STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335008	A. Building B. Wing	12/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Johns Health Care Corporation	150 Highland Avenue Rochester, NY 14620

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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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46880 Based on observations, interviews, and record review conducted during a Recertification and complaint investigation (#NY00305787) completed 12/6/23 to 12/13/23, it was determined that for two (Residents #62 and #235) of five residents reviewed for dignity, the facility did not ensure that the residents were treated in a respectful and dignified manner. Specifically, Resident #62 was observed walking on the unit completely naked from the waist down with several other residents and multiple staff members in the vicinity and Resident #235 was observed to have multiple different pureed foods mixed together for their meal and fed to them by staff. This is evidenced by the following: 1.Resident #62 had diagnoses including dementia with behavioral disturbances a history of falls, anxiety, and depression. The Minimum Data Set (MDS) Assessment, dated 11/7/23, documented the resident had severe impairment of cognitive skills and required partial assistance with dressing. Review of the current Comprehensive Care Plan (CCP) documented that Resident #62 had a history of resting in bed unclothed and at times would forget to put on clothing before leaving their room. Staff interventions included maintaining the resident's choices and dignity and using signage by the resident's door reminding them not to leave their room without wearing clothes. During an observation and interview on 12/07/23 at 11:01 AM, Resident #62 walked approximately 106 feet from one end of the hall to the opposite end of the hall where their room was located, completely naked from the waist down with dried stool visible on their buttocks. Certified Nurse Assistant (CNA) #3 walked with the resident for more than half the distance of the hallway without redirecting, requesting assist and/or covering the resident up as soon as possible. Seated at and across from the nurse's station where the resident was walking were three staff members and nine other residents all within sight of Resident #62. CNA #4 said at the time that Resident #62 had been redressed several times that day. During an interview on 12/07/23 at 12:03 PM, with CNA #3 and CNA #4, CNA #4 stated that Resident #62, who becomes undressed several times a day is redirectable at times but not always because they do not like to be touched. When asked if they could have called for help to avoid the resident walking in the hall unclothed, CNA #3 said they could have. During an interview on 12/11/23 at 11:13 AM, Licensed Practical Nurse (LPN) #1/ Clinical Coordinator said that at times Resident #62 comes out of their room not fully dressed and required staff redirection. LPN #1/Clinical Coordinator said they try to cover the resident up as soon as possible. (continued on next page)

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

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/12/23 at 11:06 AM and at 12:18 PM, the Director of Nursing (DON) said that if a resident was walking around unclothed, they would expect staff to intervene immediately to redirect the resident and by calling out for another staff person to help. The DON said even if the other residents on the unit were cognitively impaired, it was unacceptable for any resident to walk around on the unit unclothed without staff stepping in immediately. 2.Resident #235 had diagnoses including Alzheimer's disease, muscle weakness, and dysphagia (difficulty swallowing). The MDS assessment dated [DATE] documented the resident was severely impaired cognitively, had trouble swallowing requiring a mechanically altered diet, and needed extensive assistance from staff with eating. Review of the medical orders for Resident #235 revealed a pureed diet. Review of the CCP dated 12/8/23 revealed Resident #235 required feeding assistance from staff and was on a mechanically altered diet. The CCP did not include that Resident #235, or their representative had requested their meals to be all mixed together. During an observation on 12/6/23 at 1:09 PM, Resident #235 was being fed in the dining room by CNA #1. The meal that was served was all mixed together in one bowl. When asked if it was Resident #235's preference, CNA #1 stated the meal should not have been mixed all together and the foods should have been served separately. During an observation on 12/8/23 at 10:04 AM, Resident #235 was being fed in the dining room. Their meal had been put on a plate and mixed together. During an interview on 12/11/23 at 10:41 AM, LPN#1/ Clinical Coordinator said that residents on a pureed diet should have their meals served in a divided plate or in bowls and not all mixed together. 10 NYCRR 415.5(a)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46526 Based on observations, interviews, and record reviews conducted during the Recertification Survey 12/6/23 to 12/13/23, it was determined that for 4 (South 3, South 4, Reservoir 4, Reservoir 6) of 11 resident care units reviewed, the facility did not provide housekeeping and maintenance services necessary to maintain a safe, clean, comfortable, and homelike environment. Specifically, multiple resident wheelchairs, sit-to-stand lifts (assistive standing device), a shower mat, a resident reclining chair, and a dining room floor were observed soiled. This is evidenced by the following: During multiple observations on South 4 day shift on 12/6/23, 12/7/23, 12/8/23, 12/11/23 and 12/12/23 four wheelchairs, all occupied by residents had multiple dried food debris visible on them over three and four days. During observations on 12/6/23 at 9:40 AM on Reservoir 6, a shower mat on top of a wheeled stretcher located in the shower room near resident room [ROOM NUMBER] was soiled. The underside of the mat had a brown smear that appeared to be feces and the mesh on the stretcher below the mat had an accumulation of hair and white and brown debris. During observations on 12/6/23 at 9:58 AM on Reservoir 6 two sit-to-stand lifts located in the corridor across from resident room [ROOM NUMBER] had a significant accumulation of crumbs and debris in the foot tray. During observations on 12/6/23 at 10:56 AM-11:15 AM on Reservoir 4 two sit-to-stand lifts located in the corridor across from resident rooms #421 and #434, had a significant accumulation of crumbs and debris in the foot tray. During an interview at this time, the Director of Facilities (DOF) stated that maintenance only does the safety checks, not cleaning of the lifts. During observations on 12/7/23 at 9:11 AM on Reservoir 6 a blue recliner chair for resident use in the dining room had a foul-smelling brown substance on the seat of the chair. During observations on 12/7/23 at 10:14 AM on South 3, briefs, lift slings, and blankets were stored directly on the floor in a storage room next to resident room [ROOM NUMBER]. During an interview at this time, the DOF stated that the nurse manager needed to see this. During observations on 12/11/23 at 11:53 AM, on 12/12/23 at 2:10 PM and again on 12/13/23 at 9:43 AM, on Reservoir 6, a whitish-gray dried substance (liquid) measuring approximately seven inches by seven inches round, was on the dining room floor. During an interview on 12/11/23 at 11:18 AM, Licensed Practical Nurse (LPN) #7 stated that maintenance fixes the wheelchairs, and that nursing is responsible for cleaning the wheelchairs, and the wheelchairs are cleaned when the nursing staff have the time. During an interview on 12/12/23 at 2:22 PM, LPN #5 said the dining room assistant is responsible for cleaning the dining room and if there is not a dining room assistant, nursing staff should clean it. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 12/13/23 at 8:59 AM, LPN #7 stated that the two soiled wheelchairs (identified on South 4) definitely needed to be cleaned. During an interview on 12/13/23 at 9:46 AM, LPN #6 (Reservoir 6) said if something spilled on the floor, staff should clean it up. If a resident was incontinent while sitting in a recliner, LPN #6 said staff should let them know and they would notify Environmental Services (EVS). At 10:30 AM, LPN #6 observed the dried whitish-gray substance on the dining room floor, as well as a substance on the blue resident recliner chair and stated they would call EVS to have them cleaned. During an interview on 12/13/23 at 10:42 AM, the Director of Nursing (DON) said nursing staff can clean equipment (tables, chairs, etc.) if something needed to be wiped down. Additionally, the DON said that the dining room assistants are responsible for cleaning the dining rooms. 10 NYCRR 415.5(h)(2)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. 49368 Based on interviews and record reviews conducted during the Recertification Survey 12/6/23 to 12/13/23, it was determined that for two (Residents #99 and #182) of five residents reviewed for Minimum Data Set (MDS) Assessments (a mandated resident assessment tool) the facility did not assess the residents, using the Centers for Medicare and Medicaid Services (CMS) specified quarterly review assessment, no less than once every three months, between comprehensive assessments. Specifically, quarterly MDS Assessments were not completed within 92 calendar days from the prior MDS Assessment for both residents. Additionally, Resident #99's comprehensive MDS Assessment was also not completed in the required time frame. This is evidenced by the following: The Long-Term Care Facility Resident Assessment Instrument 3.0 Version 1.18.11 dated October 2023 included that a facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than every 3 months. 1.Resident #99 had diagnoses including diabetes, cerebral vascular accident (stroke) with hemiparesis (weakness on one side of the body), and depression. Review of the facility MDS Assessments, revealed that Resident #99 had a comprehensive annual MDS Assessment completed with an Assessment Reference Date (ARD- the official date of the assessment which drives the look back time frame) of 8/23/22. The next quarterly MDS Assessment was dated 1/31/23 and completed on 2/6/23 (130 days versus the required 92 days). The following quarterly MDS Assessment was completed with an ARD date of 6/13/23 (132 days versus 92 days). Additionally, the next required MDS Assessment had an ARD of 11/21/23 but remained incomplete as of 12/12/23. 2.Resident #182 had diagnoses including heart failure, diabetes, and schizophrenia. Review of the facility MDS Assessments, revealed Resident 182's comprehensive annual MDS Assessment was completed with an ARD date of 11/30/21. The next MDS Assessment was a quarterly with an ARD date of 3/21/22 (over 110 days). During an interview on 12/12/23 at 2:44 PM and again on 12/13/23 at 10:22 AM the MDS Reimbursement Manager stated that the department had been cleaning up from the prior MDS nurse (no longer employed at the facility) and noticed that many MDS Assessments were past due and out of compliance. They stated that the department was short staffed of MDS nurses to complete the tasks timely. The MDS Reimbursement Manager stated that Resident #99's ARD of 11/21/23 was still incomplete as they were waiting for other staff required to complete their portions of the MDS Assessments. During an interview on 12/13/23 at 1:29 PM the Administrator stated that the Quality Assurance committee was not aware of the issue but that they were aware that some of the departments were not able to complete the MDSs unless everyone does their parts. 10 NYCRR 415.11 (a)(4)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46526 Based on observations, interviews, and record review conducted during a Recertification Survey from 12/6/23 to 12/13/23, it was determined for two (Residents #48 and #52) of four residents reviewed for care planning related to respiratory care, the facility did not develop and/or implement a comprehensive, person-centered care plan for each resident that included services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as related to the need for respiratory care. Specifically Resident #48's Comprehensive Care Plan (CCP) did not include measurable goals, outcomes, and interventions for management of a tracheostomy (a surgically created hole in the windpipe that provided an alternative airway for breathing). Resident #52's CCP did not include measurable goals, outcomes, and interventions for use of oxygen (O2). This is evidenced by the following: 1.Resident #48 had diagnoses that included chronic respiratory failure (a long-term condition when the body does not have enough oxygen) and a tracheostomy. The Minimum Data Set (MDS) assessment dated [DATE] documented the resident had severely impaired cognition, received oxygen therapy and tracheostomy care. Physician's orders, dated 3/27/23, included but were not limited to, orders for humidified O2 via tracheostomy collar at 2 liters (L), change respiratory therapy tubing and humidifier (a bottle of water attached to the concentrator to provide moistened oxygen) weekly, an obturator (device used to insert a tracheostomy) needed to be with the resident at all times, change trach ties once daily, and replace trach mask once per week. Review of the CCP, dated 11/28/23, revealed Resident #48 required assistance with activities of daily living (ADLs) related to chronic respiratory failure and for staff to provide trach care every shift (8 hours). The CCP did not include a person-centered care plan with measurable goals, outcomes, or interventions for Resident #48's tracheostomy including monitoring for complications. Review of the Key to the Care of Our Elders (care card used by the Certified Nursing Assistants (CNAs) for daily care), dated 12/12/23, revealed that Resident #48 was to have continuous oxygen but did not include any information regarding that Resident #48 had a tracheostomy. During an observation on 12/7/23 at 11:15 AM, Resident #48 (in their room) had a tracheostomy and was receiving O2 at 2 L via a humified mask. No obturator was observed near the resident at this time. During an observation on 12/8/23 at 11:34 AM, Resident #48 was observed asleep in bed. The humidified face mask was observed on the bedside table, not in front of their tracheostomy. When interviewed on 12/13/23 at 9:46 AM, Licensed Practical Nurse (LPN) #6/Clinical Coordinator stated that having a tracheostomy should be in a resident's CCP with information on how to care for it. After review of Resident #48's CCP, they stated that there was no care plan for respiratory or tracheostomy care. LPN #6/Clinical Coordinator stated they had not received much training on care planning when they started the Clinical Coordinator position. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 12/13/23 at 10:42 AM, the Director of Nursing (DON) stated that the CCP is driven by the MDS Assessment and any special needs the resident may have and that Resident #48's CCP should have more information regarding their tracheostomy. 2.Resident #52 had diagnoses that included chronic obstructive pulmonary disease (COPD- a lung disease that makes it difficult to breath) and pulmonary hypertension (a disease that affects blood vessels in the lung). The MDS assessment dated [DATE] documented the resident was cognitively intact and received oxygen therapy. Physician's orders, dated 8/28/23, documented oxygen at 3L via nasal cannula every shift continuously around the clock. Review of the CCP, dated 10/6/23, revealed Resident #52 required assistance with ADLs related to COPD with the need for supplemental oxygen and that the resident would remove their oxygen at times and may decline reminders to keep it on. The CCP did not include interventions for the care of the oxygen and monitoring of. Review of the Key to the Care of Our Elders, dated 12/4/23, revealed that Resident #52 was to have oxygen per physician order. During an observation on 12/7/23 at 2:25 PM, Resident #52 was not wearing their oxygen. When interviewed at that time, Resident #52 stated that staff forgot to put it on, and they had a hard time going off the unit when they do not get assist to put their oxygen on. During several observations on 12/8/23 day shift and again on 12/11/23 at 8:50 AM, Resident #52 was wearing oxygen with an attached humidification bottle that was dated as changed 9/27/23. The undated oxygen tubing was dirty with dried yellow substance covering the nasal cannula. During an interview on 12/11/23 at 10:41 AM, LPN #4/Clinical Coordinator stated the Clinical Coordinators are responsible for the development and implementation of the comprehensive care plan. They stated that anything unique to the resident should be addressed in the care plan, including oxygen and interventions for its use. During an interview on 12/12/23 at 2:32 PM, the Director of Nursing (DON) stated care plans are created by the interdisciplinary team and the CCP should include any special needs for the resident, including oxygen. The DON stated that the LPN Clinical Coordinators start the care plans and then a Registered Nurse should be checking to make sure the care plan includes goals, outcomes, and interventions before co-signing the care plan. 10 NYCRR 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39181 Based on observations, interviews and record reviews conducted during the Recertification Survey and complaint investigations (#NY00300019 and #NY305787) 12/6/23 to 12/13/23, it was determined that for three (Resident #84, Resident #90 and Resident #183) of nine residents reviewed for Activities of Daily Living (ADLs), the facility did not provide the necessary services to maintain grooming/personal hygiene, toileting and repositioning. Specifically, Resident # 84 did not receive assistance with removing facial and ear hair. Resident # 90 did not receive timely incontinence care, turning and positioning, and Resident #183 did not receive nail care. This is evidenced by the following: The facility policy Care: Standards of Care, dated last revised 8/22/23, included to shave men during morning care as per resident choice. Make a significant position change every two to four hours as per resident choice. Follow range of motion, position goals, and toileting times per care plan and Key to Care of our Elders, nail care provided for residents as needed, and to inspect fingernails for cleanliness and need for trimming. 1.Resident #84 had diagnoses that included Parkinson's disease, chronic pain syndrome, and depression. The Minimum Data Set (MDS) assessment dated [DATE], included the resident was cognitively intact and dependent on staff for personal hygiene and grooming (including, but not limited to shaving). Review of the current Comprehensive Care Plan (CCP) revealed Resident #84 had a self- care deficit and required assistance with bathing and grooming and the resident's goal was to remain clean, neat and dressed appropriately. During an observation and interview on 12/11/23 at 12:31 PM, Resident #84 had thick facial hair around their face, neck, mouth, and hair coming out of their ears. The resident said they ask staff all the time to be shaved and that it bothers them to have hair coming out of their ears. During an observation on 12/12/23 at 9:51 AM, Resident #84 remained unshaven with hair coming out of their ears. The resident said they wanted to be shaved. During an interview on 12/12/23 at 9:59 AM and on 12/13/23 at 1:00 PM Certified Nurse Assistant (CNA) #7 (assigned CNA) said that Resident #84's shower (and shave) day was on Friday evenings (four days prior) but that they planned to shave the resident tomorrow. CNA #7 stated that grooming included shaving, but they had not asked the resident regarding their ear hair. CNA #7 stated if the resident refused care, they would notify the nurse, but that Resident #84 was generally accepting of care. During an interview on 12/12/23 at 10:21 AM, Licensed Practical Nurse #1/ Clinical Coordinator said it was possible that Resident #84 had received a shower without being shaved. During an interview on 12/12/23 at 11:18 AM the Director of Nursing (DON) said residents' choices should be followed and if a resident refused care, it should be documented, and staff should reach out for assistance. Additionally, the DON said that the staffing issues have impacted the resident's ability to receive showers and shaving and that they have noticed residents who could use a shave when touring units. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #90 had diagnoses that included Parkinson's Disease, stroke, and hemiplegia (paralysis on one side of the body). The MDS assessment dated [DATE] revealed that Resident #90 was cognitively intact, had occasional bladder incontinence, and required extensive assistance from staff for toileting. Review of the CCP dated 10/30/23 and the current Key to the Care of our Elders (care plan used by the CNAs for daily care) revealed that Resident #90 was to be toileted and checked for incontinence every two to three hours. In an observation and interview during incontinence care (requested by Resident #90) on 12/8/23 at 3:45 PM, Resident #90 brief was soaked through with urine. Resident #90's entire left buttock was red, macerated (softened/fragile skin due to excess moisture), with flaking skin and an open area that not covered with any dressing. Resident #90 stated at the time that it was the first time they had received any incontinence care since 10:00 AM and that staff had not checked on them or offered to toilet or change them since. During an interview on 12/11/23 at 9:27 AM, Resident #90's assigned CNA #2 said they provide toileting and incontinence care twice a shift usually in the morning and after lunch (versus every 2-3 hours per the resident's care plans). During an interview on 12/11/23 at 10:41 AM, LPN#4/Clinical Coordinator said that incontinence care and/or toileting should be completed every two to three hours. During an interview on 12/12/23 at 12:15 PM, Resident #90 said they had not had incontinence care since getting out of bed at 6:00 AM. During an interview on 12/12/23 at 2:32 PM, the DON said that toileting and incontinence care should be provided every couple of hours and that twice a shift was not enough. 