STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335828	A. Building B. Wing	07/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Taconic Rehabilitation and Nursing at Beacon	10 Hastings Drive Beacon, NY 12508

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 47626 Based on observation, record review and interview conducted during the recertification survey from 6/24/2024 through 7/01/2024, the facility did not ensure for 3 of 4 residents (Residents # 322, # 101 and #86) reviewed for urinary catheters, that care was provided in a manner to maintain dignity. Specifically, Residents #322, #101, and #86 had urinary catheter drainage collection bags that were not concealed to prevent direct observation, by other residents and their families. Findings include: 1. Resident #322 had diagnoses including urethral false passage, obstructive and reflux uropathy, and benign prostatic hyperplasia (BPH). The Admission Minimum Data Set (an assessment tool) dated 6/23/2024, documented Resident #322 had moderately impaired cognition, required partial to moderate assistance with activities of daily living and had an indwelling catheter for bladder drainage. The Bladder Appliance care plan dated 6/2024 documented Resident #322 had a urinary catheter related to urinary retention and interventions included catheter care every shift, change catheter bag as needed, and leg bag to be worn during day time hours. During observations on 06/24/2024 at 10:49 AM and 12:20 PM, 06/25/2024 at 08:30 AM and 10:26 AM, and 06/26/2024 at 08:37 AM the urine in the urinary catheter drainage collection bag was visible from the door without a privacy bag. The resident resided in a shared room. During an observation on 06/26/2024 at 01:17 PM, the urinary catheter drainage collection bag was attached to the resident's wheelchair and the resident was transported to the therapy room without a cover on the urinary collection bag. During an interview on 06/26/2024 at 10:00 AM, Staff #7 (Certified Nurse Aide) stated that a resident with a urinary catheter should have a privacy bag when they leave the room. During an interview on 06/26/24 at 10:08 AM, Staff #6 (Nurse Manager) stated resident's catheter bag should have been covered when they left the room to ensure the resident's privacy. The bag should be covered and not visible to other residents or visitors. (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 - Few	During an interview on 06/26/24 at 10:15AM, the Director of Nursing stated residents with urinary drainage systems should have them covered with a privacy bag for dignity. 2. Resident # 101 was admitted to the facility with diagnoses including diabetes, left below knee amputation, and pressure ulcer sacral region. The Quarterly Minimum Data Set (MDS, an assessment tool) dated 5/17/24, documented Resident #101 was cognitively intact, required assistance of one person with activities of daily living and had an indwelling urinary catheter. The care plan dated 4/15/24 documented the urinary catheter drainage collection bag to be covered while in bed and out of bed. When observed on 06/25/24 at 08:47 AM, Resident #101 was in bed with the urinary drainage collection bag hanging on bed frame visible from outside resident's room in the hallway, without a privacy cover. When interviewed on 6/27/24 at 3:20 PM, Staff #3(Licensed Practical Nurse Unit Manager) stated the residents should always have a privacy bag for their urinary drainage collection bags in bed or out of bed. When observed on 6/28/24 at 9:28 AM, the urine in Resident #101's urinary drainage collection bag was visible and there was not a privacy cover. The resident was observed while in bed and in a shared room. When interviewed on 6/28/24 at 9:34 AM, the Director of Nursing (DON) stated the urinary collection drainage bags only needed to be covered when the residents were out of their rooms. The Director of Nursing also stated they did not think it was okay for other residents or families to observe the uncovered bags. 3. Resident #86 was admitted to the facility with diagnoses including Parkinson's disease, obstructive/reflux uropathy, and dementia. The Quarterly Minimum Data Set (MDS, an assessment tool) dated 4/1/2024, documented Resident #86 had severely impaired cognition, and required extensive assistance of two people for activities of daily living, and had an indwelling urinary catheter. The care plan dated 3/27/24 documented the urinary catheter drainage collection bag to be covered while in bed and out of bed. When observed on 06/25/24 at 08:39 AM, Resident #86 in bed having their breakfast with catheter drainage collection bag uncovered and on the floor. When interviewed on 06/25/24 at 08:44 AM, Staff # 4 (Certified Nurse Aide) stated they needed to cover the bag and remove it from the floor. 10NYCRR 415.3(d)(1)(i) 49364

