STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335148	A. Building B. Wing	11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Willows at Ramapo Rehab and Nursing Center	30 Cragmere Road Suffern, NY 10901

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 37658 Based on record review and interview during the recertification and abbreviated surveys (NY 309477) conducted from 11/8/2023 through 11/17/2023, the facility did not ensure a thorough and complete investigation was conducted for 1 of 3 residents (Resident #70) reviewed for abuse/neglect. Specifically, for Resident #70 the facility did not conduct a complete and thorough investigation, including a root cause analysis to determine why physician recommended magnesium citrate scheduled for 1/10/2023 and 1/11/2023 was not administered for management of the residents' constipation. Subsequently on 1/12/2023 Resident #70 required manual dis-impaction. The findings are: An undated protocol titled Abuse and Neglect - Clinical Protocol documented that abuse included the deprivation by an individual, including a care taker, of goods and services that are necessary to attain or maintain physical, mental, and psychosocial well-being, and neglect was defined as the failure of the facility, its employees or service providers, to provide goods and services to a resident that are necessary to avoid physical harm, pain, emotional anguish, or emotional distress. The protocol Cause Identification documented the staff, with the physicians input as needed, will investigate alleged abuse and neglect to clarify what happened and identify possible causes. Resident #70 was admitted with diagnoses including anemia, thyroid disorder, anxiety disorder, and depression (other than bipolar). The 5-day Minimum Data Set (MDS: an assessment tool) dated 11/25/2022 documented Resident #70 was cognitively intact for decision making, received total dependence with one person assist for toilet use, was always incontinent of bowel and bladder and did not have a toileting program. The physician progress note dated 1/9/23 at 8:10 AM by Physician #3, documented Resident #70 complained of constipation and had not been able to move their bowels for the past 7 days. The plan was to give Magnesium Citrate (laxative) 150 milliliters (ml) to be taken in the morning and 150 ml to be taken in the evening, and if the resident was constipated to inform the physician. A physician order dated 1/10/23 documented Magnesium Citrate oral solution give 240 ml by mouth 2 times a day for constipation for 1 day, to start on 1/10/23. The nursing progress notes dated 1/10/2023 at 2:52 PM and 5:36 PM documented they were waiting on pharmacy for Magnesium Citrate. (continued on next page)

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

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician order dated 1/11/23 documented Magnesium Citrate oral solution give 240 ml by mouth 2 times a day for constipation for 1 day, to start on 1/11/23. The nursing progress notes dated 1/11/2023 documented at 11:44 AM and 5:40 PM, the Magnesium Citrate had not been delivered. There was no documented evidence in the January 2023 MAR that the Magnesium Citrate was administered on 1/10 and 1/11/23. Further review of the nursing progress notes revealed no documented evidence the physician was notified when the Magnesium Citrate was not delivered and no evidence the pharmacy was contacted. The investigation report dated 1/17/2023 revealed that on 1/26/2023 the facility was notified by the Ombudsman that Resident #70 alleged that on 1/12/2023 they were mistreated, and a nurse abused them, and stated that a Registered Nurse (RN #2) pushed their hand in their rectum and it felt like she just yanked it out, then RN #2 left the room. Resident #70 stated they were not informed of what RN was going to do ahead of time, and RN just did it. The incident was reported to the Department of Health on 1/27/2023, an investigation was completed, no findings of abuse were identified. A physician progress note dated 1/27/23 at 10:51 AM, by Physician #1, documented the resident was being seen regarding being dis-impacted on 1/12/23, due to an allegation of abuse. The resident had been very uncomfortable and had not had a bowel movement in over 7 days despite increasing laxatives and enemas and the head nurse dis-impacted her. Physician #1 documented the resident needed to be dis-impacted. In an interview on 11/16/23 at 12:03 PM, Licensed Practical Nurse LPN #2 stated they were responsible for medication administration to Resident #70 on the 7:30 AM-3:05 PM shift and stated the order for Magnesium Citrate the medication was not available. LPN #2 stated that when a medication was not available, they would call the