STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335226	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vestal Park Rehabilitation and Nursing Center	1501 Route 26 South, Vestal, NY 13850

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 48446 Based on observation, record review, and interview during the recertification and abbreviated (NY00323929 and NY00339707) surveys conducted 7/22/2024-7/26/2024, the facility did not ensure residents were treated with respect and dignity in a manner and environment that promoted maintenance or enhancement of quality of life for 1 of 1 resident (Resident #71) reviewed. Specifically Resident #71's urinary catheter drainage bag was uncovered and visible to other residents, visitors, and staff. The facility policy, Quality of Life-Dignity, revised 3/2024 documented residents should be cared for in a manner that promoted and enhanced their sense of well-being, level of satisfaction with life, feeling of self-worth and self-esteem. Residents were treated with dignity and respect at all times. Staff was expected to promote dignity and assist residents in keeping urinary catheter bags covered. Resident #71 had diagnoses including chronic kidney disease, dementia, and urinary retention (neurogenic bladder, lack of bladder control due to a nerve problem). The 4/17/2024 Minimum Data Set assessment documented the resident had moderately impaired cognition, was dependent for all activities of daily living, and had a urinary catheter. A physician order dated 7/18/2024 documented Foley catheter 16 French (size) with 10 cubic centimeter balloon (used to anchor the catheter in the bladder) for a diagnosis of neurogenic bladder (lack of bladder control). The comprehensive care plan initiated 9/26/2022 and revised 7/12/2024 documented the resident had Enhanced Barrier Precautions deficit related to having a urinary catheter. The following observations were made of Resident #71: - on 7/22/2024 at 10:40 AM in their room. The resident's uncovered urinary drainage bag could be seen from the hallway. The bag was hanging from the lower side of the bed on the door side and contained yellow urine. - 7/23/2024 at 12:45 PM in the day room with the uncovered catheter drainage bag attached to their chair. Other residents were in the area and one resident was being fed by staff. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335226	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vestal Park Rehabilitation and Nursing Center	1501 Route 26 South, Vestal, NY 13850

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/23/2024 at 3:32 PM, Certified Nurse Aide #28 stated it was nursing's responsibility to make sure catheter bags were covered. Failure to have it covered was a dignity issue. During an interview on 7/25/2024 at 12:55 PM, Registered Nurse Unit Manager #16 stated they had seen residents in public areas with catheter bags not covered and educated staff. They expected catheter bags to be covered and it was a dignity and an infection control issue if they were not. During an interview on 7/26/2024 at 9:28 AM, the Director of Nursing stated catheter bags should be covered even in the residents' room if the bag was visible from the hallway because it was a dignity issue. 10 NYCRR 415.5(b)(1-3)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335226	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vestal Park Rehabilitation and Nursing Center	1501 Route 26 South, Vestal, NY 13850

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 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** 48446 50561 Based on observation, record review, and interviews during the recertification survey conducted 7/22/2024-7/26/2024, the facility did not ensure the development and implementation of a comprehensive person-centered care plan for 4 of 6 residents (Resident #20, #69, #71, and #83) reviewed. Specifically, Resident #71's and #83's care plan did not include the use of an anticoagulant (blood thinner) or insulin (used to treat diabetes); Resident #20's care plan did not include the use of insulin; and Resident #69's care plan did not include specific resident centered care interventions for behavioral symptoms. Findings include: The facility policy, Care Planning/Care Conference revised 9/2017, documented the facility would ensure that a comprehensive care plan was developed for each resident that included measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs. The facility policy, Dementia-Clinical Protocol, revised 3/2022 documented the interdisciplinary team would identify a resident centered care plan to maximize remaining function and quality of life and would adjust interventions and the overall plan depending on the individual's progression of dementia. 1) Resident #83 had diagnoses including pulmonary emboli (a blood clot in the lung) and diabetes. The 7/11/2024 Minimum Data Set documented the resident had moderately impaired cognition and received daily insulin injections and an oral anticoagulant. Physician orders documented the following: - on 6/30/2023 an order for Eliquis (anticoagulant) twice a day for pulmonary embolism. - on 3/8/2024 an order for Basaglar (long-acting insulin) via pen injector once daily for type 2 diabetes mellitus. -on 5/15/2024 an order for Fiasp (fast-acting insulin) according to a sliding scale (the amount of insulin administered was based on results of finger stick blood sugar levels) via pen injector three times a day for type 2 diabetes mellitus. There was no documented evidence of a Comprehensive Care Plan that included the use of an anticoagulant for history of a pulmonary embolism or a diagnosis of diabetes with the need for insulin administration. The 6/9/2024 Registered Nurse #42 progress note documented the resident had coffee ground emesis (a type of vomit that could indicate internal bleeding), had a positive hemoccult (a test that detects blood in stool), and was sent to the emergency room for evaluation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335226	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vestal Park Rehabilitation and Nursing Center	1501 Route 26 South, Vestal, NY 13850