3.Resident #183 had diagnoses that included Alzheimer's disease, muscle weakness, and pressure ulcers. The MDS assessment dated [DATE] included that Resident #183 was severely impaired cognitively and required extensive assistance of one person for personal hygiene and toileting. Review of Resident #183's Key to Care of Elders included the need for total assist with grooming and dressing, a total bed bath on Friday evenings, with an alternate day of Monday day shift. During an observation on 12/7/23 at 9:10 AM, Resident #183 was observed with dirty fingernails. During an observation on 12/11/23 at 11:51 AM, Resident #183 was sitting in their wheelchair in the unit dining room and had brown debris under the fingernails on their right hand. Review of the December 2023 Treatment Administration Record (TAR) included skin check and nail care was not signed off as completed on 12/8/23 (scheduled shower day three days previous). During an interview on 12/12/23 at 2:15 PM, CNA #3 said they have been told the CNAs should do nail care, when nails are soiled, dirty, and checked daily. (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 12/12/23 at 2:22 PM, LPN #5/Clinical Coordinator stated nail care should be done on bath/shower days or when a resident asks. They stated that if a CNA did nail care, they should tell the nurse who should document it in the resident's electronic medical record. During an observation and interview on 12/13/23 at 10:30 AM, LPN #6/Clinical Coordinator observed Resident #183's fingernails and stated that the nails were dirty and needed to be cleaned. 10 NYCRR 415.12(a)(3)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46526 Based on observations, interviews and record review conducted during the Recertification Survey and complaint investigation (#NY00300345) from 12/6/23 to 12/13/23, for three (Residents #90, #108 and #183,) of six residents reviewed for pressure ulcers, the facility failed to ensure the residents received the necessary care, treatment, and services, consistent with professional standards of practice, to promote healing, prevent new pressure ulcers from developing, and/or prevent existing pressure ulcers from worsening. Specifically, the facility did not consistently provide Residents #90, #108 and #183 with physician-ordered treatments for skin impairments and/or care plan interventions. This resulted in actual harm to Resident #90 that is not Immediate Jeopardy. This is evidenced by the following: The facility policy Wounds: Pressure Ulcer Care, dated August 2023, documented that all residents admitted without a pressure ulcer will receive preventative care according to their documented Braden Scale (an assessment that indicates level of risk for skin breakdown). Residents with a pressure injury/ulcer will receive necessary treatment and services to promote healing, prevent infection, and prevent new pressure ulcers from developing. Incontinence care should be provided at least every 4 hours, repositioning should be completed every 2 hours, and treatments should be documented in the Electronic Medical Record with each completion. The facility policy Care: Standards of Care, dated 10/18/18, documented that a significant position change should be done every 2-4 hours, and toileting should be completed according to the Care Plan and Key to Care of Our Elders (care plan used by the Certified Nursing Assistant (CNA) for daily care). 1. Resident #90 had diagnoses of Parkinson's Disease (a progressive disease of the nervous system marked by tremors and muscular rigidity), stroke, and muscle weakness. The Minimum Data Set (MDS) assessment dated [DATE] documented that Resident #90 was cognitively intact, had hemiplegia (paralysis on one side of the body), was occasionally incontinent of bladder, required extensive assist from staff for toileting, and had multiple pressure ulcers at the time of the assessment. Review of the current Comprehensive Care Plan documented that Resident #90 had a pressure ulcer to the natal cleft (where the upper butt cheeks meet) and was incontinent of urine. The Comprehensive Care Plan interventions included to follow the Key to Care of our Elders. Review of the current Key to the Care of our Elders revealed that Resident #90 was to be toileted, checked for incontinence, and turned and positioned every two to three hours. During an observation of incontinence care on 12/08/23 at 3:45 PM, and again on 12/11/23 at 10:02 AM, Resident #90 had no dressing to the natal cleft unstageable pressure ulcer. The wound was macerated (skin was white and fragile from being in contact with moisture for an extended period of time) and covered with yellow slough (non-viable tissue leading to necrotic tissue-dead tissue black or brown in color). Resident #90 was wearing an incontinence brief that was saturated through with urine on both observations. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 12/8/23 at 3:45 PM, Resident #90 stated they had not received toileting assistance, incontinence care, or re-positioning since 10:00 AM. Review of Resident #90's Interdisciplinary Progress Notes revealed Resident #90 was being followed by the facility's wound care team, comprised of two Registered Nurses. In a wound care team Interdisciplinary Progress Note dated 11/7/23, Registered Nurse #2 documented that Resident #90 had Moisture Associated Skin Damage (MASD-skin damage caused by prolonged exposure to moisture such as urine) to the natal cleft, and a new Physician's order included triamcinolone acetonide paste (a medicated lotion to help promote wound healing) to be applied twice daily. In a wound care team Interdisciplinary Progress Note, dated 11/21/23, Registered Nurse #2 documented the Moisture Associated Skin Damage had worsened to a Stage 3 (full thickness tissue loss involving damage to or necrosis (dead tissue) of subcutaneous tissue) pressure ulcer. Review of Resident #90's medical orders revealed no new orders to address the new pressure ulcer documented on 11/21/23. In a wound care team Interdisciplinary Progress Note dated 12/5/23, RN #2 documented that Resident #90's Stage 3 pressure ulcer was now an unstageable pressure ulcer (wound base is unable to be seen because it is covered by necrotic tissue). The note documented that the wound was macerated, and that there was a new Physician order for the triamcinolone acetonide paste with the application of a border gauze (a dressing with an adhesive border) to be completed twice daily. Review of the Treatment Administration Records, dated 11/7/23 through 12/13/23, revealed 31 of 66 opportunities for treatments to the natal cleft wound were blank. There was no documented evidence between 11/7/23 and 12/12/23 that a medical provider had assessed Resident #90's worsening pressure ulcer. During an interview on 12/11/23 at 9:27 AM, Certified Nursing Assistant #2 (assigned to Resident #90) stated they provided toileting and incontinence care twice a shift, usually in the morning and after lunch. During an interview on 12/11/23 at 10:41 AM Licensed Practical Nurse (LPN) #4/ Clinical Coordinator stated that a blank in the Treatment Administration Record meant that the treatment had not been done. During an interview on 12/11/23 at 2:10 PM Nurse Practitioner #1 stated they do not participate in wound rounds but would go see a wound if needed. Nurse Practitioner #1 stated if medical treatments were not completed it would be considered an error and an incident report filed, which we (medical) would then see and assess. Nurse Practitioner #1 stated they have identified that wound treatments were not being completed as ordered and that staffing has been a struggle. Nurse Practitioner #1 stated that not providing incontinence care, turning, and positioning and/or wound treatments could cause a wound to worsen. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 12/12/23 at 11:20 AM, with the wound care team nurses Registered Nurse #1 and Registered Nurse #2, both stated that residents with wounds should receive toileting or incontinence care (per their care plan), and that the treatments should be completed as ordered. They both stated a wound could worsen if care plan interventions were not being completed, and Registered Nurse #2 stated a resident with a wound should be turned and positioned at least several times a shift (8 hours). Registered Nurse #1 stated that any wound over a stage 3 should be reported to medical. During an interview on 12/12/23 at 12:15 PM, Resident #90 stated they had not been toileted, had incontinence care, or been re-positioned since getting out of bed at 6:00 AM. During an interview on 12/12/23 at 2:32 PM, the Director of Nursing stated that toileting, incontinence care, and turning and positioning should be completed per the Comprehensive Care Plan and the Key to the Care of Our Elders. 2. Resident #183 had diagnoses that included Alzheimer's disease, muscle weakness, and pressure ulcers. The Minimum Data Set assessment dated [DATE] revealed Resident #183 was severely impaired cognitively and had multiple pressure ulcers requiring the application of dressings and pressure ulcer care. Resident #183's current Comprehensive Care Plan and their Key to Care of Elders included they had a pressure ulcer to the right heel, right hip and coccyx (tailbone), with interventions that included but were not limited to providing treatments as ordered, and a specialized boot (soft boot to offload pressure for the heel) to the right foot at all times. During an observation on 12/12/23 at 2:04 PM, Resident #183 was observed sitting in their wheelchair in a common area. There was no specialized boot on their right foot, which was resting on the floor. Review of Physician orders dated 9/6/23 revealed collagenase (a medicated ointment to promote wound healing by removing dead tissue) and border gauze once daily and as needed to the unstageable pressure ulcer of the upper coccyx. Physician orders dated 10/27/23 included to clean the right heel ulcer with normal saline, pat dry, and apply skin prep twice daily. Review of November 2023 Treatment Administration Records revealed that the wound care to the coccyx was not documented as administered on 11 of 30 opportunities. Wound care to the right heel pressure injury was not documented as administered on 27 of 60 opportunities. Review of December 2023 Treatment Administration Records from 12/1/23 through 12/12/23 revealed that wound care to the coccyx had not been documented as administered on 4 of 12 opportunities. Wound care for the right heel had not been documented as administered on 7 of 24 opportunities. 3. Resident #108 has diagnoses that included paraplegia (paralysis of the lower extremity), osteomyelitis (infection of the bone), and pressure injury. The Minimum Data Set assessment dated [DATE], revealed that Resident #108 was cognitively intact, was always incontinent of bladder and bowel, and had multiple unhealed pressure ulcers. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #108's Comprehensive Care Plan included pressure ulcers to the left ischium (upper buttocks) and interventions included, treatments as ordered, and weekly wound assessments by the skin team. Resident #108's current medical orders included the following: a. Stage 4 (full thickness tissue loss with extensive destruction to the tissue that could involve bone and muscle) pressure ulcer of upper left ischium: clean wound with soap and water, pat dry, apply skin-prep to periwound then pack with alginate (absorbs wound drainage) and cover with foam dressing daily and as needed. b. Pressure ulcer to the left distal ischium: apply skin prep twice daily. c. Stage 3 pressure ulcer distal to existing Stage 3 ulcer: apply triamcinolone ointment once daily. During an interview on 12/7/23 at 10:27 AM, Resident #108 stated that they have had their sore forever, and some staff do not change the dressings. Review of the November 2023 Treatment Administration Records revealed that the wound care to the left ischium was not documented as administered as ordered on 6 of 30 days. Review of the December 2023 Treatment Administration Records revealed wound care to the left ischium was not documented as administered as ordered on 4 of 11 days. During an interview on 12/13/23 at 9:46 AM, Licensed Practical Nurse #6/Clinical Coordinator stated there were wound nurses (who do dressing changes when on duty), but if they were not on then the unit nurses are responsible for doing the treatments. Licensed Practical Nurse #6/Clinical Coordinator stated that a blank box on the Treatment Administration Record meant the treatment was not done or that the nurse forgot to document it; if unable to complete the treatment, the nurse should let the next shift or nursing supervisor know. Licensed Practical Nurse #6/Clinical Coordinator said on some weekends, there is only one nurse (on the unit) and the treatments do not always get done. After reviewing Resident #183 and Resident #108's Treatment Administration Records (observing blank boxes for ordered treatments), Licensed Practical Nurse #6/Clinical Coordinator said they were not notified by staff that the wound treatments were not done as ordered. Licensed Practical Nurse #6/Clinical Coordinator said the wound nurses do audits (of ordered treatments) and did mention to them Resident #183 missing treatments. Licensed Practical Nurse #6 stated that Resident #183 had the right heel pressure injury for a while, and it was likely from positioning (lack of). They said that after they had been made aware that Resident #183 had not been wearing their special boot the day before, that it may have been because float aides (aides from other departments) had been assigned to Resident #183 that day. During an interview on 12/13/23 at 10:42 AM, the Director of Nursing (DON) stated wound care treatments should be signed off on the Treatment Administration Record when they are completed, and if not done, an error report should have been generated. The Director of Nursing stated they have recently hired treatment nurses to assist with the dressing changes. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 12/13/23 at 1:29 PM, the Administrator stated that they had addressed this issue in their Quality Assessment meetings, resulting in hiring a treatment nurse to improve the issue. 10 NYCRR 415.12 (c)(1)