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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41666 Based on interviews and record review conducted during the Recertification survey from 06/24/2024 to 07/01/2024, the facility did not ensure the resident and the resident's representative were given the opportunity to participate in the development and implementation of the residents person-centered plan of care. This was evident for 1 (Resident #41) of 32 total sampled residents. Specifically, the facility did not include the resident's representative during the planning of their care plan meeting as requested. The findings are: The facility policy titled Comprehensive Care Planning dated 10/2016 documents each resident and his/her family members and/or legal to participate in the development and implementation of his/hers plan of care including the initial planning process and changes to the plan of care. The resident/representative has the right to participate in the planning process including the right to individuals or roles to be included in the planning process. Resident #41 had diagnoses of functional quadriplegia, primary adrenocortical insufficiency, and Diabetes Mellitus. The Minimum Data Set assessment dated [DATE], documented Resident #41 was cognitively intact. During the interview for daily preferences the resident indicated that it was very important for their family to be involved in discussions of the resident's care. The resident needed set up assistance with meals and dependent on staff for assistance with toileting, bathing, and transfers. During an interview with the resident on 6/24/24 at 3:40 PM, they stated they usually went to their care plan meeting but not the last one in April because their sister could not make the meeting and there was no alternate date or time given. The resident stated they wanted to be at the meeting since it was about them and their care, and was disappointed it could not be arranged. The Social Worker note dated 4/3/24 documented the resident was invited to their care plan meeting but family was unable to attend. The resident stated they did not want the meeting without their family and it would be reschedule. A second Social Worker note dated 4/8/24 documented the resident's care plan meeting was held 4/4/24 without the resident or their representative. The resident stated they will attend only if the resident's representative attends. Will reschedule for another date. There was no documented evidence a rescheduled meeting occurred with the resident or their representative. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Staff #10 Social Worker, on 6/27/24 at 2:35 PM, they stated they knew about the care plan meeting conflict and must have forgotten to reschedule it with the resident's family. Staff #10 stated they should have called the resident's representative and rescheduled for a more convenient time but got busy and did not do it. 415.11(c)(2)(i-iii)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50815 Based on record review and interviews conducted during the recertification survey from 6/24/2024-7/1/2024, the facility failed to ensure that for 1 of 26 residents, screened for mental disorder or intellectual disability, had an identification number documented on their pre-admission screening and resident review assessment prior to their admission to the facility. Specifically, Resident #420's electronic medical record revealed that the pre-admission screen and resident review (PASRR) assessment dated [DATE] did not include an identification number prior to admission. Findings include: Review of the facility policy for Pre-Admission Screening & Resident Review, dated 1/1/2000 and revised 11/2023, documented that a screen was required for every patient/resident prior to admission regardless of length of stay. Resident #420 was admitted with diagnoses which included dementia, muscle weakness, and dysphagia (difficulty swallowing). Review of Resident #420 electronic medical record revealed that the pre-admission screen and resident review assessment dated [DATE] was signed but did not include an identification number prior to admission. During an interview on 07/01/2024 at 10:30 AM, Staff #10 stated new admission screens were sent to them and reviewed. The resident screens were found under miscellaneous in the electronic medical record. Staff #10 stated they kept a log for all admissions. The process was to review the screen and check to see if there was an identification number on the screen. If the screening was missing any information, it would be sent back to Admissions. Staff #10 stated that they would review Resident #420 ' s screening form further to find out why it was incomplete. 