

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335876	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2024
NAME OF PROVIDER OR SUPPLIER Delhi Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 41861 State Route 10 Delhi, NY 13753	

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)
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48413</p> <p>Based on record review, and interviews conducted during a recertification and abbreviated (NY00344171) survey, the facility did not ensure Comprehensive Care Plans were reviewed and revised to reflect f resident current conditions for 2 (Resident #'s 33 and 108) of 32 residents reviewed. Specifically, for (a.) Resident #33's Comprehensive Care Plan for accidents and abuse was not revised after the resident was involved in a resident-to-resident altercation; (b.) Resident #108's, Comprehensive Care Plan for medications was not reviewed and revised to include completion of treatment and resolution of medical issues.</p> <p>This is evidenced by:</p> <p>Resident #33 was admitted with diagnoses of sensorineural hearing loss (hearing loss in the inner ear), chronic obstructive pulmonary disease, and major depressive disorder. The Minimum Data Set (an assessment tool) dated 5/16/2024, documented the resident had moderate cognitive impairment, could be understood, and could understand others.</p> <p>The Comprehensive Care Plan for Behavior and Aggressive tendencies last updated on 5/13/2024 documented the resident would demonstrate appropriate coping skills. The Comprehensive Care Plan was not updated after an altercation had occurred between Resident #33 and another resident resulting in an injury to Resident #33 on 6/04/2024.</p> <p>During an interview on 7/25/2024 at 12:22 PM, Social Worker #1 stated Resident #33 did not have any issues or problems since the initial altercation on 6/04/2024 and the care plans should have been updated.</p> <p>During an interview on 7/29/2024 at 1:01 PM, Registered Nurse #1 stated the Comprehensive Care Plans should be person-centered and include non-pharmacological interventions and monitoring. The Comprehensive Care Plan should be reviewed and changed as necessary, based on changing goals, preferences, and needs of the resident and in response to current interventions reviewed and revised by the interdisciplinary team after each assessment.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #108 was admitted with diagnoses including unspecified dementia (a neurological disorder affecting memory), hemiplegia and hemiparesis following cerebral infarction affection left non-dominant side (a clot in the brain causing one side of the body to be weak or nonfunctional), and gastrointestinal hemorrhage (bleeding in the digestion track, stomach and/or intestines). The Minimum Data Set, dated dated [DATE], documented the resident was usually understood and could sometimes understand others. The Minimum Data Set did not document resident's cognition status.</p> <p>The Comprehensive Care Plan for Infection initiated 3/29/2023 and last updated on 4/22/2024 documented the resident had a history of cellulitis to their left hand and required antibiotics twice a day for 10 days. The completion of the antibiotic therapy and resolution of the infection was not documented on the care plan.</p> <p>Physician order dated 3/20/2024 documented Doxycycline 100 milligrams twice a day for 10 days.</p> <p>The Comprehensive Care Plan for infection initiated 4/23/2023 and last revised on 4/26/2024 documented the resident had a history of a urinary tract infection and required antibiotics for 7 days. The completion of therapy and resolution of the infection was not documented on the care plan.</p> <p>Physician order dated 4/23/2024 documented Cephalexin 500 milligrams twice a day for 7 days for Urinary tract infection.</p> <p>There was no documented evidenced on the care plan that the care plan was updated or revised when the resident completed the antibiotic use.</p> <p>During an interview on 7/30/2024 at 10:38 AM, Assistant Director of Nursing #1 stated care plans should be updated as things change. They stated care plans were updated at care reviews which were done every 3 months. For example, if a resident was receiving antibiotic therapy and the infection was resolved, the care plan should have been updated to read completed or resolved. Care plans should not have outdated therapy or treatments listed on it. Assistant Director of Nursing #1 stated that care plans were based more on medical management than individual treatments.