STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335865	A. Building B. Wing	08/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Samaritan Senior Village, Inc	22691 Campus Drive Watertown, NY 13601

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 50561 Based on observation, interview, and record review during the recertification and abbreviated (NY00347064) surveys conducted 8/12/2024-8/16/2024, the facility did not ensure each resident had the right to a safe, clean, comfortable, and homelike environment for 1 of 1 resident (Resident #92) reviewed. Specifically, Residents #92's electric wheelchair was unclean. Findings include: The facility policy, Wheelchair/Transport Chair Cleaning Protocol, revised 9/10/2017 documented the facility ensured the resident was provided a sanitary and pleasant environment, equipment was cleaned and disinfected once a month and daily as needed, and each unit had a designated week of cleaning throughout the month. The undated facility document Skilled 4A Side Wheelchairs (wheelchair cleaning log) did not document the resident's chair was cleaned. Resident #92 was admitted to the facility with the diagnoses including left hemiplegia and hemiparesis (weakness and paralysis of the left side of the body) following a cerebral infarction (stroke). The 7/18/2024 Minimum Data Set documented the resident had intact cognition and used a manual or electric wheelchair. During observations on 8/12/2024 at 3:50 PM, and 8/13/2024 at 11:32 AM Resident #92's wheelchair had a significant amount of dried debris underneath and around the footrest and on the front middle portion of the seat. The debris was dried on the surface and embedded in the crevices. During an interview on 8/14/2024 at 11:25 AM, Office Manager #27 from an outside medical office stated during the resident's office appointment on 6/27/2024 the resident's electric wheelchair was filthy. There was dried, unidentified material on it. During an interview on 8/14/2024 at 12:37 PM, Resident #92 stated housekeeping usually cleaned their chair. They were unsure what the cleaning schedule was or when the chair was last cleaned. They felt their chair took extra asking to get it cleaned and they once wheeled themselves into License Practical Nurse Manager #9's office to express how dirty it was just so it would be cleaned. They preferred to sit in a clean chair and had never refused to have their chair cleaned. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 8/15/2024 at 11:11 AM Resident #92's wheelchair had a significant amount of dried debris underneath and around the footrest and on the front middle portion of the seat. The debris was dried on the surface and embedded in the crevices. During an interview on 8/15/2024 at12:58 PM, Certified Nurse Aide #13 stated wheelchairs were deep cleaned by housekeeping on the night shift, but they were unsure what the schedule was. Housekeeping had to be reminded sometimes as quite a few chairs were missed. They had not seen Resident #92's wheelchair recently, but typically it was dirtier than others because the resident dropped a lot of food. Sitting in a dirty chair was undignified, and in the case of an electric chair, uncleanliness could cause an electrical short. During an interview on 8/15/2024 at 1:09 PM, Housekeeper #14 stated the housekeeping department cleaned the wheelchairs on the overnight shift but was unsure what the schedule was. If they found a dirty wheelchair they would clean it. Resident #92's chair was usually dirty, especially the footrest area. The resident had not refused to have their chair cleaned and thought if they asked the resident, the resident would let them wash their chair. It was important for chairs to be clean, otherwise it would be unsanitary. During an interview on 8/16/2024 at 11:07 AM, License Practical Nurse Manager #9 stated wheelchairs were cleaned weekly by the environmental services staff on the day shift, but they were unaware if there was a particular schedule. Anyone could clean a chair anytime. If they noticed a soiled wheelchair, they should clean it or contact environmental services. They did not have a process to monitor wheelchair cleanliness. Resident #92's wheelchair got very dirty, and the resident had brought it to their attention in the past. A clean wheelchair was important as a dirty chair could smell bad and affect a resident's dignity. During an interview on 8/16/2024 at 12:26 PM, Environmental Services Supervisor #15 stated wheelchairs were cleaned by their staff monthly on Sunday nights. Nursing staff brought any chairs that needed to be cleaned out into the hallway. Housekeeping staff then took the chairs to the spa room to clean, and then returned the chairs to the hallway once cleaned. If a chair was not brought out to the hallway it was not cleaned. The process was the same for electric wheelchairs. The wheelchair cleaning log was filled out with the date the chair was cleaned. A blank on the log indicated that the chair had not been cleaned. Anytime there was a dirty chair, they expected their staff to either clean it or notify them so they could do it regardless of the cleaning schedule. Resident #92's chair was never brought out into the hall, and they were not sure why. They had not spoken with the Nurse Manager about it. They checked the log and spot-checked wheelchairs periodically to ensure chairs were being cleaned. Clean chairs were important for overall resident health, wellness, and dignity. During an interview on 8/16/2024 at 1:34 PM, Director of Nursing #2 stated they did not know the process for wheelchair cleaning but thought environmental services performed the cleaning. If a wheelchair was dirty, it should be spot cleaned, and a work order should be put in for further cleaning. Staff were trained to follow the wheelchair cleaning schedule. 10 NYCRR 415.29(j)(1)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 40803 Based on record review and interviews during the recertification and abbreviated (NY00344487) surveys conducted 8/12/2024-8/16/2024, the facility did not ensure that prompt efforts were made to resolve grievances for 1 of 1 resident (Resident # 26) reviewed. Specifically, Resident #26's family member sent an electronic message to the facility's Administrator regarding their concerns and their concerns were not addressed timely. Findings include: The facility's policy, Complaint Grievance and Recommendation, revised 7/28/2024 documented that residents' next of kin or designated representatives were provided a method by which to express complaints and/or recommendations, both verbally and in writing, and that such complaints and/or recommendations would be responded to as soon as possible. Resident #26 was admitted to the facility with diagnoses including transient ischemic attack (mini stroke), abnormalities of gait and mobility, and muscle weakness. The 6/20/2024 Minimum Data Set Assessment documented the resident had intact cognition, did not reject care, and required partial/ moderate assistance with most activities of daily living. A 6/4/2024 electronic mail from Resident #26's family member addressed to the facility's Administrator expressed their concerns over long call bell wait times and other various issues. On 6/5/2024, the facility's Administrator replied to the family member's electronic mail and acknowledged the family member's email and poor experience. The Administrator documented they could not read the sender's attachment and asked for it to be sent again in another manner. On 6/6/2024, Resident #26's family resent an electronic message along with an attachment, they asked to be notified if the attachment could not be opened. There was no documented evidence facility staff responded to Resident #26's family members concerns in a timely manner. During an interview on 8/13/2024 at 11:17 AM Resident #26 stated staff did not respond to call bells in a timely manner and they had to call their family member who then called the Assistant Director of Nursing to have someone respond to their call bell. During an interview on 8/13/2024 at 2:36 PM Resident #26's family member stated call bell wait times could take longer than 1 hour before being answered. They sometimes had to contact the Assistant Director of Nursing who sent staff to answer the call bell. They felt their issues were not being addressed. They sent an electronic mail to the Administrator on 6/4/2024 regarding their concerns over long call bell wait times and other issues but they never received any follow up from the facility other than the electronic message documenting attachments could not be opened. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/15/2024 at 11:49 AM the Assistant Director of Nursing stated If a resident or family member had concerns with care, they could alert the Nursing Supervisor or Unit Manager. They provided the residents and family members with their personal cell phone so they could also call them when issues arose. Concerns with care should be addressed as quickly as possible and all concerns should be acknowledged. During an interview on 8/15/2024 at 3:46 PM the Administrator stated if a resident or family member reached out to them and expressed concerns with care, they would get back to them and try to tackle the problem as quickly as possible. They did not consider complaints to be grievances. They stated grievances were unresolved issues. They stated Resident #26's family member reached out to them by an electronic mail on 6/4/2024 and they could not open the attachment that was provided. They responded and asked for the information to be sent again. The family member replied on 6/6/2024, but they were still unable to open the attachment. They did not follow up with the family member or resident. They were unaware of any unresolved issues. During a follow up interview on 8/16/2024 at 11:51 AM the Assistant Director of Nursing stated Resident #26's family member did not call them a lot and they had not received any calls from them recently. If they received complaints of long waits for call bells to be answered, they followed up with staff. They were unaware of any issues that were outstanding with Resident #26. During an interview on 8/16/2024 at 12:27 PM the Director of Social Services and Grievance Officer stated grievances and complaints were the same thing. The facility should follow up with any complaints and grievances reported to staff. If a family member or resident expressed issues with long call bell wait times that was considered a complaint, and the nursing department heads should be made aware so the issue could be investigated. Residents and family members could express their concerns via electronic messages, verbally, or in writing. It was important to follow up with resident concerns. During a follow up interview on 8/16/2024 at 12:43 PM the Administrator stated they should have reached out to Resident #26's family member. It was important to follow up with resident concerns. 10NYCRR 415.3(C)(1)(ii) 49448

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 50561 Based on observation, record review, and interviews during the recertification survey conducted 8/12/2024-8/16/2024, the facility did not ensure the development and implementation of a comprehensive person-centered care plan for 1 of 2 residents (Resident #125) reviewed. Specifically, Resident #125's comprehensive care plan did not include a diagnosis of Type 2 diabetes (the body is unable to use insulin properly causing high blood sugar). Findings include: The facility policy, Comprehensive Care Planning, revised 10/1/2023, documented the facility would ensure that an individualized care plan was initiated for all residents, and chronic, active diagnoses would be care planned for. The facility policy, Diabetes Management, revised 2/3/2020 documented staff would identify and report issues that may affect, or be affected by, a patient's diabetes and diabetes management such as foot infections, skin ulceration, increased thirst, or hypoglycemia (low blood sugar). Resident #125 was admitted to the facility with a diagnosis of diabetes mellitus. The 7/19/2024 Minimum Data Set documented the resident had moderately impaired cognition, had a diagnosis of diabetes, and received a hypoglycemic (used to lower blood sugar) daily. Physician orders documented: - on 7/17/2023 the resident was to receive Metformin 500 milligrams (a hypoglycemic) twice daily for diabetes. - on 10/23/2023 the resident was to receive a no concentrated sweets diet. - on 7/30/2024 HGBA1C every 3 months (a lab test that measures average blood sugar level over 2-3 months). A 6/24/2024 Physician Assistant #45 progress note documented the resident had been eating and drinking less lately and was not as interested in food. There was no documented evidence the Comprehensive Care Plan included a diagnosis of diabetes with associated interventions. During an interview on 8/16/2024 at 10:14 AM, Certified Nurse Aide #7 stated the nurse aides had access to resident care plans. It was important to know if a resident was diabetic as it would make them more alert for symptoms of high or low sugar levels such as headaches, dry mouth and dizziness. Resident #125 was a diabetic but was not listed as a diabetic in their care plan or their resident care instructions. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/16/2024 at 10:57, Licensed Practical Nurse Unit Manager #9 stated care plans were done on admission and updated quarterly and as needed. They tried to match diagnoses and medications with care plan problems. If a resident was diabetic, there should be a care plan problem with interventions such as monitoring labs, monitoring finger sticks, and monitoring for signs of abnormal glucose levels. This was important as abnormal glucose levels could lead to coma and even death. Resident #125 was a diabetic and took an oral hypoglycemic daily. They should have a related care plan but did not. During an interview on 8/16/2024 at 1:34 PM, Director of Nursing #2 stated nursing care plans were initiated by the Unit Manager or Supervisor and the Licensed Practical Nurses Managers could update them. Care plans should reflect if someone had diabetes mellitus so that residents could be monitored for changes in condition such as hyperglycemia/hypoglycemia (abnormally high and low glucose levels). If a resident did not have a care plan, the resident should still be monitored. 10NYCRR 415.11(c)(1)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 40803 Based on observation, record review, and interview during the recertification and abbreviated (NY00344344, NY00344487, and NY00347064) surveys conducted 8/12/2024-8/16/2024, the facility did not ensure residents who were unable to carry out activities of daily living received the necessary services to maintain grooming and personal hygiene for 1 of 8 residents (Resident #26) reviewed. Specifically, Resident #26 was not assisted out of bed as requested. Findings include: The facility policy, Activities of Daily Living, revised 4/2024 documented activity of daily living tasks included personal hygiene, toileting, feeding, bed mobility, transfer, walking in the room and corridor, locomotion on and off the unit and dressing. Certified nurse aides documented activity of daily living support and performance. Resident #26 had diagnoses including transient ischemic attack (mini stroke), abnormalities of gait and mobility, and muscle weakness. The 6/20/2024 Minimum Data Set Assessment documented the resident had intact cognition, did not reject care, and required partial/ moderate assistance with most activities of daily living including bed mobility. The 3/5/2024 Comprehensive Care Plan documented the resident required substantial/ maximum assistance of 1 for rolling left to right, sitting to lying, and lying to sitting; substantial/maximum assistance of 2 with mechanical lift for sitting to standing and chair to bed transfers. The undated care instructions documented the resident required substantial/ maximum assistance of 1 for lying to sitting on side of bed, sitting to lying, and rolling left to right. On 6/1/2024 at 1:33 PM, a progress note by Licensed Practical Nurse #36 documented the resident stayed in bed. There was no documentation of a reason why the resident stayed in bed. During an interview and observation on 8/13/2024 at 11:17 AM, Resident #26 was seated in their electric wheelchair and stated at times they had been asked to stay in bed because there was not enough staff to get them up. During an interview on 8/13/2024 at 2:36 PM, Resident #26's family member stated the resident called them when their call bell wait times were long and they in turn called the Assistant Director of Nursing to have someone answer the resident's call bells. They had attempted to reach out to the facility's Administrator on 6/4/2024 to discuss their concerns regarding the weekend of 6/1/2024 when the resident was left in bed all day, but no one from the facility had gotten back to them. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/16/2024 at 10:03 AM Licensed Practical Nurse #36 stated residents should not be asked to stay in bed. If a resident requested to get out of bed and staff was unable to, they should let the nurse know so they could assist. At times the unit was staffed with 3 certified nurse aides and 2 licensed practical nurses so staff might not be able to get the resident up at that moment they were providing care to other residents, but the resident should be assisted as soon as possible. They stated they usually worked the overnight shift, but on 6/1/2024 they were mandated to stay over for the day shift. Resident #26 did not refuse care and they did not recall being asked to assist with resident care. During an interview on 8/16/2024 at 12:58 PM Certified Nurse Aide #35 stated sometimes on the weekends only 2 certified nurse aides were scheduled. The weekend of 6/1/2024 was tough. On Saturday 6/1/2024 there were only 2 certified nurse aides until 10:00 AM. Staff had to prioritize who they got up as some residents needed to be up for breakfast. Any residents that did not have to be assisted with meals were not gotten up until after the breakfast meal. Resident #26 was not happy about having to stay in bed but was understanding. They stated they provided care to the resident as fast as they could, but it was almost lunch time when they were able to get to the resident. They washed the resident up and provided assistance as needed. Staff documented the care provided to the residents and they typically did not get to their charting until the end of the day. They stated the 2 licensed practical nurses were aware it was a tough weekend. During an interview on 8/16/2024 at 1:48 PM the Assistant Director of Nursing stated staff was expected to document the care provided each shift. If there was no documentation it was assumed the care did not happen. It was unacceptable for staff to ask a resident to stay in bed because there was not enough staff. They did not recall being notified the unit was short staffed on 6/1/2024 and they expected to be notified about those types of issues. 10NYCRR 415.12(a)(3) 48446 49448

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 49448 Based on observation, record review, and interview during the recertification survey conducted 8/12/2024-8/16/2024, the facility did not ensure ongoing provision of programs to support each resident in their choices of activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident for 1 of 2 residents (Resident #137) reviewed. Specifically, Resident #137 was not assisted to attend an activity that was meaningful to them and met their interests and preferences. Findings include: The facility policy, Activities, effective 4/19/2024 documented the activities program appealed to each resident's interests and enhanced the resident's highest practicable level of physical, mental, and psychosocial wellbeing based upon the resident's comprehensive assessment. Activities were relevant to the specific needs, interests, cultural, background, etcetera of the individual. The facility's August 2024 Recreational Therapy Calendar documented on 8/14/2024 at 2:00 PM there was a Petting Zoo activity on the front lawn. Resident #137 had diagnoses including dementia, muscle weakness, and need for assistance with personal care. The 1/31/2024 Minimum Data Set assessment documented the resident felt it was very important to go outside to get fresh air when the weather was good. The 6/26/2024 Minimum Data Set assessment documented the resident had moderately impaired cognition, required substantial/ maximum assistance with transfers, and was dependent for locomotion with a wheelchair. The comprehensive care plan initiated 2/1/2024 and revised 4/3/2024 documented the resident did not wish to attend activity programs and was content watching television, resting and visiting with family. Interventions included the resident was allowed to change their mind about attending activity programs. The 1/30/2024 Admission Activity Assessment completed by Activity Coordinator #29 documented the resident got around by wheelchair with assistance. The resident was able to make their needs known and made their own decisions about activity preferences. The resident enjoyed pets and their communication method was verbal. The activities One to One (Room Visits Form) documented the resident was invited to the zoo activity on 8/14/2024 by Activity Coordinator #29. During a telephone interview on 8/15/2024 at 8:40 AM the resident's family member stated the resident was excited to attend the zoo activity yesterday and they were surprised because the resident rarely had an interest in attending the facility's activities. They stated they were visiting with the resident in their room, the resident was ready in their wheelchair and was added to the list of residents that wished to attend. They left around 2:00 PM because the resident was supposed to attend the zoo activity. They stated they called the resident on the telephone around 4:00 PM to ask about the zoo activity and the resident stated they were never picked up to attend the activity. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 8/15/2024 at 9:02 AM Resident #137 was in their room lying in bed. They stated they wanted to attend the zoo event, but staff never came to take them to the activity. They stated that was life and it was not always fair. During a telephone interview on 8/15/2024 at 2:26 PM Activity Coordinator #29 stated Resident #137 wanted to attend the zoo activity but did not. They stated Certified Nurse Aide #30 was supposed to get the resident ready to go. When they came to the floor to pick up the resident, the resident was not ready by the elevator. The resident was not able to get themself to the elevator and required staff to get them there. The resident should have been able to attend the activity because they rarely came out of their room and was excited to attend. It was important for the residents to get fresh air, to socialize, and to have pleasure and enjoyment. They loved to see the residents smiling and happy at activities and this was important for their quality of life. During an interview on 8/16/2024 at 10:45 AM Certified Nurse Aide #30 stated Activity Coordinator #29 let them know who wanted to attend the zoo activity and they got them ready and then took them over to the elevator to be transported to the activity. Resident #137 wanted to attend the zoo activity and they got them ready to go but did not take them to the elevator because the resident was visiting with family in their room. They stated Activity Coordinator #29 was going to come back to get the resident when they were ready. They should have taken the resident to the elevator. They had not communicated to Activity Coordinator #29 the resident was ready but was still in their room. Attending activities of preference was important for the residents' quality of life and mental health, and it was important for residents to get fresh air. During an interview on 8/16/2024 at 10:54 AM Social Worker #25 stated it was important for residents to attend activities of their preference for their quality of life. Resident #137 should have attended the zoo activity if they wanted to go. It was not acceptable they were left behind. The resident was getting older and may not have another opportunity for a zoo activity. After the resident voiced they wanted to attend the activity and was not picked up, it could have negatively affected their mood. If the resident wanted to attend the activity, they should have. 10NYCRR 415.5(f)(1)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 49448 Based on observations, record review, and interview during the recertification and abbreviated (NY00344344, NY00344487, and NY00347064) surveys conducted 8/12/2024-8/16/2024, the facility did not ensure residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 3 of 3 residents (Residents #59, #67 and #86) reviewed. Specifically, Resident #59 did not have their palm protectors (contracture management device) applied as care planned; Resident #67 did not have their elastic tubular compression bandage (Tubigrip) applied as ordered; and Resident #86 had a skin tear (a wound resulting from separation of the top layer of skin from the second layer) and initial treatment orders were not obtained, and the wound dressing was unclean. Findings include: The facility policy, Rehab-Splints-Upper Extremities-SSV reviewed 3/11/2024 documented the occupational therapist evaluated the resident's upper extremities and provided an appropriate splint/orthotic to meet the individual resident's needs if indicated and established an appropriate wearing schedule. The results of the occupations therapy evaluation and recommendations were documented in the medical record. The splint was fitted to the resident and issued for use on the unit; the care plan was updated; and nursing staff were educated on the application and use of the splint. The facility policy, Skin Tear Protocol, reviewed 11/10/2023 documented all skin tears were evaluated by nursing and the qualified medical provider was notified. Treatment was applied per provider orders; all skin tears were documented upon occurrence and with every dressing change until closed; and the order was discontinued when the area was healed with a provider order. 