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46526 Based on observations, interviews, and record reviews conducted during a Recertification Survey from 12/6/23 to 12/13/23 it was determined for two (Resident #52 and #152) of four residents reviewed for respiratory care, the facility did not ensure that residents who needed respiratory care, were provided such care, consistent with professional standards of practice, goals and preferences. Specifically, Residents #52 and #152 were observed with dirty oxygen (O2) tubing and/or humidification bottles (water bottles attached to the concentrator to provide moistened oxygen) not changed according to the physician's orders, and multiple missing documentation that the oxygen was being administered and/or equipment changed as ordered. This is evidenced by the following: The facility policy, Oxygen: Oxygen Administration via O2 Cylinder or Concentrator (a medical device that delivers oxygen), last reviewed June 2022 included to ensure there was an order from the medical provider for O2 therapy, that masks and nasal cannulas (device used to deliver oxygen through the nose) were to be replaced weekly and as needed, and O2 was to be documented on the treatment sheet (verifying administration as ordered). 1.Resident #52 had diagnoses that included chronic obstructive pulmonary disease (COPD- a lung disease that makes it difficult to breath) and pulmonary hypertension (a disease that affects blood vessels in the lung). The MDS assessment dated [DATE] documented the resident was cognitively intact and received O2 therapy. Review of the current Comprehensive Care Plan (CCP) and the Key to the Care of Our Elders (care plan used by the Certified Nursing Assistants (CNAs) for daily care), included Resident #52 required O2 per physician orders and that the resident would remove their O2 at times and may decline reminders to keep it on. Current Physician's orders documented 3 liters (L) of O2 via nasal cannula every shift continuously around the clock and to change the O2 tubing and humidification (bottle) every week and as needed. During an observation and interview on 12/7/23 at 2:25 PM, Resident #52 was not wearing their O2. When interviewed at that time, Resident #52 stated that staff forgot to put it on and added that they had a hard time going off the unit because they need assistance to put their oxygen on. During an observation on 12/8/23 at 8:45 AM, Resident #52 was asleep in bed wearing their O2 at 3L. The oxygen tubing was undated, and the humidification bottle was dated 9/27/23. At 1:16 PM, Resident #52 was not in their room. Their O2 tubing was connected to the concentrator and the nasal cannula was lying in the garbage can next to the bedside table. During an observation on 12/11/23 at 8:50 AM, Resident #52 was wearing O2 attached to the same humidification bottle that was dated 9/27/23 and the undated oxygen tubing that appeared dirty with a dried yellow substance covering the nasal cannula. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the October 2023 and November 2023 Medication Administration Record (MAR) revealed documentation that the oxygen tubing and humidification bottle had been changed 10/16/23, 11/13/23, 11/20/23 and 11/27/23 (despite the attached 9/27/23 label on the humidification bottle). There was no documentation of any changes in the December 2023 MAR as of 12/8/23. Review of the Treatment Administration Records (TAR) revealed the following: a. September 2023 TAR revealed missing documentation (nothing signed off in the scheduled blocks) verifying that the O2 was administered as ordered on 54 of 90 (three shifts a day) opportunities. b. October 2023 TAR revealed missing documentation that the O2 was verified as administered as ordered on 64 of 93 opportunities. c. November 2023 TAR revealed missing documentation that the O2 was verified as administered as ordered on 45 of 90 opportunities. d. December 2023 revealed missing documentation that the O2 was verified as administered as ordered on 19 of 36 opportunities. 2.Resident #152 had diagnoses including chronic respiratory failure dependent on O2 and obstructive sleep apnea (blockage of the upper airway leading to pauses in breathing during sleep). The MDS assessment dated [DATE] documented the resident was cognitively intact and received O2 therapy. Physician's orders, dated 6/13/23, documented O2 at 3L via nasal cannula for chronic respiratory failure and orders to change the O2 tubing and humidification bottle once a week. Review of the Key to the Care of Our Elders, dated 12/4/23, revealed that Resident #152 was to have O2 on at all times. During an observation on 12/06/23 at 2:14 PM, Resident #152 was in bed and receiving O2 at 3L via nasal cannula. The nasal cannula was dirty and covered with what appeared to be dried secretions. The O2 tubing was yellow and orange (versus clear) and neither the tubing nor humidification bottle were labeled as to when they were last changed. During observations on 12/8/23 at 1:15 PM and again on 12/11/23 at 8:57 AM, Resident #152 was wearing O2 at 3L via nasal cannula. The O2 tubing remained dirty, discolored, and unlabeled and the humidification bottle remained unlabeled. Review of the TARS for November 2023 and December 2023 revealed no documented evidence that the oxygen tubing or humidification bottle had been changed at all. Additionally, in November 2023, there was missing documentation to verify that the O2 had been administered every shift as ordered on 44 of 90 opportunities. In December 2023, there was missing documentation to verify that the O2 had been administered every shift as ordered on 21 of 36 opportunities. During an interview on 12/11/23 at 10:18 AM, Licensed Practical Nurse (LPN) #2 stated the nurses on the floor were responsible for O2 administration and changing the tubing and humidification bottle weekly per the physician's order. LPN #2 stated dirty O2 tubing should be changed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/11/23 at 10:41 AM, LPN #4/Clinical Coordinator stated that blank boxes on the MAR or TAR meant the prescribed orders had not been documented as done. During an interview on 12/11/12 at 12:50 PM Resident #152 stated they do not want to wear dirty oxygen tubing. During an interview on 12/12/23 at 2:32 PM the Director of Nursing stated residents O2 tubing should not be dirty and should be changed (as ordered or as needed). 