</p> <p>10 New York Codes of Rules and Regulations 415.11(c)(2)(i-iii)</p> <p>48744</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48615</p> <p>Based on observations, record review, and interviews conducted during a Recertification and Abbreviated (Case #NY00330031) Survey, the facility did not provide needed care and services that were resident centered and in accordance with professional standards of practice to meet each resident's physical, mental, and psychosocial needs for 2 (Resident #'s 24 and 87) of 32 residents reviewed for quality of care. Specifically, for (a.) Resident #24 missed two scheduled specialist appointments. Resident #24 had multiple co-morbid conditions and subsequently underwent amputation of 5 toes. (b.) Resident #87 went on a 3-day Leave of Absence without supplies for daily wound care. Resident returned on day #3, and on day #4 dressings were still unchanged.</p> <p>This is evidenced by:</p> <p>The Facility's Transportation Policy dated July 2023; documented facility would assist residents in arranging transportation to/from outpatient clinic appointments/diagnostic appointments when necessary. In the event that the transportation company canceled transportation for a consult, alternative means of transportation would be made, if possible. If alternate transportation was not available, medical provider would be informed and consult would be rescheduled. A virtual consult or alternative medical review (i.e. In-house provider/contract vendor) would be pursued to the extent possible in the event that alternate transportation arrangements were not available.</p> <p>The Facility's Out on Pass (OOP) Therapeutic Leave Policy effective 7/13/2023, documented Nurse would order necessary medications from pharmacy for Out on Pass as needed. Nurse would provide education to resident/responsible party regarding any medication that is sent Out on Pass.</p> <p>Resident #24 was admitted to the facility with diagnoses of diabetes type 2 (a problem in the way the body regulates and uses sugar as a fuel), diabetic foot ulcers leading to osteomyelitis (inflammation or swelling that occurs in the bone usually as a result of infection), and peripheral vascular disease (a slow and progressive circulation disorder caused by narrowing, blockage or spasms in a blood vessel). The Minimum Data Set (an assessment tool) dated 10/11/2023, documented resident had severe cognitive impairment, could be understood, and understand others.</p> <p>Based on review of complaint NY00330031, the complainant stated Resident #24 had repeated cancellations of appointments related to the nursing home not having transportation. The resident ended up having to have a full amputation.</p> <p>Wound Care progress note dated 10/19/2023 documented Resident #24 was seen on follow up for left 3rd toe wound. Resident had left partial hallux and second digit amputation for presumed infection and osteomyelitis on 8/1/8/2023. Wound status: worsening. Size: Size: 1 centimeter x 1 centimeter x u.1 centimeter. ca1cu1atec area 1s 1 sq centimeter. Exudate: Moderate amount of serous drainage.</p> <p>Wound Care progress note dated 12/19/2023 documented Resident #24 rescheduled for amputation of left 3rd toe on 12/21/2023, secondary to transportation needs. Left 3rd toe showed exacerbation and deterioration.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/25/2024 at 11:28 AM, Licensed Practical Nurse #5 stated Resident #24 was admitted to the facility with diabetic foot ulcers and a history of osteomyelitis. Resident was hospitalized for foot infections in August, September, and October of 2023. Thereafter, Resident was seen by infectious disease in November of 2023, along with orthopedics every two weeks in November of 2023. In December 2023 resident underwent amputation of left 5 metatarsals (toes). Resident had been stable since amputation in 2023.</p> <p>During an interview on 7/25/2024 at 11:54 AM, Transportation Scheduler #1, stated orthopedic appointment on 10/25/2023 for Resident #24 was re-scheduled to 11/08/2023. They stated the facility had two residents with appointments for same day. The facility did not have transportation because both were non-Medicaid and had no transportation benefit. Therefore, the facility was to provide transportation. Transportation Scheduler #1 stated the new admission resident had a post-op appointment which took priority. They stated on 11/16/2023 orthopedic appointment for Resident #24 was re-scheduled due to COVID positive and Resident #24 had an appointment on 11/24/2023 of the following week.