1) Resident #59 had diagnoses including functional quadriplegia (a condition that causes complete immobility), contracture (tightening of the muscles, tendons, and joints) of the left hand, and contracture of the right hand. The 5/22/2024 Minimum Data Set assessment documented the resident had severely impaired cognition, had functional limitation in range of motion for both upper and lower extremities, was dependent for dressing upper body and did not reject care. The Comprehensive Care Plan initiated 3/7/2024 and revised 7/29/2024 documented the resident required assistance with self-care and mobility related tasks. Interventions included palm protector to left and right hand at all times, off for hygiene as resident allowed. The undated Kardex (care instructions) documented a palm protector to left and right hand at all times, off for hygiene as resident allowed. The 7/15/2024 Occupational Therapist #21 Discharge Summary documented discharge recommendations included hand roll to the right hand and palm protector to the left hand at all times. There was no documented evidence of a physician order for left or right hand palm protectors or a palm roll. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 8/2024 Treatment Administration Record did not document the use of palm protectors or palm rolls. Resident #59 was observed without a palm protector to the left and right hands or a hand roll to the right hand at the following times: - on 8/12/2024 at 11:25 AM in their room sitting in their positioning chair; at 12:30 PM in the dining room while being assisted with their lunch meal; and at 4:02 PM in the common television area sitting in their positioning chair. - on 8/13/2024 at 11:01 AM in their room sleeping in their positioning chair; at 11:17 AM in the dining room sitting in their positioning chair. - on 8/14/2024 at 9:24 AM and 11:18 AM in their room sleeping in their positioning chair - on 8/15/2024 at 9:25 AM in their room sleeping in their positioning chair. During an interview on 8/15/2024 at 10:57 AM, Occupational Therapist #20 stated Resident #59 had left and right hand palm protectors initiated upon therapy discharge on 7/15/2024 by former Occupational Therapist #21. This information was located on the care plan and the certified nurse aides were responsible to ensure the palm protectors were placed. Prior to therapy discharge the occupational therapist educated the certified nurse aides on the use of the palm protectors and how they were put on and taken off. It was verbalized to the licensed practical nurse on the floor that the resident required them. If a resident was not wearing the palm protectors as recommended, their contractures could get worse and there could be skin issues or infections. During an interview on 8/15/2024 at 11:26 AM, Certified Nurse Aide #22 stated they were assigned to Resident #59 that day. Palm protectors prevented skin breakdown and contractures from getting worse. Placement or refusal was not documented anywhere. If they were refused, they reported to the licensed practical nurse on the unit. Resident #59 had contracted hands and they knew they had splints ordered but they did not put them on today because it slipped their mind. They did not tell anyone they did not put the splints on. They stated they should have put the splints on, so the resident did not get any skin breakdown, or so their hand contractures did not get worse. During an interview on 8/15/2024 at 11:40 AM, Licensed Practical Nurse #19 stated directions for palm protectors were located on the Kardex and the certified nurse aides looked at it every day. The certified nurse aides reported any refusals to them. Resident #59 had palm protectors because of contracted hands, and they were responsible to verify the placement of the palm protectors. There should be an order and placement should be documented in the treatment administration record. The order should have been entered in the computer when therapy discharged the resident and provided the certified nurse aides with the palm protectors. They did not know why there was not an order that placement of the palm guards was checked, or why they were not verifying the palm protectors were placed. During an interview on 8/15/2024 at 1:57 PM, Registered Nurse Unit Manager #18 stated Resident #59 had bilateral palm protectors listed on their Kardex that was referenced every shift by the certified nurse aides. They stated if there were any issues or refusals they should be reported to the licensed practical nurse. Without somewhere to document the placement of the palm protectors, the licensed practical nurse would not have known the placement needed to be checked. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The comprehensive care plan initiated 7/28/2024 and revised 8/13/2024 documented the resident had potential/ actual impairment to skin integrity related to fragile skin, advanced age, and anticoagulation therapy. A skin tear to the left forearm was documented on 8/11/2024. Interventions included facility protocols for treatment of injury were followed and the location, size, and treatment of skin injury was monitored and documented. The 8/11/2024 at 10:26 AM Registered Nurse #6 progress note documented they were notified the resident had a skin tear to their left forearm approximately 4 centimeters by 4 centimeters V-shaped with scant bleeding noted. The area was cleansed and steri-strips (thin, sticky bandages that hold wound edges together) were applied. The family and the provider were notified. The 8/12/2024 at 6:53 PM Assistant Director of Nursing progress note documented the resident had aging, fragile skin and was on Eliquis (blood thinner medication). The resident sustained a skin tear when bumped while staff assisted with transferring. Skin care as scheduled and medical was aware. The 8/12/2024 at 8:46 PM Nurse Practitioner #17 progress note documented the resident was seen today for follow up of a skin tear reported by nursing on 8/11/2024. Nursing applied steri-strips, the on call provider was notified and no new orders were given. Steri-strips were intact and there was no drainage or signs of infection. There were no documented physician orders from 8/11/2024- 8/12/024 for a treatment for the skin tear. A physician order dated 8/13/2024 documented left arm skin tear, steri-strips in place. Monitor daily and report any adverse findings to the charge nurse until healed. The order was discontinued on 8/16/2024. The August 2024 Treatment Administration Record documented the left arm skin tear with steri-strips were in place, the skin tear was monitored, and adverse findings were reported to the charge nurse until healed daily from 8/13/2024-8/16/2024. Resident #67 was observed on 8/12/2024 at 1:16 PM and 3:57 PM; on 8/13/2024 at 11:22 AM; and on 8/14/2024 at 9:30 AM sitting in their recliner chair in their room. They had 3 steri-strips in place on their left forearm/elbow area that were brown in color. There was a moderate amount of dark colored dried blood in an approximately 3-4-inch area distal (toward the hand) from the elbow: The 8/14/2024 at 1:49 PM Registered Nurse Unit Manager #18 progress note documented per Licensed Practical Nurse #23 the resident's steri-strips had fallen off the left forearm/ elbow area skin tear, the scab was intact, and there were no signs of drainage or infection. During an observation and interview on 8/15/2024 at 9:09 AM Resident #67 was sitting in their recliner chair in their room with an undated Kerlix (gauze bandage roll) wrap to their left elbow. They stated the steri-strips had fallen off during the day yesterday and when an unidentified certified nurse aide assisted them to get ready for bed last night, their scab had rubbed off their elbow when they were putting on a hospital gown for bedtime. The wound started bleeding and an unidentified nurse came in and placed the kerlix wrap and told them it was just temporary because there was no order for it. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no documented evidence of a physician order for a treatment dressing or Kerlix wrap to the left forearm/elbow through 8/16/2024. During an interview on 8/16/2024 at 11:24 AM, Licensed Practical Nurse #23 stated in the event of a new skin tear they contacted the Nursing Supervisor who determined the appropriate dressing to be placed. Wound treatments required orders. Wounds and dressings should be clean even if they were steri-strips, they should not be discolored, and dried blood around the area should be cleaned as this was an infection control issue. They contacted Registered Nurse Unit Manager #18 on 8/14/2024 after the steri-strips fell off and told them the area was gookey looking. They reported dried blood but no active drainage, and Registered Nurse Unit Manager #18 came and looked at the wound and told them to keep it open to air and it would heal. During an interview on 8/16/2024 at 11:46 AM, Registered Nurse Unit Manager #18 stated Licensed Practical Nurse #23 notified them Resident #86's steri-strips had fallen off a couple days ago. An order was always needed for a wound treatment. Dressings should be clean and that included steri-strips. There should not have been dried blood around the area, and each nurse that signed off that the resident's wound was monitored should have seen that and cleaned it. They recalled a scab yesterday but did not recall any dried blood. They stated medical had seen the resident yesterday and there were no new orders. They had rounded on the resident today, saw the Kerlix wrap, and the resident reported the wound had reopened. There were no new orders. Whoever wrapped the wound should have contacted the provider and entered the appropriate order. Without orders to new, open wounds, the nurses could not monitor or change the dressing. There should have been a progress note and treatment order documented when the Kerlix was placed. 10NYCRR 415.12

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 49448 Based on observation, record review, and interview during the recertification survey conducted 8/12/2024-8/16/2024, the facility did not ensure that residents who required dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly) services received such services consistent with professional standards of practice for 1 of 1 resident (Resident #37) reviewed. Specifically, Resident #37 received hemodialysis treatments at a community-based dialysis center and did not have ongoing assessments of their condition and monitoring for complications before and after dialysis treatments. Additionally, there was not consistent ongoing communication and collaboration between the facility and the dialysis center. Findings include: The facility policy, Dialysis, effective 4/19/2024 documented the facility maintained proper standards related to dialysis protocol and good communication was maintained with the facility that provided dialysis. A communication book went with the resident each time they went to dialysis. The purpose of the book was to share information/ ask questions with the dialysis center. The policy did not document what specific information was included in the communication book, pre or post dialysis assessments to be completed, or dialysis access site monitoring. Resident #37 had diagnoses including end stage renal (kidney) disease with dependence on renal dialysis, hypotension (low blood pressure), and hypertension (high blood pressure). The 7/16/2024 Minimum Data Set assessment documented the resident was cognitively intact, did not reject care, and required hemodialysis treatments. The Comprehensive Care Plan initiated 7/12/2024 documented the resident needed dialysis related to renal failure. Interventions included a dialysis book went with resident to dialysis appointments, dialysis was on Tuesday, Thursday, and Saturdays, and signs/symptoms of infection to the access site were monitored. The Comprehensive Care Plan did not include the type of dialysis access site the resident had. The 7/13/2024 physician order documented the resident attended dialysis on Tuesday, Thursday, and Saturday. The order did not include pre or post dialysis assessments or access site monitoring. The 8/5/2024 Registered Nurse #6 admission progress note documented the resident was readmitted from the hospital. The resident had a left chest permacath (a catheter placed into a blood vessel in the chest and threaded to the heart, used for dialysis access). The August 2024 Treatment Administration Record documented the resident attended dialysis on 8/6/2024, 8/8/2024, 8/10/2024, 8/13/2024 and 8/15/2024. There was no documented evidence the dialysis access site was monitored daily or pre or post dialysis assessments were completed. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 8/12/2024 at 1:43 PM, Resident #37 was sitting in their room in their recliner chair. They stated they started dialysis less than 6 months ago and attended 3 times weekly. A dual lumen (tubes) left chest permacath was observed with a dry, intact, white border gauze and the lumens were wrapped with a dry, intact, white dressing. The resident stated facility staff never looked at their dialysis access site. A registered nurse at the dialysis center looked at the access site and changed the dressing. They also had an arteriovenous fistula (a surgically created connection between an artery and a vein for dialysis access) to the left arm, but it was not yet in use. They did not believe any assessments or vital signs were obtained pre or post dialysis at the facility. During a follow up interview on 8/14/2024 at 11:28 AM, the resident confirmed they had dialysis on 8/13/2024 and there were no pre assessment or vital signs taken, and there was no post assessment, or vital signs taken. No facility staff looked at their permacath access site. The resident's dual lumen left chest permacath had a dry, intact, white border gauze and the lumens were wrapped with a dry, intact, white dressing. During an interview on 8/15/2024 at 4:05 PM Unit Clerk #39 stated Resident #37 kept their dialysis communication book with them in their room. The certified nurse aides took the post dialysis weight from the book and documented it in the electronic medical record. During an observation and interview on 8/15/2024 at 4:07 PM, Resident #37 was sitting in their room in their recliner chair. Their dialysis communication book was in a bag they took with them to dialysis. The book contained various post-it notes that documented a date and a weight. The dialysis treatment sheets in the book were dated May 2024 or older. The active medication list was dated 2/22/2024. Resident #37 stated they kept the dialysis communication book with them. The certified nurse aides were the only staff that looked at their communication book and they just wanted the weight out of the book to document it. During an interview on 8/16/2024 at 11:17 AM Licensed Practical Nurse #23 stated the dialysis communication binder had order sheets and current medications. The purpose was for communication between the facility and the dialysis unit. They were not sure who was responsible to ensure the communication binder was updated. A medication list from February 2024 was not a current list. It was important for dialysis to know what medications the resident was taking; they were on heart medications and could have a drop in blood pressure. The dialysis center should know what medications they were on so any side effects could be monitored. They did not know what type of dialysis access site the Resident #37 had. They looked in the electronic record and stated the resident had a left arm dialysis port. They were unsure if they had a fistula or a permacath. They had cared for the resident this week and they had not looked at the dialysis site or the communication book. They stated there was no pre or post dialysis assessments. They were unsure if a permacath site should be monitored. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/16/2024 at 11:39 AM Registered Nurse Unit Manager #18 stated the dialysis communication book should include vital signs, weights, orders, and any changes. It should also include a current medication list. A medication list from February was not current and the resident's medications had likely changed in the past 6 months. Dialysis should know what medications the resident was on because they could have adverse reactions. The licensed practical nurse should look at the book when the resident returned from dialysis to know if dialysis had any information they wanted to relay. Dialysis sites should be monitored for swelling, redness, pain, bleeding, and any leakage as there could be complications and negative outcomes. Nurses were expected to know what type of a dialysis access site the resident had. If dialysis access sites were monitored, the nurses would have known what type of access site the resident had. The access site should be monitored and documented on routinely. If there was nowhere to document, it would not have triggered the nurse to monitor the site. Pre and post dialysis assessments should have been completed so any changes could be monitored. During an interview on 8/16/2024 at 1:48 PM the Assistant Director of Nursing stated the dialysis book had weights documented in it. Resident #37 had a fistula that was not being used and a port that was being used. The port (permacath) should be monitored that it was clamped. They did not think the dialysis facility needed a current medication list because the dialysis facility had their phone number and could call with questions. A medication list from February was not current and should not have been in the book. If a medication list was going to be in the book it should have been current. There should be documentation of the permacath site being monitored, and if the permacath site was not monitored, the resident could bleed out. 10NYCRR 415.12(k)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48446 Based on observation and interview during the recertification survey conducted 8/12/2024-8/16/2024, the facility did not ensure drugs and biologicals were labeled and stored in accordance with currently accepted professional principles for 3 of 5 medication carts (Second floor B side and Fourth floor A and B sides), and 1 of 4 medication rooms (First floor B side). Specifically, the First floor B side medication room was missing medication refrigerator temperatures; the Fourth floor B side medication cart was unlocked and unattended; the Second floor B side and the Fourth floor A side medication carts had eye drops that were not labeled after they were opened. Findings include: The facility policy, Storage of Medication Policy, last reviewed 3/4/2024, documented all medications and biologicals were stored safely, securely, and properly, and followed manufacturer's recommendations or those of the supplier. Medication rooms, carts, and medication supplies were locked when they were not attended by persons with authorized access. All medications were maintained within the temperature ranges noticed in the United States Pharmacopeia (USP) and by the Centers for Disease Control (CDC). The facility maintained a temperature log in the storage area and recorded temperatures at least once a day. Outdated, contaminated, or deteriorated medications and those in containers that were cracked, soiled, or without secure closures were immediately removed from inventory. Medication Room Refrigerator Temperatures: During an observation on 8/14/2024 at 9:16 AM the First floor B side medication room's refrigerator log did not have documented temperatures for 8/4/2024 and 8/9/2024. During an interview on 8/14/2024 at 9:16 AM, Licensed Practical Nurse #5 stated medication refrigerator temperatures were taken daily by the night shift and documented on the log. If there was no documented temperature, it was not done. They stated it was important the temperature was taken and recorded because medications like insulin required proper storage and if not stored properly, they were not as effective. During an interview on 8/14/2024 at 11:10 AM Registered Nurse Unit Manager #6 stated refrigerator temperatures were completed by the night shift. The temperatures were documented in a log in the front of the narcotic book to make sure medications that required refrigeration were held at the proper temperature. They stated if medications were not held at the proper temperature, they may not be effective. During an interview on 8/16/2024 at 1:34 PM the Director of Nursing stated refrigerator temperatures should be checked daily on the night shift and documented on the medication log in the medication room to ensure medications were maintained at the proper temperature. Medication carts: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 8/15/2024 at 1:21 PM the medication cart on the Fourth floor B side was unlocked and unattended in an alcove across from room [ROOM NUMBER]. Licensed Practical Nurse #10 stated it was unlocked for at least 20 minutes. They had not locked it after they last administered medications because they got pulled away to assist another staff member. They stated the medication cart contained medications that were dangerous if ingested accidently. They stated the unit had residents that wandered, and they should have locked the cart when they stepped away. During an interview on 8/16/2024 at 1:34 PM the Director of Nursing stated the standard of practice was the medication cart was always locked when out of view. They stated the medication cart contained medications that should not be taken if not prescribed. Eye drops not labeled: During an observation and interview on 8/14/2024 at 9:26 AM the Fourth floor A side medication cart contained the following eye drops that were not labeled with an opened date: - latanoprost 0.005% (used to treat glaucoma) for Resident #103. - brinzolamide (used to treat glaucoma), Alphagan 0.15% (used to treat glaucoma), and latanoprost 0.005% for Resident #82. - brimonidine/timolol 0.2/0.5% (used to treat glaucoma), latanoprost 0.005%, and Combigan 0.2/0.5% (used to treat glaucoma) for Resident #2. Licensed Practical Nurse #12 stated they were not sure how long eye drops were good for once they were opened. If they noticed a bottle of eye drops that did not have an opened date on them, they looked at the date dispensed or called the pharmacy and got the dispensed date. They stated they used that date as the date opened. They stated it was important not to administer expired medications because they may not be effective. They started to put the medications in the cart and stated, I should not put them back. During an observation and interview on 8/14/2024 at 10:04 AM the Second floor B side medication cart contained the following eye drops that were not labeled with an opened date: - 2 fluorometholone ophthalmic suspension 0.1% (used to treat inflammation) for Resident #126. - latanoprost ophthalmic solution 0.005% for Resident #20. Licensed Practical Nurse #11 stated they used both medications earlier in the day. Resident #126 received fluorometholone ophthalmic suspension 0.1% in their left eye from a bottle that was not labeled when opened. Eye drops were labeled when opened and discarded after 28 days. They stated if the resident received the expired medication they could get an infection, have vision changes, and eye irritation. They stated Resident #20 also had two bottles of eyedrops, one was not labeled, and one was labeled 7/17/2024. That medication was used for glaucoma and expired 42 days after being opened and they were not sure if they used the one that was labeled. If the resident was administered the expired medication, it may not be as effective, and the resident could have increased pressure in their eyes. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/16/2024 at 1:34 PM the Director of Nursing stated eye drops were stored according to manufacturer's recommendations and should be labeled with an opened date. If there was no opened date on the eye drops, they expected staff to look at the dispensed date and put that on the label. If there was no date on the label, staff were trained to discard the medication and reorder it from the pharmacy. 10NYCRR 483.45 (g)(h)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 40803 48446 Based on record review, observation, and interview during the recertification survey conducted 8/12/2024-8/16/2024, the facility did not ensure each resident received and the facility provided food and drink that was palatable, attractive, and at safe and appetizing temperatures for 1 of 2 meal test trays (the 8/13/2024 First floor A side lunch meal); for 2 of 2 residents (Residents #22 and #31) reviewed; and for 7 of 7 anonymous residents present at the Resident Council meeting. Specifically, food was not served at palatable and appetizing temperatures for the First floor A side lunch meal on 8/13/2024; and Residents #22, #31, and the attendees of the Resident Council meeting stated the food did not taste good and was not hot. Findings include: The facility policy, Food Procurement Receiving Handling Storing Preparing, revised and reviewed 7/12/2024 documented food above 41 degrees Fahrenheit and below 135 degrees Fahrenheit allowed the rapid growth of pathogenic microorganisms that could cause foodborne illness. The facility policy, Adequate Diet and Menu Planning to Accommodate Resident Needs and Choice, reviewed 7/20/2024, documented food was to be attractive, palatable, and served at the appropriate temperature. During an interview on 8/12/2024 at 11:06 AM, Resident #22 stated they did not each much of the food because it was always cold. During a Resident Council group meeting on 8/12/2024 at 12:58 PM, 7 anonymous residents stated the food did not taste good, the hot foods were not always hot, the cold foods were not always cold, and they often were missing food items from their meal trays. During an interview on 8/12/2024 at 2:05 PM Resident #31 stated the food was not good. It was not hot and had no flavor. During an interview and observation on 8/13/2024 at 10:46 AM, Resident #31 stated there was no hot food on their breakfast tray, only a muffin and fruit which they ate. The coffee was cold, and they did not drink it. During a lunch meal observation on 8/13/2024 at 12:20 PM on the First floor A side, Resident #119 was served their lunch meal tray. Their lunch tray was tested , and a replacement meal was requested. The chicken tender's temperature was measured at 127.8 degrees Fahrenheit and was soggy on the bottom; the potatoes measured temperature was 117.3 degrees Fahrenheit and had no flavor; the asparagus measured temperature was 146.1 degrees Fahrenheit and was mushy and had no flavor; and the peaches measured temperature was 39 degrees Fahrenheit. Licensed Practical Nurse #28 was present for the temperature readings of the lunch tray. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 8/13/2024 at 12:34 PM, Resident #31 was seated in the dining room for the lunch meal. They ate a few bites of the grilled chicken tender and 1/2 of the broccoli and stated the chicken was warm, not hot enough to eat and the broccoli was cold. They ate 3/4 of the buttered noodles. They stated they would have eaten more if the food was hot and had more flavor. During an observation and interview on 8/13/2024 at 12:39 PM, Resident #22 ate 1/2 of their pork and stated it was ok, 1/4 of the asparagus and stated it was mushy and had no flavor, and one bite of the mashed potatoes and gravy and stated, it was not hot. During an observation and interview on 8/14/2024 at 8:59 AM, Resident #22 ate one bite of the bacon and none of the eggs on their breakfast tray and stated they were cold. They would have eaten them if they were hot. During an interview on 8/14/2024 at 9:37 AM, Certified Nurse Aide #31 stated residents often complained that food was cold and had no flavor. When residents said food was cold, they heated it in the microwave for an undetermined time and did not use a thermometer for testing the temperature of the food because there was not one available. During an interview on 8/15/2024 at 1:49 PM, Food Service Worker #32 stated food was cooked in the main kitchen and brought to the unit in a hot box. They placed the food from the hot box in the steam table. They stated hot food was served at 140-160 degrees Fahrenheit with the ideal temperature of 165 degrees Fahrenheit. They heard residents complained the asparagus was soggy and the French fries were not cooked because French fries do not hold their temperature very long. They did not do test trays anymore because they were short staffed. Chicken tenders should not have been served at 127.8 degrees Fahrenheit and the potatoes should not have been served at 117.3 degrees Fahrenheit. They stated if foods were served at inappropriate temperatures residents might not eat or could get food poisoning. During an interview on 8/15/2024 at 4:47 PM, the Food Service Director #33 stated all entrees were prepared and temperatures were taken in the main kitchen. They stated test trays were done weekly; however they did not have any documentation. They attended Resident Council meetings and heard complaints about the food. They stated serving temperatures for hot foods should be 140-165 degrees Fahrenheit. They stated chicken tenders should not have been served at 127.8 degrees Fahrenheit and the potatoes should not have been served at 117.3 degrees Fahrenheit. During an interview on 8/16/2024 at 11:37 AM, Registered Nurse Unit Manager #6 stated residents complained that food was not hot, or they did not like what they ordered. If they did not like what they ordered, staff offered another option and if it was not warm enough, staff heated it in the microwave. They were not sure if the kitchen did test trays. During an interview on 8/16/2024 at 1:34 PM, Director of Nursing #2 stated when food was not hot it was heated in the microwave. They were unsure if test trays were being completed regularly. 10NYCRR 415.14(d)(1)(2)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43754 Based on observation, record review, and interview during the recertification survey conducted 8/12/2024-8/16/2024 the facility did not ensure food was stored and prepared in accordance with professional standards for food service safety in the main kitchen. Specifically, potentially hazardous foods were not cooled properly in the main kitchen, and there was insufficient lighting in the walk-in cooler and walk-in freezer. Findings include: The facility policy, Food Procurement Receiving Handling Storing Preparing, revised 7/12/2024, documented the facility ensured proper cooling of food, and proper sanitation and food handling practices to prevent the outbreak of foodborne illness. 1) Improperly Cooled Potentially Hazardous Foods The facility document Temperature-Time Cooling Log did not document any food products cooled on 8/12/2024. One item was documented as cooled on 8/13/2024, but it did not identify what the food was on the form. The log documented when cooling any stock, sauce, or potentially hazardous food, the use of the log would enable one to monitor and document the total time for cooling by taking a reading every 30 minutes until it reached 45 degrees Fahrenheit or lower. Remember to cool from 120 degrees Fahrenheit to 70 degrees Fahrenheit in the first 2 hours, and an additional 4 hours may be used to get the item to 45 degrees Fahrenheit. During an observation on 8/13/2024 at 11:23 AM, the bottom shelf of Refrigerator #2 in the main kitchen had a pan of cooked beef covered by plastic wrap that measured 68 degrees Fahrenheit. During an observation on 8/13/2024 at 11:28 AM, four covered hotel pans of cooked pasta were double stacked on two lower shelves in Refrigerator #2 in the main kitchen. The bottom pans had metal lids that enabled the double stacking and all four were covered with plastic wrap. The bottom pans of pasta measured 49 degrees Fahrenheit, and the top pans measured 46 degrees Fahrenheit along the outside edge. During an interview on 8/13/2024 at 11:28 AM, [NAME] #40 stated the pasta was cooked yesterday by Dietary Supervisor #41. The pasta should have been cooked, rinsed in an ice bath until it was cooled to 34-36 degrees Fahrenheit, and then put away in the cooler. They stated they had cooked the beef that morning which was to be used for tomorrow's dinner. They stated the proper cooling of potentially hazardous food requirements were four hours to get down to 34-36 degrees Fahrenheit and the beef should have been left uncovered to allow it to cool quicker. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation and interview on 8/13/2024 at 11:45 AM, Dietary Supervisor #41 stated they cooked the pasta the previous day. To cool it, they drained the cooked pasta, refilled with cool water and ice, drained again, portioned the pasta into the four hotel pans, then covered and labeled the pans and placed them into Refrigerator #2. They did not measure the temperature of the pasta before it was portioned because they did not know they were supposed to. They stated the cooling requirements required a four-hour window during which the product had to go from hot to cold and get below 40 degrees Fahrenheit. They thought they followed that requirement for the pasta and was not sure how it was warmer than the other items in that cooler. Cooling was documented for meats, but not for pastas. The temperature of the pasta was checked again in the middle of each pan and measured between 48-53 degrees Fahrenheit. At 11:59 AM, the beef remained covered on the bottom shelf of Refrigerator #2 and was measured at 68 degrees Fahrenheit. During an interview on 8/16/2024 at 11:18 AM, Food Service Director #42 stated the cooling requirement was to get to temperature within six hours. Cooling occurred in the walk-in cooler or walk-in freezer and should not be done in the upright cooler (Refrigerator #2). Proper cooling was important to prevent food borne illness, the growth of bacteria, and to ensure the safe quality of food. 2) Improper Lighting During an observation on 8/13/2024 at 11:22 AM, both the walk-in cooler and walk-in freezer had very limited lighting and required the use of a flashlight to see the contents. During an interview on 8/13/2024 at 11:28 AM, [NAME] #40 stated there was not enough light in the coolers and they often needed to use their cell phone flashlight to see inside. During an interview on 8/16/2024 at 11:18 AM, Food Service Director #42 stated there was not enough lighting in the walk-in coolers, there needed to be more lighting, and the lighting had always been a challenge. 10NYCRR 415.14(h)