10 NYCRR 415.12(k)(6)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46526 Based on observation, interviews and record review conducted during the Recertification Survey and complaint investigation (#NY00300019) 12/6/23 to 12/13/23, it was determined that for one (Resident #83) of one resident reviewed, the facility did not ensure that the resident was free from significant medication errors. Specifically, the resident did not receive multiple medications on 12/10/23, which included (but not limited to) an anticoagulant or blood thinner used to prevent strokes, an antidepression medication used to treat insomnia or depression, a medication used to treat dementia or Alzheimer's disease and multiple prescription eye drops for glaucoma. This is evidenced by the following: The facility policy Medication Administration, dated last reviewed on 6/1/23, included that the nurse who prepares the medications is responsible for administering it to the resident, and that medications are to be administered within one hour before or after the scheduled administration time. Resident #83 had diagnoses that included blindness, glaucoma, deep vein thrombosis, pulmonary embolism, depression, and dementia. The Minimum Data Set assessment dated [DATE], included that the resident was cognitively intact. Review of Resident #83's December 2023 Medication Administration Record (MAR) revealed no documentation that the following medications had been administered on 12/10/23 as ordered by the physician: a. Eliquis twice a day for thrombophilia (a condition in which the blood forms blood clots more easily). b. trazodone at bedtime for insomnia and depression. c. donepezil at bedtime for dementia. d. brimonidine eye drops three time a day for glaucoma. e. dorzolamide eye drops twice a day for glaucoma. f. latanoprost eye drops at bedtime for glaucoma. g. acetaminophen three time a day for pain. h. atorvastatin at bedtime for hyperlipidemia. i. melatonin at bedtime (two hours before sleep) for insomnia. j. senna (laxative) twice a day for constipation. k. Miralax twice a day for constipation. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #83's Interdisciplinary Progress Notes dated 12/10/23 to 12/11/23 did not include any information or explanation as to why the medications had not administered, were administered late, or that the covering provider had been notified. During an interview on 12/11/23 at 9:22 AM, Resident #83 stated that they did not receive any of their medications, including their eye drops that were scheduled to be given the night before (12/10/23). During an interview on 12/12/23 at 12:59 PM, Licensed Practical Nurse (LPN) #8 /Clinical Coordinator said they spoke with Resident #83 on 12/11/23, who had told them they had not received any of their night (evening) medications (on 12/10/23). LPN #8 /Clinical Coordinator stated they were working to identify which nurse was assigned to Resident #83 on 12/10/23. LPN #8/Clinical Coordinator said that they would also check the medication carts (where medications are stored) to see if the resident's medication pouches (resident-specific pre-packaged medications) had been given. Review of Resident #83's December 2023 MAR and the resident's medication box at this time with the surveyor confirmed that the evening/night shift medications scheduled for 12/10/23 had not signed as administered (indicated by blank boxes or lack of initials) and remained in the resident's medication box for the scheduled 9:00 PM or bedtime medications. LPN #8/ Clinical Coordinator stated if a medication was not given or refused, the nurse should document this. LPN #8/Clinical Coordinator could not provide a reason as to why the medications had not administered. During an interview on 12/13/23 at 10:42 AM, the Director of Nursing said if a medication is listed on the MAR, it needs to be given (and documented). The DON stated they would consider Eliquis and Trazodone significant medications. The DON said they learned that a nurse had walked out that day (12/10/23) and that it was safe to assume that those medications had not been administered to the resident. 10 NYCRR: 415.12(m)(2)

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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** 46526 Based on observations, interviews, and record reviews conducted during the Recertification Survey from 12/6/23 to 12/13/23, it was determined that for eight of nine medication carts reviewed for medication storage, the facility did not ensure that all drugs and biologicals were properly stored in accordance with State and Federal Laws. Specifically, multiple loose unlabeled pills were observed in the drawers of several medication carts ([NAME] 1, [NAME] 2, [NAME] 3 and Reservoir 6 cart 1) and medications were observed unlabeled and/or expired ([NAME] 1, Reservoir 4, Reservoir 5 and Reservoir 6 cart 2). The evidence included but not limited to the following: The facility Policy Medication Administration, dated reviewed 6/1/23, documented that the medication pouches will include the name and description of each medication included in that pouch, along with the full directions for use and the expiration date, do not use medication from an unmarked or poorly labeled bottle or container, the nurse is to check the expiration date of the medication before administering, and all medication carts are to be cleaned monthly. During an observation of medication storage on 12/11/23 at 11:06 AM on [NAME] 1 resident care unit, there were approximately 50, loose unlabeled pills (medications) of varying colors, size and shapes, an unlabeled bottle of medicated cream and an uncapped inhaler labeled with a first name only in a drawer of one of the medication carts. During an observation on 12/11/23 at 11:20 AM on [NAME] 3 resident care unit, there were approximately 30, loose unlabeled pills of varying colors, size and shapes were in a drawer of one of the medication carts. During an observation on 12/12/23 at 9:07 AM on Reservoir 4 resident care unit there was a bottle of docusate sodium (stool softener) with had an expiration date of May 2023 in one of the medication carts. During an observation on 12/12/23 at 9:18 AM on Reservoir 5 resident care unit there was a bottle of opened nitroglycerin tablets (used for acute chest pain) without any resident information or instructions for use in one of the medication carts. During an observation on 12/12/23 at 10:01 AM on Reservoir 6 resident care unit there were 7 loose unlabeled pills of varying colors, size and shapes in cart 1 and an uncovered bottle of calcium containing approximately 50 pills and an open bottle of medicated cream that was not labeled with any resident information in cart 2. In an interview on 12/11/23 at 11:06 AM LPN #4/Clinical Coordinator stated medication bottles in the medication carts should be labeled and have expiration dates, and the carts should be organized and not have any free-floating pills in the drawers. (continued on next page)

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St Johns Health Care Corporation	150 Highland Avenue Rochester, NY 14620