</p> <p>During an interview on 7/26/2024 at 11:17 AM, Director of Nursing #1 stated Resident #24 was admitted in July of 2023 with history of gangrene and osteomyelitis. They stated Resident #24 was sent to hospital on the following dates:</p> <ul style="list-style-type: none"> -8/12/2023 - 8/24/2023 after seen on wound rounds with left great toe red and warm to touch. -9/2/2023 - 9/6/2023 diagnosis of Altered Mental Status, oxygen desaturation and sepsis. -9/13/2023 - 9/14/2023 replaced peripherally inserted central catheter (PICC) line. -10/1/2023 - 10/5/2023 Sepsis -12/21/23 - 12/27/23 Amputation left 5 metatarsals (toes). Director of Nursing #1 stated Resident #24 had scheduled orthopedic appointments. The 10/25/2023 appointment was rescheduled to 11/08/2023 because facility was unable to provide transportation for two residents appointments on the same day. The 11/16/2023 orthopedic appointment was canceled because Resident #24 was COVID positive, and the resident had another scheduled appointment on 11/24/2023. They stated the two appointments were rescheduled at their discretion and the facility physician and or Nurse Practitioner were not notified. They stated moving forward, physician and or Nurse Practitioner would be notified according to facility's policy and procedure. <p>During an interview on 7/29/2024 at 2:34 PM, Nurse Practitioner #1 stated if a resident missed an appointment the protocol was to notify the provider. The provider would then make an assessment and determine what alternative could be done for missed appointments or if appropriate for appointment to be rescheduled.</p> <p>Resident #87 was admitted to the facility with diagnoses of cervical region radiculopathy (inflammation of any of the nerve roots of your cervical spine (neck), contracture left wrist (a deformity caused by injury to the muscles), and adjustment disorder (a group of symptoms, such as stress, feeling sad or hopeless, and physical symptoms that could occur after you go through a stressful life event). The Minimum Data Set, dated dated [DATE], documented resident had intact cognition, could be understood, and understand others.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 7/29/2024 at 12:07 PM, Resident #87 was observed sitting in wheelchair in their room. They were calm and cooperative and stated they were waiting for nurse to change bilateral lower extremity dressings. Resident #87 stated they were Out on Pass from Friday 7/26/2024 and returned Sunday 7/28/2024. They were not provided with any supplies to change bilateral lower extremity dressings while on leave, and dressings had not been changed even after their return on Sunday 7/28/2024. Dressings observed were soiled and sliding down both legs.</p> <p>Review of the Treatment Administration Record dated July 2024 documented the following order : Medihoney Wound/Burn Dressing External Paste (Wound Dressings). Apply to right 1st &5th toe topically as needed for wound care. Cleanse all areas on bilateral feet with Dakin's 0.125% Apply Medihoney & calcium alginate to wound bases and cover with bordered foam dressing.</p> <p>Review of the Treatment Administration Record dated July 2024 documented the following order: Medihoney Wound/Burn Dressing External Paste (Wound Dressings). Apply to right heel topically as needed for wound care, Cleanse wound to right heel with Dakin's 0.125% apply Medihoney & calcium alginate to wound bed, cover with foam dressing.</p> <p>During an interview on 7/29/2024 1:00 PM, Licensed Practical Nurse #5 stated Resident #87 was Out on Pass Friday 7/26/2024 and returned Sunday 7/28/2024. Resident sent with medication for dates out of facility. They stated since request for Out on Pass was last minute, they forgot about sending dressing change supplies and did not enter a nurse note. Licensed Practical Nurse #5 stated whoever took care of resident would be educated on dressing change.</p> <p>During an interview on 7/29/2024 at 2:34 PM, Nurse Practitioner #1 stated residents who were Out on Pass were required to give the facility a 72-hour notice. The facility physician and or Nurse Practitioner would assess if resident was stable to go Out on Pass. If appropriate for Out on Pass, a responsible person, such as a family member, was advised to sign-out resident. The person who signed resident out would be given medications and supplies for dates out on pass; educated on when and how to administer prescribed medications, and on any treatments or dressing changes that were ordered during leave of absence.</p> <p>During an interview on 7/29/2024 at 2:52 PM, Director of Nursing #1 stated Out on Pass policy request required 3 days in advance of leave, pharmacy preferred 5 days notice. The request was discussed during morning meeting. Once approved for Out on Pass, nurse manager would give medications and supplies that would be needed during leave to resident or resident representative upon leaving. An Out on Pass form would be signed by resident or representative upon leaving and then upon return. A progress note would be documented in Point Click Care (an electronic medical record) and Resident would be placed on leave until return. Upon return resident would return to Point Click Care as active, and a nurse should conduct a brief assessment.