10NYCRR 415.11(e) During a follow up interview on 07/01/24 at 11:26 AM, staff #10 stated they called the hospital about Resident #420 screen form. The screener was not picked up in the hospital's internal system. The internal system does not pick up the screener's identification number. Staff #10 acknowledged that it is their responsibility to review the screening form for a documented resident's signature, screener signature, and screener's identification number. Staff #10 states, I ' m not sure why it's missing on the screen.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43478 Based on observation, interview and record review conducted during the recertification and abbreviated (NY00330557) surveys from [DATE] -[DATE], it was determined for 2 of 6 residents (Residents #320 and #71) reviewed for Nutrition and Hydration, the facility did not ensure the residents were provided the necessary care to maintain an acceptable body weight. Specifically, 1) Resident #320 medical record documented a 24 pound weight gain and the medical provider was not made aware; the physician's orders documented daily weights but Resident #320's weight record did not reflect daily weights; and the facility did not have a system in place to accurately weigh, monitor and report weights. 2) Resident #71's medical record documented a 7.93% weight loss in 30 days with a physician order for a 3-day calorie count, and dietitian recommendations for fortified mash potatoes and to increase the supplement to 4 times a day; there was no documented follow through for the recommendations. The findings are: 1) Resident #320 had diagnoses which included congestive heart failure, hypertension, and diabetes mellitus. The admission Minimum Data Set (resident assessment tool) dated [DATE] documented a BIMs Score of 13 which indicated intact cognition. The Physician's order dated [DATE] documented to weigh the resident daily and to update the physician if over 3 pounds gained in a day or 5 pounds in one week. The Care Plan, Cardiac / Circulatory: Impaired cardiac function related to Congestive Heart Failure, Hypertension documented interventions which included to administer cardiac medications as ordered, labs obtained per orders, monitor blood pressure, pulse, respirations, breath sounds, edema, chest pain, intake and output, leg elevation, diet compliance, level of activity tolerance, shortness of breath. The [DATE] Nursing Admission Evaluation documented Resident #320 weight was 222 pounds. Resident #320's electronic medical record documented on: -[DATE] at 8:46 PM, weighed 200 pounds in the wheelchair. -[DATE] at 10:49 PM, weighed 200 pounds by mechanical lift. -[DATE] at 3:48 PM, weighed 200 pounds standing. -[DATE] at 10:35 PM, weighed 200 pounds sitting. -[DATE] at 11:34 PM, weighed 202 pounds by mechanical lift. -[DATE] at 8:31 PM, weighed 225 pounds standing. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-[DATE] at 10:15 PM, weighed 124 pounds in the wheelchair. -[DATE] at 4:53 PM, weighed 224 pounds standing. -[DATE] at 9:27 PM, weighed 221.4 pounds by mechanical lift. -[DATE] at 6:06 PM, weighed 221.6 pounds standing. There were no weights in the resident's electronic medical record for ,d+[DATE], ,d+[DATE], ,d+[DATE], , d+[DATE], and [DATE]. Weights recorded in a binder on the unit where the resident resided documented on: - [DATE] weight was 226.1 pounds. - [DATE] weight was 226.0 pounds. - [DATE] weight was 225.0 pounds. The [DATE] Physician's note documented lungs were clear to auscultation bilaterally, decreased breath sound at bases. The Assessment/Plan was to administer oxygen to maintain saturation greater than 92%, weekly labs, and daily weights. The [DATE] Physician's note by the Physician's Assistant, documented breathing at baseline. No medical complaints. Lungs clear to auscultation bilaterally, decreased breath sound at bases. The Assessment/Plan was to administer oxygen to maintain saturation greater than 92%, weekly labs, and daily weights. The [DATE] Physician's note by the Physician's Assistant, documented breathing at baseline. The Assessment/Plan was to administer oxygen to maintain saturation greater than 92%, weekly labs, and daily weights. Weight 225 pounds on [DATE]. The [DATE] Physician's note by the Physician's Assistant, documented seen for acute visit, breathing at baseline. The [DATE] Nurse's note documented chest X-Ray result was indicative of fluid overload as well as tuberculosis. The results were called to the Primary Physician and orders for Lasix were received. The [DATE] Physician's note by the Physician's Assistant, documented increasing shortness of breath and 24 pound weight gain recorded. Weight 224 pounds on [DATE]. Oxygen saturation 96% on oxygen via nasal cannula. Inspiratory crackles bilaterally, no edema. The Assessment/Plan was oxygen to maintain saturation greater than 92%, weekly labs, daily weights, Lasix twice a day for 7 days, Zaroxylyn for 3 days, and fluid restriction. The [DATE] Nurse's note documented resident alert and verbal, denied pain, no shortness of breath, no cough noted, declined bipap complained hard to breath with bipap mask. 1500 ml fluid restriction for fluid overload. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The [DATE] Medical Visit note by the Physician's Assistant, documented resident with shortness of breath. Chest x-ray was positive with bilateral multifocal infiltrates consistent with fluid overload or tuberculosis. Discussed with the physician and continue diuretics for 24 pound weight gain. Most recent weight 221.4 pounds on [DATE]. The [DATE] Physician's note by the Physician's Assistant, documented the resident was found unresponsive and pronounced expired this morning. During an interview on [DATE] at 1:30 PM, the Physician's Assistant stated that if they had been made aware of a weight gain on [DATE], they would have immediately entered new orders on [DATE] or [DATE] to address the weight gain, such as extra Lasix and Zaroxylyn, Chest X-Ray, and 1500 ml fluid restriction. During an interview on [DATE] at 1:52 PM Staff #14 (Registered Nurse) stated they entered the resident's weight of 225 pounds on [DATE]. Staff #14 (Registered Nurse) stated they were aware of the Physician's order to weigh the resident daily every evening and to notify the Physician if the resident's weight increased more than 3 pounds in one day or more than 5 pounds in a week. They stated Resident #320's weight was 226 pounds on [DATE] on admission on the paper weight log sheet, so they were not concerned about a weight of 225 pounds on [DATE]. They stated they could not find a note which documented that they notified the Physician's Assistant or the Physician. During an interview on [DATE] at 2:16 PM the Assistant Director of Nursing stated that in the Evaluation Notes Template in Point Click Care, the most recent weights and vitals will populate in each new Evaluation Note. The Assistant Director of Nursing stated that the nurse who entered the weight in the Medication Administration Record did not see Resident #320 previous weights. They stated the nurse was responsible to notify the Physician of a weight increase, as per Physician's order, and was responsible to notify the Nursing Supervisor. The Assistant Director of Nursing reviewed the Medication Administration Record and observed the Resident's weight of 225 on [DATE] which was entered by Staff #14 (Registered Nurse). The Assistant Director of Nursing stated that the nursing staff were trained to document resident's weights on a paper weight log sheet in the weight binder, and the nurse responsible for entering the weights into the Electronic Medical Record must record the weight from the paper weight log sheet into the computer. The Assistant Director of Nursing stated that the nurse recording the weight into the Electronic Medical Record was responsible to check the previous weight on the paper weight log sheet, and notify the Physician as ordered if there is a weight increase. They stated that the paper weight log sheet did not document a weight change of 24 pounds. During an interview on [DATE] at 2:35 PM with the Physician, they stated the Physician's Assistant was at the facility every day and the either the Physician or the Physician's Assistant should have been notified if there had been a weight increase. The Physician stated they were not made aware of a weight gain. They stated they would have done something for Resident #320 if they had a weight gain. The Physician stated they were on call every night for the unit and stated they should have been notified with the Resident #320's change in status. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 3:45 PM, the Director of Nursing stated Resident #320 did not gain 24 pounds. The Director of Nursing reviewed the paper weight log sheets from the weight binder with this surveyor, which documented the Resident weighed 226 pounds on admission on [DATE], and on [DATE] the weight was 225.0 pounds. They stated the weights of 202 and 200 in the electronic medical record were erroneous and the nurse must have accidentally entered 202 pounds instead of 220 pounds (5 entries for 200 or 202 pounds). The Director of Nursing stated the resident was seen regularly by the Physician's Assistant and was being monitored for shortness of breath. The Director of Nursing stated the resident was treated on [DATE] for symptomatic heart failure. 