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/12/23 at 2:32 PM Director of Nursing (DON) stated the medication carts should have no loose pills. Resident specific meds should be labeled and there should never be expired medications in the carts, but the nurses should check expiration dates before administering medications. The clinical coordinators should help monitor the carts, but the nurse who is working the cart should be looking for all these things. 10 NYCRR 415.18(d)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46526 Based on observations, interviews, and record reviews conducted during the Recertification Survey completed 12/6/23 to 12/13/23, it was determined that for one of one main kitchen, and five (Reservoir fifth and sixth floors, [NAME] first and second floors, and South third floor) of twenty resident use floors, the facility did not store, prepare, distribute, and serve food in accordance with professional standards for food service safety. Specifically, potentially hazardous foods were not cold held at or below 45 degrees Fahrenheit (F), potentially hazardous foods were not properly cooled, there were undated and unlabeled food items, and a freezer had a significant buildup of ice. The findings are: The undated facility policy titled 'Resource: Food Safety for Your Loved One' included the following: If you plan to bring food into the facility for your loved one, please be sure that the food is handled safely. Food or beverages should be labeled and dated to monitor for food safety. Food or beverage items without a manufacturer's expiration date should be dated upon arrival in the facility and thrown away three days after the date marked. Foods in unmarked or unlabeled containers should be marked with the current date the food item was stored. Observations during the initial tour of the main kitchen on 12/6/23 at 9:25 AM included three large six-inch-deep stainless-steel pans of cooked elbow pasta covered in plastic wrap and dated 12/6, located in the prep walk-in refrigerator. When measured by the surveyor using a digital Thermapen, the pans of cooked elbow pasta were 45 F, 47 F, and 48 F. In an interview at that time, the Director of Dining Services (DDS) stated that the elbow pasta was prepared yesterday afternoon and that they have a cooling log. Record review of the cooling log provided by the DDS included no documentation of how the elbow pasta was cooled. The DDS then voluntarily discarded the three pans of elbow pasta. Observations on 12/6/23 at 9:45 AM included a significant amount of solid ice built up at the top of a 'Kelvinator' brand upright freezer located in the central dining room across from resident room [ROOM NUMBER] (Reservoir sixth floor). The ice was observed to completely cover the internal temperature gauge and had dripped down all over and inside a box of popsicles. Additionally at this location was an upright refrigerator that contained a black plastic container of an unlabeled and undated food item. Observations on 12/6/23 at 10:12 AM included an undated and unlabeled glass jar of an unknown semi-liquid substance located in the Reservoir fifth floor dining room refrigerator. The jar was only marked with the word 'BONDI'. When interviewed at this time, a food service worker stated that they were not sure what was in the jar. Observations on 12/7/23 at 10:23 AM included a container of three hard boiled eggs, one of which was cracked, stored on the counter near the kitchenette in the South third floor dining room. When interviewed at this time a food service worker stated that the eggs were brought up from the kitchen at breakfast. The eggs were then voluntarily discarded. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations on 12/7/23 at 10:28 AM included a refrigerator in the South third floor Snack Center across from room [ROOM NUMBER] contained four plates of unlabeled and undated food items that appeared to be meat, broccoli, and mashed potatoes, and five cups that appeared to be gravy. Additionally, there were three covered containers of food items that were only labeled as 'Milton' and 'Drees'. During an interview at this time, the clinical coordinator stated that the plates were from a recent party and saved for night staff, and the three containers of food were for residents and will be discarded. Observations on 12/7/23 at 1:18 PM included two covered plates of eggs, sausage, and bacon were stored on the counter in the [NAME] second floor kitchenette, and temperatures of each item were between 73 F and 77 F. When interviewed at this time a food service worker stated that the plates were from breakfast and should be thrown out. Observations on 12/7/23 at 1:44 PM included a cardboard box containing plastic containers of sliced meats and meat salads dated 12/10/23 were stored on the counter in the [NAME] first floor kitchenette. When measured by the surveyor using a digital ThermaTech thermometer the temperatures were as follows: Roast beef - 61 F, Egg salad - 57 F, chicken salad - 59 F. When interviewed at this time a food service worker stated they think the temperature should be about 50 and the food items came up from the kitchen with the lunch meal. The food service worker also stated that they had not received any training regarding safe food temperatures. A review of the posted meal times included that lunch is served starting at 11:30AM. Additionally, there was a bowl of fried eggs in the oven which was off, and the temperature of the eggs was 69 F. The food service worker stated that they had no idea about the eggs and then voluntarily discarded them. Record review at this time included the temperature log from the lunch meal was dated 12/7/23 and included: Hot foods: soup-76, blended soup - 74, entree 1 - 71, entree 2 - 95 and veg. 1 - 81. At 2:10 PM the surveyor asked the food service worker to discard the plastic containers of salads and sliced meats. 10NYCRR: 415.14(h); 10NYCRR: Subparts 14-1.10(b)(2), 14-1.31, 14-1.40, 14-1.43(e), 14-1.95

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46526 Based on observations, interviews, and record review conducted during the Recertification Survey completed 12/6/23 to 12/13/23, it was determined that the facility did not ensure compliance with all applicable State codes. Specifically, the facility was not in compliance with Section 915 of the 2015 Edition of the International Fire Code as adopted by New York State, which requires the use of carbon monoxide (CO) detection in a building that has fuel-burning appliances. The findings are: Record review on 12/8/23 at 11:35 AM revealed a list of facility carbon monoxide detectors within the facility was provided to the surveyor by the Director of Facilities (DF). The list of the locations of the carbon monoxide detectors were as follows: 1) [NAME] basement hallway by laundry, 2) [NAME] basement hallway between parts room doors, 3) Reservoir basement between two boiler room doors, 4) Reservoir first floor cafeteria by emergency exit, 5) East end hallway of second floor Reservoir building, 6) Ground floor South hallway near pay phone/vending. Two additional hard-wired carbon monoxide detectors were listed as passing a functional test on the fire alarm system testing report dated 2/27/23. During an interview at this time, the Director of Facilities stated that only the two hard wired carbon monoxide detectors are being tested but not the battery-operated ones. Observations on 12/12/23 at 10:50 AM included two hard-wired ceiling mounted carbon monoxide detectors located on the ceiling of the [NAME] building ground floor gas fireplace lounge. The 2015 Edition of the International Fire Code requires that carbon monoxide alarms shall be maintained in accordance with NFPA 720. The 2012 Edition of NFPA 720, Standard for the Installation of Carbon Monoxide Detection and Warning Equipment, requires that single-station carbon monoxide alarms shall be inspected and tested in accordance with the manufacturer's published instructions at least monthly. 10NYCRR: 415.29(a)(2), 711.2(a)(1), 42 CFR: 483.70(b), 2015 IFC: Section 915, 915.6 2012 NFPA 720: 8.7.1