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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. 49448 Based on observation, record review, and interview during the recertification survey conducted 8/12/2024-8/16/2024, the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 4 residents (Resident #54) reviewed. Specifically, Licensed Practical Nurse #23 did not maintain infection control precautions when administering medications to Resident #54 who was on transmission based precautions (contact precautions) and staff were not aware why the precautions were in place. Findings include: The facility policy, Infection Prevention and Control Plan/ Program, revised 2/16/2024 documented transmission-based precautions were additional infection control precautions in health care for residents who were known or suspected to be infected or colonized with infectious agents, including certain epidemiologically important pathogens (highly contagious germs). The infection preventionist was responsible and all staff was educated and monitored for compliance and periodic observations of nursing units were completed to assure transmission-based precautions were maintained. Resident #54 had diagnoses including history of methicillin resistant staphylococcus aureus (a resistant bacteria) infection (site not specified) and obstructive and reflux uropathy (poor urine flow). The 7/3/2024 Minimum Data Set assessment documented the resident required modified independence with daily decision making, was independent or required set-up assistance with most activities of daily living, had an indwelling urinary catheter (removes urine from the bladder), and did not have multi-drug resistant organisms. The 7/28/2024 physician order documented the resident was on contact precautions for methicillin resistant staphylococcus aureus. The 8/1/2024 Nurse Practitioner #17 progress note documented the resident was seen for a positive COVID-19 test, and this was communicated with facility staff. There was no documentation the resident had methicillin resistant staphylococcus aureus or was on transmission-based precautions. The 8/1/2024 at 9:24 PM nursing progress note by the Assistant Director of Nursing documented the resident was COVID-19 positive and an order for droplet precautions was obtained. The Comprehensive Care Plan initiated 8/2/2024 documented the resident had methicillin resistant staphylococcus aureus in the urine. Interventions included the resident/ family/ caregivers were educated on the importance of hand washing, family/ visitors/ caregivers were instructed to wear disposable gown and gloves during physical contact with the resident, gown/gloves were discarded in the appropriate receptacle, and hands were washed before leaving the room. The Comprehensive Care Plan did not document the resident had COVID-19. The August 2024 Medication Administration Record documented the resident was on strict respiratory and contact isolation for COVID-19 precautions for 10 days from 8/2/2024-8/12/2024. There was no documentation for the contact precaution order for methicillin resistant staphylococcus aureus. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a medication administration observation on 8/14/2024 at 9:49 AM Licensed Practical Nurse #23 took Resident #54's ordered medications to the resident's room. There was a contact precautions sign outside the room that documented contact precautions everyone must: Clean their hands, including before entering and when leaving the room. Providers and staff must also: Put on gloves before room entry. Discard gloves before room exit. Put on a gown before room entry. Discard gown before room exit. Do not wear the same gown and gloves for the care of more than one person. Use dedicated or disposable equipment. Clean and disinfect reusable equipment before use on another person. Licensed Practical Nurse #23 did not perform hand hygiene, put on gloves, did not put on a gown, and entered the resident's room for medication administration. In addition to the oral medications, an inhaler and a vial of eye drops were also brought into the room by Licensed Practical Nurse #23. After the medication administration was completed, Licensed Practical Nurse #23 removed their gloves, picked up the inhaler and the vial of eye drops with their ungloved hands, exited the room, and placed the inhaler and vial of eye drops on top of the medication cart. Licensed Practical Nurse #23 did not perform hand hygiene, put on a new set of gloves obtained from another resident's room and wiped the outside of the inhaler and the eye drops with a disinfectant wipe. They discarded the gloves, did not perform hand hygiene, and placed the medications back into the medication cart. During an interview on 8/14/2024 at 9:54 AM Licensed Practical Nurse #23 stated Resident #54 was on contact precautions for methicillin resistant staphylococcus aureus in a wound and they also had an indwelling urinary catheter. They stated they should have worn a gown into the room but there were none available outside the door and because they had already prepared the medications in the medication cup, they just went in the room. A gown should be worn anytime they entered the resident's room. They should have utilized hand sanitizer before the room was entered and after each time gloves were removed. Not doing so they could carry the germs with them out of the room. They should have taken a wipe into the room with them and wiped the medications down before exiting the room as they also had germs on them that exited the room. Those germs were then placed on the medication cart. Gloves did not replace the need for hand hygiene, and they should have performed hand hygiene before and after glove use to prevent the spread of infection. During an interview on 8/15/2024 at 3:56 PM Registered Nurse Unit Manager #18 stated if a resident was on contact precautions, personal protective equipment should be worn per the directions on the signage outside the door. Contact isolation required the use of gown and gloves and prevented the spread of infection of whatever organism the resident had. Gloves were not a replacement for hand hygiene. Hand hygiene was performed anytime hands were visibly soiled, in between tasks, and any time before gloves were put on or after they were taken off. It was not acceptable the nurse did not wear a gown because there were none available outside the room. They expected the nurse to go back to their medication cart, lock up the medications, obtain gowns, and start the process over again. Hand washing and cleaning items brought into the room before they exited was important to prevent the spread of the organisms. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/16/2024 at 1:30 PM, the Infection Preventionist #16 stated when a contact precaution room was entered gloves and gowns had to be worn every time, regardless of the reason the room was being entered, including a medication pass. Hands should be washed before entering and exiting the room and in between glove changes. This prevented the spread of organisms and kept residents safe. Personal protective equipment was in a storage device outside the precaution rooms. If those supplies were depleted, they expected staff restock it before they went into the room. There were extra gowns and gloves in the clean utility room on each unit so depleted supplies outside the room was not a viable excuse for entering the room without applying the necessary equipment. Any items being brought out of a precaution room should be wiped down with the proper wipe and allowed to completely dry before removing from the room. Items such as inhalers and medication vials were included so the items did not cross contaminate in the medication cart. Housekeeping placed personal protective equipment storage devices outside the rooms when precautions were initiated and removed them when precautions were discontinued. They, or the Director of Nursing, communicated those needs to housekeeping and double checked it was done. Resident #54 was on contact precautions for COVID-19, but as of 8/11/2024 precautions were discontinued. If there was precaution signage outside a resident's door, even if the resident's precautions had been discontinued, staff were educated the signage was followed or it was clarified whether the precautions were still active. 10NYCRR 415.19(a)(b) 50561