</p> <p>10 New York Codes, Rules, and Regulations 415.12</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48744</p> <p>Based on observation, record review, and interviews during a recertification survey, the facility did not ensure the resident environment remained as free of accidents hazards as possible and provided adequate supervision to prevent accidents for 1 (Resident #11) of 32 residents reviewed for accidents and hazards. Specifically, for Resident #11, medications were left in the resident's room unattended without the resident being assessed to independently self-administer their medication. Additionally, Resident #11 was in the bathroom when the medication was left unattended on their lunch tray.</p> <p>This is evidenced by:</p> <p>Resident #11 was admitted with diagnoses including multiple sclerosis (a degenerative muscle disease), bipolar disorder (a mental health disorder causing variable mood swings), and failure to thrive (inability to care for oneself). The Minimum Data Set (an assessment tool) dated 4/22/2024, documented the resident had minimal cognitive impairment, could be understood, and could understand others. The Minimum Data Set, dated dated dated [DATE] did not document that Resident #11 was capable or desired to self-administer their medications.</p> <p>A facility policy and procedure titled Administration of Medications - General dated 9/2020, documented that medications may not be left unattended and medications should be always secured in a locked area or in visible control. The policy also documented that medication should be administered at the time it was prepared and</p> <p>never pre-poured. The policy also documented that medication were never to be left at resident bedside, and if a situation occurred which necessitated that the nurse must step away from the resident prior to administration of all medications, medication must be removed from room and secured in locked medication cart until medications could be administered to the resident.</p> <p>A facility policy and procedure titled Self-Administration of Medications dated 3/2022, documented residents have the right to self-administer medications if the interdisciplinary team had determined that it was clinically appropriate and safe for the resident to do so. Additionally, the policy documented that the staff and practitioner will document an evaluation of decision-making capacity and the resident's ability and desire to self-administer their medications.</p> <p>The Comprehensive Care Plan initiated 5/21/2021 and last updated on 7/03/2024, did not document that Resident #11 was capable or desired to self-administer their medications.</p> <p>During an observation on 7/23/2024 at 9:38 AM, a medication cup with 4 medications i was observed sitting on the Resident #11's lunch tray in room # 107 B, (Aspen unit) unattended. Resident#11 was observed to be in the bathroom [ROOM NUMBER] feet away and not within the site of the medication.</p> <p>A review of all the physician orders on 7/28/2024 did not have documented evidence of a physician orders for the Resident #11 to self-administer their medications.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/25/24 at 1:10 PM, Licensed Practical Nurse #4 stated it was not appropriate to leave medications at the resident's bedside.</p> <p>During an interview on 7/25/2024 at 2:07 PM, Licensed Practical Nurse #3 stated medications could be left at the bedside if the physician indicated the resident could self-administer their own medication. They stated resident's care plan should reflect that they were capable to self-administer their own medication and not cause any harm to roommate by leaving their medication unattended.</p> <p>During an interview on 7/30/2024 at 10:38 AM, Assistant Director of Nursing #1 stated it was never appropriate to leave medications unattended with residents unless they had assessments that allowed the resident to do that.</p> <p>During an interview on 7/30/2024 at 10:50 AM, Director of Nursing #1 stated medications should not be left at the bedside unless the resident was assessed to be able to self-administer their medications.</p> <p>The nursing staff that left the medication sitting on the bedside table of Resident #11 was not available for interview.</p> <p>New York Codes of Rules and Regulations 415.12(h)(1)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48413</p> <p>Based on observations, record reviews, and interviews during the recertification and abbreviated (NY00322544) survey, the facility did not ensure that food and drink were palatable and attractive for 19 (Resident #s 1, 11, 12, 23, 26, 60, 62, 63, 65, 66, 71, 74, 76, 78, 108, 127, 131,145, and 150) of 32 residents reviewed for palatable and attractive food and drink. Specifically, residents complained of food being cold, unattractive, and not palatable in general during the resident council meeting. Additionally, 3 units (Aspen, Fir, and Chestnut) of 6 units served food that was not palatable and was not appetizing in appearance.