and affixed to the corridor walls. This is evidenced by: During observations on 6/11/2024 from 9:33 AM through 10:33 AM, handrails were loose and not securely attached to the wall on the second-floor east corridor, fourth floor east corridor, and outside room [ROOM NUMBER]; additionally, the handrail end turn piece was missing from the handrail by room [ROOM NUMBER]. During an interview on 6/11/2024 at 10:30 AM, Director of Maintenance #1 stated that they would assign a maintenance worker to check and secure all handrails and install the turn piece. During an interview on 6/11/2024 at 2:44 PM, Administrator #1 stated the facility would audit the entire building and securely attach any loose handrails. 10 New York Codes, Rules, and Regulations 713-1.8(a)