pharmacy and tell them that the medication was not available and would document this. LPN #2 stated that they would text the physician to inform them that the resident did not get the prescribed dose of medication. There was no documented evidence produced that the pharmacist and/or physician had been contacted regarding the unavailable Magnesium Citrate. In an interview on 11/16/23 at 1:02 PM LPN #3, the nurse responsible for medication administration of the 5 PM dose of Magnesium Citrate for Resident #70 on the evening shift (3:30 PM - 11:30 PM) on 1/11/2023, stated they documented in the progress notes on 1/11/23 at 17:41 that they were awaiting delivery of the Magnesium Citrate. LPN #3 stated they did not remember if the pharmacy or physician was contacted. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 11/16/23 at 4:29 PM, the Director of Nursing (DON) stated that they were not aware of the order for Magnesium Citrate for constipation. DON stated that when a medication is unavailable the staff are to contact the pharmacist to find out the estimated time of arrival of the medication, if the medication is not given on the nurse's shift, they are to inform the nursing supervisor, contact the physician and inform them, document, and implement the physicians' instructions, and endorse this information to the next shift. DON stated that for a medication that was not administered, and the physician was not notified, and the pharmacy was not contacted to find out why the medication was not delivered, that would fall under the category of medication omission When asked if the medications should have been reviewed as part of the incident investigation , the DON stated that the resident already had other protocols in place, and they did not pick up on the order for magnesium citrate being unavailable. In a telephone interview on 11/20/2023 at 3:02 PM the resident's primary care physician (Physician #1) stated that they were told by RN #2 after the occurrence that the resident's stool was impacted, half-way in/ half out. Physician #1 stated they were not aware the Magnesium Citrate had not been received and administered prior to dis-impaction, and stated nursing should have notified them and the pharmacy. 10 NYCRR 483.12

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 37658 Based on observation, record review and interviews conducted during the recertification survey from 11/8/23 to 11/17/23, the facility did not provide an ongoing program of activities for 1 of 4 residents (Resident #39) reviewed for activities. Specifically, Resident #39 was not provided opportunities to consistently participate in independent activities of their choice and to be regularly reassessed for their preferences. Findings include: Resident #39 was admitted with diagnoses including Multiple Sclerosis and optic neuritis. The annual Minimum Data Set (MDS: an assessment tool) dated 4/11/2023 documented the resident was cognitively intact for decision making. Preferences for daily activities included music, keeping up with the news, and getting fresh air. The MDS documented the resident was totally dependent on staff for activities of daily living except for eating, for which the resident received extensive assistance. The resident had participated in the assessment. The resident's Care Plan for Activities dated 7/14/2021, and updated 4/28/2023, documented the resident preferred self-directed activities, the goal was for the resident to engage in daily independent activities of choice, and interventions were to encourage independent activities of choice, and to respect leisure lifestyle activities. Observation and interview conducted on 11/08/23 at 3:06 PM revealed Resident #39 liked to watch television in their room. Resident #39 stated that the Activities staff did not visit them, they did not have any activities in their room, and they would like to speak with activities if they could do something. In an interview on 11/15/23 at 9:34 AM the Director of Activities stated Resident #39 had expressed a preference not to attend group activities, and to their knowledge the resident's preference was to watch TV and movies in their room. The Director of Activities stated that they kept track of the resident's attendance at activities by documenting in the EMR (Electronic Medical Record) after the activity was completed. The surveyor requested to see the resident's Activities attendance records. In a follow up interview on 11/15/23 at 12:55 PM, the Director of Activities stated that when gathering the resident's Activities attendance records, they were unable to find evidence that the resident had been provided with independent activities of their choice since 2/2023. 