</p> <p>This is evidenced by:</p> <p>A facility policy titled Food and Nutrition Services dated 11/15/2023 documented the facility would provide each resident with a nourishing, palatable, well-balanced diet that met their daily nutritional and special dietary needs, considering each resident's preferences.</p> <p>Resident #11 was admitted with diagnoses of cerebral infarction due to embolism (stroke due to blood clot), mild vascular dementia with other behavior disturbances, and seizures. The Minimum Data Set (an assessment tool) dated 4/22/2024, documented the resident had no cognitive impairment, could be understood, and understood others.</p> <p>During an interview on 7/23/2024 at 9:13 AM, Resident #11 stated that the food was not very good but was edible.</p> <p>Resident #62 was admitted with the diagnoses of morbid obesity due to excessive calories, acute kidney failure dependent on dialysis, and anxiety disorder. The Minimum Data Set, dated dated [DATE], documented the resident had minimal cognitive impairment, could be understood, and understood others.</p> <p>During an interview on 7/23/2024 at 12:24 PM, Resident #62 stated the food was not very good, always cold, and had no flavor. They stated that they usually received sandwiches for dinner or ordered out because the food was not very good.</p> <p>Resident #66 was admitted with the diagnoses of end-stage renal disease dependent on dialysis, type 2 diabetes mellitus, and peripheral artery disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). The Minimum Data Set, dated dated [DATE], documented the resident had no cognitive impairment, could be understood, and understood others.</p> <p>During an interview on 7/23/2024 at 10:14 AM, Resident #66 stated the food was not appealing and that they were on a dialysis diet. They stated they do not get specialized diet as they were told by staff that they do not have the budget for those items.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident #74 was admitted with the diagnoses of end-stage renal disease dependent on dialysis, acute, chronic respiratory failure with hypoxia (a condition when the lungs have trouble loading oxygen into the blood or removing carbon dioxide), and type 2 diabetes with neuropathy. The Minimum Data Set, dated dated [DATE], documented the resident had no cognitive impairment, could be understood, and understood others.</p> <p>During an interview on 7/23/2024 at 11:25 AM Resident #74 stated that food was good once in a blue moon, and always cold. They stated there was supposed to be an alternate but when asked for the alternate, they were told that they do not have any.</p> <p>During a resident council meeting conducted on 7/23/2024 at 11:50 AM with Residents #'s 1, 26, 62, 78, and 127. Each resident stated that the food at the facility was usually cold, not attractive, or appetizing. Many resident council participants stated they usually would order food out to be delivered because of the unappetizing food. The resident council had a separate food council meeting before the regular meetings.</p> <p>Review of food council minutes from May 2024, June 2024, and July 2024 meetings, documented resident concerns were cold food, under or over-cooked food, inedible food due to cooking and temperatures, and food not matching on menus distributed.</p> <p>During a test trays for temperature and taste performed on multiple units. The following were observed:</p> <p>-A lunch meal test tray was obtained on 7/26/24 at 12:26 PM, on the Chestnut unit. The beef [NAME] was 101 degrees Fahrenheit, the bun was 76.2 degrees Fahrenheit, the cottage cheese and fruit was 46 degrees Fahrenheit, macaroni salad was 49.4 degrees Fahrenheit. The taste of the hotdog was adequate no condiments were provided, and the bun for the hotdog was soft and chewable. The macaroni salad had no seasoning or flavor.</p> <p>-A lunch meal test tray was obtained on 7/29/24 at 12:22 PM, on the Fir unit. The grilled chicken was 114.6 degrees Fahrenheit, the carrots was 99.1 degrees Fahrenheit, the milk was 51.3 degrees Fahrenheit, and the soda was 52.2 degrees Fahrenheit. The tray ticket had designated a fruit cup to be included but was missing. The taste of the chicken was bland, had no flavor, and was very tough to eat. The carrots were hard to chew and no flavor to them.