47626 2. Resident #71 with diagnoses of Metabolic Encephalopathy, Diabetes, and dysphagia (difficulty swallowing). An Admission Minimum Data Set (an assessment tool) dated [DATE] documented the resident's cognition was moderately impaired, and the resident was dependent with all care including eating. The resident's admission weight was 114 pounds, height was 62 inches, and weight loss as no or unknown. The resident's Care Plan: Eating Nutrition, dated [DATE], documented the goal was for weight to be stable 115 pounds, plus or minus 5%. Resident #71's weight record documented on [DATE] the resident weighed 112.2 pounds, on [DATE] weighed 113.8 pounds, on [DATE] weighed 110. 6 pounds, on [DATE] weighed 105.6 pounds, on [DATE] weighed 103.3 pounds, on [DATE] weighed 103.3 pounds and on [DATE] weighed 102 pounds. The resident's interdisciplinary team note dated [DATE], documented the dietitian recommendations included adding fortified cereal for breakfast, fortified mash potatoes for lunch and dinner, and to consider decreasing diabetic medications. The dietary progress note dated [DATE], documented the resident had poor oral intake and weight loss. The plan was a 3-day calorie count, increase Glucerna (supplement) to 4 times a day, and discuss with insulin dosage with the physician. The dietary progress note dated [DATE] (entered on [DATE] as a late entry) documented the resident had a significant weight loss with no new interventions were documented. A review of the [DATE] Medication Administration Record documented a calorie count on ,d+[DATE], , d+[DATE], and [DATE]; however, the results could not be located for review. An observation on [DATE] at 12:14 PM, the resident was in the day room, staff was feeding the resident. The tray ticket documented apple juice however the resident did not receive apple juice. During an interview on [DATE] at 11:34 AM, the Food Service Director stated the Kitchen Supervisor was responsible for ensuring all trays were sent to the unit with the items on the ticket. They were unaware the resident did not receive the apple juice. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on [DATE] at 12:34 PM the resident was being fed lunch, the tray ticket documented 4 ounces of mashed potatoes and 4 ounces of fortified mash potatoes, the tray had 4 ounces of mashed potatoes with gravy. During an interview on [DATE] at 12:42 PM, Staff #5 (Kitchen Supervisor) stated the resident had both mashed potatoes and fortified mash potatoes on the ticket and they did not know why. They stated all mashed potatoes were fortified and they provided the resident with 4 ounces of mash potatoes. During an interview with the dietitian [DATE] 12:41 PM, they stated they were only at the facility on Thursdays and as needed, and depended on the Director of Nursing to discuss nutritional issues with the medical provider and obtain orders for the recommendations. The supplements should have been ordered 4 times a day, and they did not know why it was not ordered. They also stated fortified mash potatoes were ordered for residents that needed more calories. When requesting a calorie count they would send an email to the unit manager, they were not sure why they did not follow up on the calorie count. During an interview on [DATE] at 12:56 PM, the Food Service Director stated fortified mash potatoes and mash potatoes were not made the same, they had 2 different recipes. During an interview on [DATE] at 3:49 PM, Staff # 6 (Nurse Manager) stated they were aware the resident was losing weight, and had a meeting and the dietitian was involved. The medical provider saw the resident on [DATE] and was aware of the weight loss and did not want to change the residents insulin's. They stated the calorie count was done but they were unable to find it. Staff #6 did not know why the supplement was not increased to 4 times a day or if the recommendation was communicated to the physician. 10 NYCRR 415.12 (g)(1)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 47626 Based on observation, interview, and record review during recertification survey conducted 6/24/2024 - 7/1/2024, the facility did not ensure menus were followed for 2 of 2 residents (Resident # 61 and # 71) reviewed for Nutrition. Specifically, 1. Residents #61 received fish that was not documented on the meal ticket and 2. Resident # 71 had a meal ticket that documented 4 ounces of mashed potatoes and 4 ounces of enriched mashed potatoes, the tray had 4 ounces of mashed potatoes and Resident #71 did not receive nectar thick apple juice as indicated on the tray ticket. Findings include: A review of the policy and procedure titled Dietary Department Admission Procedure, dated 1/1/2000 documented it is the policy that the dietary department will ensure that upon admission the nutritional care plan is developed. On admission the resident's dietary needs are identified. 