10NYCRR 415.15(f)(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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37658 48045 Based on observation, record review, and interviews conducted during the recertification and abbreviated surveys (#NY00326212 and NY00309477) from 11/8/23 to 11/17/23, the facility did not ensure 1 of 3 residents (Resident #70) reviewed for abuse/neglect and 1 of 3 (Resident #63) reviewed for medications, received care and treatment in accordance with professional standards. Specifically, 1) Resident #70's medications for constipation was not given timely, the physician and pharmacy were not notified when the medication was unavailable; and 2) Resident #63 was not provided their medication with meals as ordered. Findings include: 1) Resident #70 was admitted with diagnoses including anemia, anxiety disorder, and constipation. The 5-day Minimum Data Set (MDS: an assessment tool) dated 11/25/2022 documented the resident was cognitively intact for decision making. Functional status indicated total dependence with one person assist for toilet use. The resident was always incontinent of bowel and bladder and did not have a toileting program. The physician progress note dated 1/9/23 at 8:10 AM by Physician #3, documented the resident complained of constipation and had not been able to move bowels for the past 7 days. The plan was to give Magnesium Citrate 150 milliliters (mL) to be taken in morning and 150 mL to be taken in evening, and if the resident was constipated to inform the physician. The physician progress note dated 1/9/23 at 8:20 AM by Physician #3, documented following up on constipation for resident not able to move bowel for the past 7 days despite interventions. The plan was to have the resident take [NAME] 8 oz every 10 minutes until the resident had moved bowels. Review of physician orders revealed no new orders for 1/9/23. The nursing progress notes dated 1/1/23 through 1/9/23 documented no evidence of gastro-intestinal concerns and no complaints of constipation. The physician progress note dated 1/10/23 at 8:34 AM by Physician #1, documented the resident had a history of constipation and was complaining of severe constipation and rectal pain and was found to have hemorrhoids which were treated. The resident's Miralax dose was increased, and she was to be given Magnesium Citrate. If this did not work, Lactulose would be added. A physician order dated 1/10/23 documented Magnesium Citrate oral solution give 240 ml by mouth 2 times a day for constipation for 1 day, to start on 1/10/23. The nursing progress notes dated 1/10/2023 documented: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- at 10:28 AM, Resident #70 continues to report no bowel movement since 12/31/22. The physician ordered Magnesium Citrate 8 ounces (oz) to be given twice a day for one day. - at 2:52 PM, waiting on pharmacy for Magnesium Citrate Oral Solution. - at 5:36 PM, waiting on pharmacy for Magnesium Citrate. A physician order dated 1/11/23 documented Magnesium Citrate oral solution give 240 ml by mouth 2 times a day for constipation for 1 day, to start on 1/11/23. The nursing progress notes dated 1/11/2023 documented at 11:44 AM and 5:40 PM, the Magnesium Citrate had not been delivered. Further review of the nursing progress notes revealed no documented evidence the physician was notified when the Magnesium Citrate was not delivered and no evidence the pharmacy was contacted. The nursing progress note dated 1/12/2023 at 9:25 AM documented Resident #70 had been reporting that they had not moved their bowels. They had a very large bowel movement, and the consistency was dry and clay like. The nursing progress note dated 1/12/2023 at 11:12 AM documented the Magnesium Citrate was given (2 days after originally ordered). A physician progress note dated 1/27/23 at 10:51 AM, by Physician #1, documented the resident was being seen regarding being disimpacted on 1/12/23, due to an allegation of abuse. The resident had been very uncomfortable and had not had a bowel movement in over 7 days despite increasing laxatives and enemas and the head nurse disimpacted her. Physician #1 documented the resident needed to be disimpacted. In a telephone interview on 11/16/23 at 11:19 AM, RN #2 stated that Certified Nurse Aide (CNA) #1 came to them about 9 AM on 1/12/23 and told them that the resident could not move their bowels and they were straining and needed help. Registered Nurse (RN) #2 stated they observed the resident's anus, it was dilated and filled with clay, pasty stool, and it was not impacted hard stool. RN #2 stated that they put a glove on and using their index finger they ran the index finger around the perimeter of the resident's anus and the stool came out. RN #2 stated that resident had been taking medications for