</p> <p>-A breakfast meal test tray was obtained on 7/30/2024 at 8:16 AM, on the Aspen unit. The meal ticket documented biscuits and sausage gravy matched the meal with the exception that cranberry juice was not included. Orange juice was given as a substitute for the cranberry juice. The biscuits were 122 degrees Fahrenheit, and the sausage gravy was 114.3 degrees Fahrenheit. The appearance of the meal was not appealing or flavorful and the biscuits were slightly difficult to chew and cut.</p> <p>10 New York Code of Rules and Regulations 415.14(d)(1)(2)</p> <p>48615</p> <p>48744</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>21414</p> <p>Based on observation, record review, and interviews during the recertification, the facility did not maintain a pest-free environment and an effective pest control program on 2 of 2 resident unit serveries and the main kitchen. Specifically, evidence of insect infestation was found in the main kitchen and resident unit serveries, and the facility did not implement the remediation recommendations of the pest control vendor.</p> <p>This is evidenced by:</p> <p>During observations of the main kitchen on 7/24/2024 at 1:21 PM and again on 7/30/2024 at 9:37 AM:</p> <p>A swarm of small flies were found around the drink preparation area floor drain.</p> <p>A swarm of small flies were found around the drain in and in the corridor just outside of the cart-wash room.</p> <p>7 of 7 floor drains in the main kitchen were soiled with food debris and/or a black residue.</p> <p>The floor drain in the cart-wash room was heavily soiled with a black build-up.</p> <p>The floor and drain below and behind the dishwashing machine were heavily soiled with a black build-up.</p> <p>Dead cockroaches were found above the suspended ceiling and in ceiling light fixtures in the main kitchen and the main kitchen servery.</p> <p>Door sweeps were not installed on the 3 doors to the main pantry and the door to the snack pantry.</p> <p>Empty boxes and wiring debris was found above the suspended ceiling.</p> <p>During observations of the Aspen/Birch Servery on 7/24/2024 at 1:51 PM:</p> <p>Small flies were found around the floor drain.</p> <p>Dead cockroaches were found above the suspended ceiling.</p> <p>The floor was caked with a black build-up and food debris along the wall and under the steamtable, worktable, and dishwashing machine.</p> <p>During observations of the Chestnut/Dogwood Servery on 7/24/2024 at 2:14 PM:</p> <p>food debris and dead cockroaches were found on the floor under the steamtable, worktable, and dishwashing machine.</p> <p>small flies were found around the floor drain in the serving station.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335876	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2024
NAME OF PROVIDER OR SUPPLIER Delhi Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 41861 State Route 10 Delhi, NY 13753	
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)		
<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During observations on 7/24/2024 at 2:31 PM, vegetation overgrowth was found around the perimeter of the building, and old equipment and solid waste was found in the receiving area behind the building.</p> <p>The facility pest control sighting log documented that from 7/24/2023 through 7/15/2024, facility staff had sighted cockroaches and/or drain flies on the Chestnut Unit, Birch Unit, main kitchen, and reception area.</p> <p>The document titled [vendor] Service Report and dated 6/17/2024, 5/29/2024, 5/14/2024, 4/19/2024, 10/18/2023, 09/22/2023, 8/23/2023, and 7/11/2023 documented that the pest control vendor advised the facility to clean floor drains and kitchen floors daily, to install sweeps to the kitchen pantry doors, and to clear vegetation from the perimeter of the building. There was no documented evidence that a pest control vendor provided services from 11/2023 through 03/2024.</p> <p>During an interview on 7/24/2024 at 12:14 PM, Director of Maintenance #1 stated that about 11 months ago, the dietary staff reported sightings of cockroaches first in the main kitchen then in the servery kitchens. The pest control vendor was contacted and began treatment to control and overtake the infestation. Treatment was not provided from November 2023 through March 2024 as the vendor canceled their contract with the facility. A sweep was installed on the rear exit door from the main kitchen several years ago, but the pest control vendor had not updated their records.</p> <p>During an interview on 7/25/2024 at 12:14 PM, Administrator #1 stated that the facility was in process of addressing the concerns listed on the pest control vendor reports, such as clearing vegetation from around the building and cleaning and monitoring the cleanliness of kitchens and floor drains; the pest control vendor would be asked to reassess the facility to ensure their recommendations were being followed.</p> <p>10 New York Codes, Rules, and Regulations 415.29(j)(5)</p>		