1. Resident #61 had diagnoses including a fracture femur, atrial fibrillation, and congestive heart failure. An admission Minimum Data Set (an assessment tool) dated 5/14/2024 documented the resident's cognition as intact. The resident required set up assistance with eating and was dependent on staff for all other activities of daily living. The resident received a modified diet. A review of the eating/nutritional status care plan dated 5/28/2024 Goal stable weight, Therapeutic diet Chopped, honey thick liquids. Set up help, lip plate, supplement between meals. During an observation on 06/25/2024 at 11:59 AM, the resident was eating lunch in the day room. The resident's ticket documented stewed tomatoes chopped. The resident's tray had chopped stewed tomatoes and a piece of fish. When interviewed on 06/27/2024 at 12:52 PM, Staff #5 (kitchen supervisor) stated they knew the resident's ticket only documented stewed tomatoes, and it was because the resident was lactose intolerant, and the meal was macaroni and cheese. Staff #5 stated they knew to add a protein, and put fish on the tray but did not consult the dietitian. When interviewed on 6/27/2024 at 12:45PM the food service director said the kitchen staff should provide the resident with what was on the ticket, and if there was a question they should have consulted with the dietitian. When interviewed on 06/27/24 at 12:52 PM the Dietitian stated, they were unaware the ticket only documented stewed tomatoes, and the kitchen staff should have asked them or the food service director prior to adding additional food items on the tray. 2. Resident # 71 had diagnoses including metabolic encephalopathy, diabetes, and dysphagia (difficulty swallowing). (continued on next page)

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Admission Minimum Data Set (an assessment tool) 5/14/2024 documented the resident's cognition as moderately impaired, the resident was dependent with all care including eating. The resident has recorded on the admission 1 stage 2 Pressure Ulcer and 1 Deep Tissue Injury. The resident admission weight was 114, height 62 inches, and documented weight loss as no or unknown. A review of the current physician orders documented a regular, puree, nectar thick diet. The Nutrition Care Plan dated 5/28/2024 documented regular puree diet with nectar thick liquids with a goal to maintain a stable weight goal weight at 115 +/- 5% . During an observation on 06/24/2024 at12:14 PM in the day room, the staff were feeding the resident, the meal ticket documented apple juice but the resident did not receive apple juice. During an observation on 06/26/2024 at 09:29 AM the staff were feeding in bed. The tray ticket documented ketchup, but there was no ketchup on the tray. During an observation on 6/27/2024 at 12:34 PM the resident was being fed lunch, the tray ticket documented 4 ounces of mashed potatoes and 4 ounces of fortified mash potatoes, the tray had 4 ounces of mashed potatoes with gravy. During an interview on 06/26/2024 at 11:34 AM, the Food Service Director stated the software was interfaced with the electronic medical record, when the diet order was placed in the electronic medical record it flowed over to the dietary software. The tickets were printed out and the first staff on the food service line would call out to the cook what was needed on the tray based on the ticket. The second staff would put the cold food on based on the ticket and checked for accuracy. The Kitchen Supervisor was responsible to ensure all trays were sent to the unit with what was documented on the ticket and any discrepancy should be discussed with the dietitian. During an interview on 06/27/2024 at 12:42 PM, Staff #5 (kitchen supervisor) stated the resident had both mashed potatoes and fortified mash potatoes on the ticket. They did not know why they would both be on the ticket as all mashed potatoes were fortified. They provided the resident with 4 oz of mashed potatoes. During an interview on 06/27/2024 at12:41 PM, with the dietician stated they were unaware everyone got fortified mashed potatoes. They also stated a pre-thickened apple juice should have been on the tray if it was on the ticket. During an interview on 06/27/2024 at 12:56 PM, the Food Service Director stated fortified mashed potatoes and mashed potatoes were not made the same. The kitchen staff should have provided fortified mashed potatoes if that was what was ordered. They stated both mashed potatoes and fortified mashed potatoes should not have been on the meal ticket together, and kitchen staff should have clarified that with the dietitian. 