constipation, but they did not recall specifics and had not given the resident an enema. RN #2 stated that she was trying to help the resident and saw that they could fix the problem. In an interview on 11/16/23 at 12:03 PM, Licensed Practical Nurse LPN #2 stated they were responsible for medication administration to Resident #70 on the 7:30am-3:30pm shift and stated the order for Magnesium Citrate the medication was not available. LPN #2 stated that when a medication was not available, they would call the pharmacy and tell them that the medication was not available and would document this. LPN #2 stated that they would text the physician to inform them that the resident did not get the prescribed dose of medication. There was no documented evidence produced that the pharmacist and/or physician had been contacted regarding the unavailable Magnesium Citrate. LPN #2 stated RN #2 told them that they removed the stool manually. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 11/16/23 at 1:02 PM LPN #3, the nurse responsible for medication administration of the 5 PM dose of Magnesium Citrate for Resident #70 on the evening shift (3:30PM - 11:30PM) on 1/11/2023, stated they documented in the progress notes on 1/11/23 at 17:41 that they were awaiting delivery of the Magnesium Citrate. LPN #3 stated they did not remember if the pharmacy or physician was contacted. In an interview on 11/16/23 at 4:29 PM, the Director of Nursing (DON) stated that they were not aware of the order for Magnesium Citrate for constipation. DON stated when a medication was unavailable the staff were to contact the pharmacist to find out the estimated time of arrival of the medication. If the medication was not given on the nurse's shift, they were to inform the nursing supervisor, contact the physician and document. Then they would implement the physician's instructions and provide this information to the next shift. The DON stated that for a medication that was not administered, and the physician was not notified, and the pharmacy was not contacted to find out why the medication was not delivered, that would fall under the category of medication omission. In a telephone interview on 11/20/2023 at 3:02 PM the resident's primary care Physician #1 stated that they were told by RN #2 after the occurrence that the resident's stool was impacted, half-way in/ half out. Physician #1 stated they were not aware the Magnesium Citrate had not been received and administered prior to disimpaction, and stated nursing should have notified them and the pharmacy. 2) Resident #63 was admitted to the facility with diagnoses including but not limited to end stage renal disease, heart disease, and diabetes. The quarterly Minimum Data Set (MDS- a resident assessment tool), dated 9/20/23, documented Resident #63 had a brief interview of mental status score of 15 (cognitively intact). A physician order dated 10/8/23, documented Resident #63 was ordered Sevelamer 800 mg (a medication that binds to phosphorus in foods, often given to people who suffer from end stage renal disease requiring dialysis whose bodies cannot excrete phosphorus), with the directions to give 2 tablets by mouth with meals. On 11/14/23 at 12:56 PM, Registered Nurse Unit Manager (RNUM) #1 was observed giving Resident #63 their lunch tray and did not provide Resident #63 their Sevelamer medication with their lunch. During an interview on 11/14/23 at 1:11 PM, Licensed Practical Nurse (LPN) #6 stated they were Resident #63's medication nurse for the shift. LPN #6 stated residents got their meal trays often without them knowing and they were late with Resident #63's Sevelamer often because of this. LPN #6 stated the medication should have been given with meals as ordered, and then stated they were going to give Resident #63 their Sevelamer now. During an interview on 11/14/23 at 1:19 PM, Registered Nurse Unit Manager (RNUM) #1 stated they passed the tray to Resident #63 and the resident should have gotten the Sevelamer with meals. During an interview on 11/15/23 at 12:58 PM, the facility's Medical Director stated they were unaware of the specifics of the medication Sevelamer, however it was prescribed by the resident's nephrologist and if the medication was ordered to be given with meals, the expectation was for it to be given with the resident's meals. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10NYCRR 415.12

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 48848 Based on observation, record review and interview conducted during the recertification survey, the facility did not ensure that residents were provided the appropriate treatment to improve and/or prevent a further decline in range of motion (ROM) for 1 of 2 residents, (Resident #120) reviewed for positioning and limited mobility. Specifically, Resident # 120 was not provided soft booties as per physical therapy recommendations. Resident #120 was admitted with diagnoses and medical conditions including but not limited to encephalopathy, cerebral vascular accident (Stroke), and generalized muscle weakness. The 11/05/2020 risk for chronic pain related to contractures and impaired mobility care plan, revised 11/10/23, did not include use of soft booties or monitoring the effect(s) of their use. The 11/8/2020 alteration in musculoskeletal status related to contracture of bilateral hand and feet care plan, revised on 11/10/23, directed supportive devices as recommended. The 9/14/2021 Physical Therapy (PT) evaluation documented Resident # 120 was referred to skilled PT due to noted bilateral (left and right) foot drop (the inability to raise the front part of the foot due to weakness or paralysis of the muscles that lift the foot). The 10/18/2021 PT discharge summary documented the resident was to always use soft boots to both ankles, keep ankles in a neutral position to prevent pressure sores and contracture (permanent stiffness and loss of movement in a joint) to ankles and heels. Nursing caregivers were instructed in use of soft boots and that the resident was always tolerating use. The 8/13/2023 quarterly Minimum Data Set (MDS: an assessment tool) revealed Resident #120 had severe cognitive impairment, required extensive assistance with all activities of daily living (ADLs), and had functional limitation of both upper and both lower extremities. There was no documented evidence in the current physician's order for the use of bilateral soft booties. Review of the September, October, and November 2023 Certified Nurse's Aide (CNA) task reports revealed there were no directives for the use of bilateral soft booties. The 11/6/2023 nursing progress note stated refer resident to PT for contracture management. Observations on 11/9/2023 at 1:48 PM revealed that Resident #120 did not have soft booties on (two soft booties were noted on the windowsill next to resident's bed) and on 11/16/2023 at 11:14 AM Resident #120 was in a wheelchair in the activity room and was not wearing soft booties. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 11/16/2023 at 8:51 AM with the Director of the Rehabilitation who stated walking rounds were conducted on 10/29/2023 just prior to residents annual MDS review and the resident was referred to the rehabilitation department due to contracture of the bilateral ankles. The Director of Rehabilitation stated the cause was immobility and the residents' not being able to position themselves. The Director of Rehabilitation also stated the resident had soft booties to maintain a neutral alignment of the ankles and they were to be used at all times; their review of resident chart revealed there was no physician's order, and no documentation in the care plan or on CNA tasks assignment directing use of soft booties. 10 NYCRR 415.12

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 48822 Based on observations, interviews and record reviews conducted during the recertification survey conducted from 11/8/2023 to 11/17/2023, it was determined that for one of four (Resident #82) reviewed for respiratory care, the facility did not ensure that the resident received proper respiratory treatment and care consistent with professional standards of practice, and the comprehensive person-centered care plan. Specifically, Resident #82 did not receive continuous oxygen 3L/min via nasal cannula as per physician order. Findings include: Resident #82 was admitted to the facility with diagnoses including cerebral infarction, respiratory failure and anxiety. The 8/15/2023 Minimum Data Set Assessment documented Resident #82 had severely impaired cognition and required oxygen therapy. The 3/18/2023 physician order documented continuous oxygen 3L/min via nasal cannula. The November 2023 Medication Administration Record (MAR) documented continuous oxygen 3L/min was administered every shift from 11/1/2023 through the 11/15/2023 day shift. The 4/28/2023 revised Comprehensive Care Plan (CCP) titled Shortness of Breath documented continuous oxygen. During an observation on 11/14/2023 at 01:38 PM Resident #82 was noted to be in their wheelchair, not wearing the nasal cannula for oxygen. The oxygen tubing and cannula were noted by the nightstand. The oxygen concentrator was on and running. During an observation on 11/14/2023 at 03:20 PM Resident #82 was noted to be in their wheelchair sleeping. The nasal cannula for oxygen was not on the resident. The nasal cannula was on the floor by the nightstand table near the window. The oxygen concentrator was on. During an interview conducted on 11/15/2023 at 09:29 