10NYCRR 415.14(c)(1-3)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335828	A. Building B. Wing	07/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41666 Based on observation, record review and interviews conducted during a recertification survey (6/24/24-7/1/24), the facility did not ensure infection control prevention practices including hand hygiene, enhanced barrier precautions, and catheter care were maintained to help prevent the development and transmission of communicable diseases and infections for 4 (#37,#61,#322, #86) of 32 sampled residents. Specifically, 1) Staff #11 (Licensed Practical Nurse) did not follow proper hand hygiene during a wound care treatment for Resident #37; 2) Enhanced barrier precautions were not implemented when Staff #9 (Registered Nurse) performed Resident #61's dressing change, and when Staff #8 (Physical Therapy Assistant) handled Resident #322's catheter drainage bag without gloves or a gown; and 3) Resident #86 urine catheter collection bag was observed on the floor. Findings include: 1) Resident #37 was admitted with diagnoses including Diabetes Mellitus, hemiplegia, Dementia, Hypertension and seizures. The Minimum Data Set (an assessment tool) quarterly assessment dated [DATE] documented the resident had severe cognitive impairment and was totally dependent on staff for all cares. A nursing progress note dated 4/11/24 documented Resident #37 developed a Stage 2 sacral pressure ulcer. The 6/20/24 physician order documented Santyl ointment applied to sacrum topically every day. Cleanse area with normal saline, apply nickel layer of Santyl to wound base and lightly pack at center. An observation was made on 6/26/24 at 10:26 AM of the sacral pressure ulcer dressing change with Staff #11 (Licensed Practical Nurse). Staff #11 washed hands and donned gloves. The old dressing was removed, and the dirty gloves were doffed and placed in the garbage pail. A second set of gloves was observed under the first and were not removed to perform hand hygiene. The wound was cleaned with normal saline and dabbed dry. The wet and dirty gloves were doffed and thrown in the garbage pail revealing another set of gloves already on Staff #11 hands. With gloves on, the Santyl ointment was applied, and a dry dressing was put in place. Staff #11 removed their gloves and threw them in the garbage pail. During an interview with Licensed Practical Nurse Staff #11 on 6/26/24 at 10:36 AM they confirmed that they donned 4 pairs of gloves prior to performing the dressing change and doffed a set at each interval. Staff #11 stated they were not aware they should not wear 4 layers of gloves or that they need to perform hand hygiene after removing gloves and donning a clean pair of gloves. During an interview with Staff #13 (Staff Development Licensed Practical Nurse) on 6/26/24 at 11:00 AM, they stated they coordinated a competency fair a few months ago and staff were able to perform return demonstrations for tube feeds, dressing changes, and medication administration. Staff #13 stated that wearing multiple layers of gloves and pulling off a set as it got soiled was not the way to perform dressing changes and it was not the facility policy. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) Resident #61 had diagnoses including a fractured femur, Atrial Fibrillation, and Congestive Heart Failure An admission Minimum Data Set (an assessment tool) dated 5/14/2024 documented the resident's cognition was intact and had a Stage 2 pressure ulcer. The physician order dated 6/6/2024 documented Enhanced Barrier Precautions. During an observation on 06/26/2024 at 9:45 AM, Staff #9 (Registered Nurse) was changing the residents dressing to his right calf and was not wearing a gown. During an interview on 06/26/2024 at 9:50 AM, Staff #6 (Nurse Manager) stated if a resident was on Enhanced Barrier Precautions, the staff should have been following precautions and was expected to wear a gown during the dressing change. During an interview on 06/26/2024 10:00 AM, with the Director of Nursing stated staff were educated to use appropriate personal protective equipment when providing care for residents on enhanced barrier precautions, and should have been wearing a gown during a dressing change. During an interview on 06/26/2024 at 10:20 AM, Staff #9 stated they were aware they should have been wearing a gown, but the resident was leaving for an appointment and they needed to do it quickly. 3. Resident #86 was admitted to the facility with diagnoses including Parkinson's disease, obstructive/reflux uropathy, and dementia. The Quarterly Minimum Data Set (MDS, an assessment tool) dated 4/1/2024, documented Resident #86 had severely impaired cognition, and required extensive assistance of two people for activities of daily living, and had an indwelling urinary catheter. The care plan dated 3/27/24 documented the urinary catheter drainage collection bag to be covered while in bed and out of bed. When observed on 06/25/24 at 08:39 AM, Resident #86 in bed having their breakfast with catheter drainage collection bag uncovered and lying directly on the floor. When interviewed on 06/25/24 at 08:44 AM, Staff # 4 (Certified Nurse Aide) stated they needed to cover the bag and remove it from the floor. 10 NYCRR 415.19 (b) (4) 47626 49364