AM Physician (#2) stated that the purpose of the oxygen was to maintain the resident's saturation rate. The expectation was that staff would check the oxygen saturation rate if the resident had removed the oxygen and make sure the resident had an oxygen saturation above 88%. During an observation on 11/15/2023 at 09:59 AM Resident #82 was noted to be dressed and sitting in the wheelchair. The nasal cannula for oxygen was not on the resident. The tubing was wrapped around the tube feeding pole and the cannula was in the nightstand drawer. During an interview conducted on 11/15/2023 at 10:08 AM Licensed Practical Nurse (LPN) #1 stated that if a resident removed their oxygen, the staff would check the oxygen saturation level, speak with the nurse manager and check to make sure the resident was doing ok. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[10 NYCRR 415.12(k)(6)]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335148	A. Building B. Wing	11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Willows at Ramapo Rehab and Nursing Center	30 Cragmere Road Suffern, NY 10901

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 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. 37658 Based on observations and interviews conducted during the recent recertification survey, the facility did not ensure that food was stored, prepared, distributed, and served in accordance with professional standards for food service safety. Specifically, 1. Cold foods were stored in a soiled, unsanitary refrigerated unit, 2. Cold foods to be served at activities events were stored in an unsanitary manner in a refrigerated unit, 3. Unlabeled, defrosted, uncooked, ground beef was stored in a refrigerated unit, 4. cooling logs were being utilized to ensure that foods were cooled in a safe and timely manner, 5. 2 of 7 nourishment refrigerators were not maintained at safe temperatures for food safety, and 5. Two food service staff did not follow safe food handling practices while recording food temperatures. The findings are: The initial tour of the kitchen was conducted on 11/08/2023 at 10:23 AM and the following were noted: 1) A chest freezer was in use as a refrigerated unit. The chest freezer unit was observed with external soiling which included grimy, black-ish colored smears, and yellow-ish colored dried debris. The interior of the unit was heavily soiled with yellow-ish colored spills that were wet-to-the-touch, and dried yellow-ish, brown-ish, red-ish, orange-ish, pink-ish and black-ish colored grime, dried spills, and raised -to -the-touch debris. The rubber gasket was soiled with grime and black-ish colored mold. In an interview at that time, the Food Service Director (FSD) stated that the porter cleans the chest freezer every 2 days, and it looked like it should be cleaned again. The FSD was asked if the chest freezer was in a sanitary condition for food storage and stated no, they then revised their initial statement, and stated that their process is to clean the chest freezer unit after every meal, the unit is emptied, and cleaned, and it did not look like it had been cleaned after the dinner meal last night. 2) A walk-in refrigerated unit contained: a. A heavily soiled, blue, cloth-like grocery bag was observed stored on a shelf next to other food items. In an interview at that time, the FSD stated the bag had stains, and they did not know when it was last washed. The FSD stated that the bag belonged to recreation and contained items for the resident's Coffee Social, which included coffee creamer, whipped cream, and syrups. The FSD stated that the Activities department did not have a separate refrigerator for food storage. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview at that time, the unit Licensed Practical Nurse (LPN #1) stated that they had just changed the thermometer in that refrigerator, as the previous thermometer had read 44 degrees (F). 5) During an observation of meal service food temperatures conducted on 11/13/23 at 11:41 AM the following were observed: e. The cook (cook #1) was observed wearing gloves, they placed their hands into a drawer to retrieve alcohol wipes while still wearing the gloves, and then proceeded to sanitize the thermometer probe and check the temperature of a hot food item. In an interview at the time, cook #1 stated they should have removed their gloves and washed their hands. f. The FSD was observed assisting cook #1 by opening alcohol wipes with their bare hands and handing the wipes to cook to sanitize the thermometer probe. In an interview at that time, the FSD stated they had just washed their hands, they should have put on gloves immediately after and before touching something that was going to touch the thermometer. 10 NYCRR 415.14(h)