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/26/2024 at 10:54 AM, Certified Nurse Aide #34 stated If someone was diabetic it would be on their care plan for the aides to see. They would monitor the type of food a diabetic resident was given and report if the resident was lethargic. They would not be able to see if a resident was on a blood thinner. They knew Resident #83 was a diabetic and often asked for snacks and usually ate well. During an interview on 7/26/2024 at 11:07 AM, Certified Nurse Aide #39 stated they could see what medical conditions a resident had by looking in the computer. If they knew someone was a diabetic, they would watch sugar intake and make sure appropriate snacks were given. If someone was on a blood thinner, they were told by nursing as they did not cut nails for those residents. During an interview on 7/26/2024 at 11:27 AM, Registered Nurse #15 stated care plans were generated by the Nurse Manager and the admissions nurse. They expected care plans to include whether a resident was a diabetic or on any high-risk medications such as insulin and anticoagulants so staff could be aware of any detrimental effects such as bruising. Resident #83 was a diabetic and received glucose checks before meals. During an interview on 7/26/2024 at 11:49 AM, Licensed Practical Nurse Unit Manager #14 stated care plans were updated with any incidents and as needed. A registered nurse had to enter the care plan problems and goals. Once entered, they could update the care plan and could choose to have interventions populate so the certified nurse aides had access to that information. Residents that were only at risk for a problem would have a care plan with generic interventions but if they had an actual problem there would be specific interventions tailored to that resident. They felt medical conditions such as diabetes and use of certain medications such as anticoagulants should be care planned due to needed monitoring for bleeding and diabetic symptoms. Resident #83 was taking Eliquis and two different insulins and should have related care plans due to the need for monitoring for bleeding and diabetic symptoms. 2) Resident #20 had diagnose including diabetes. The 4/30/2024 Minimum Data Set documented the resident had severely impaired cognition and received daily insulin injections. Physician orders documented the following: - on 3/9/2024 an order for Lispro (fast-acting insulin) according to a sliding scale via pen injector three times a day for type 2 diabetes mellitus. - on 3/27/2024 an order for Levemir (long-acting insulin) via pen injector once daily for type 2 diabetes mellitus. There was no documented evidence of a Comprehensive Care Plan that included a diagnosis of diabetes with the need for insulin administration. During an interview on 7/26/2024 at 11:27 AM, Registered Nurse #15 stated Resident #20 was a diabetic and received insulin. They expected there to be a care plan for insulin to better monitor for detrimental effects. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335226	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vestal Park Rehabilitation and Nursing Center	1501 Route 26 South, Vestal, NY 13850

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/26/2024 at 11:07 AM, Certified Nurse Aide #39 stated Resident #20 was a diabetic and ate well. There was a white board in their room that intakes and glucose levels were documented on it for the family to see. During an interview on 7/26/2024 at 11:49 AM, Licensed Practical Nurse Unit Manager #14 stated Resident #20 was a diabetic and received insulin daily. They did not have a diabetes care plan but should have due to the need for monitoring of diabetic symptoms. 3) Resident #69 had diagnoses including dementia, depression, and restlessness and agitation. The 6/30/2024 Minimum Data Set documented the resident had severely impaired cognition, did not exhibit behavioral symptoms, and received antidepressants daily. Physician orders documented the following: -On 1/22/2024 an order for Melatonin (a supplement used to promote sleep) 3 milligrams once daily for insomnia. -On 2/8/2024 an order for Trazodone (an antidepressant) 50 milligrams once daily for insomnia. -On 1/22/2024 an order for Sertraline (an antidepressant) 25 milligrams once daily for depression. -On 5/20/2024 an order for Remeron (an antidepressant) 15 milligrams once daily for depression. -On 6/18/2024 an order for Memantine (a medication used to treat confusion) 5 milligrams once daily for dementia with behavioral disturbance. -On 7/3/2024 an order for Nudexta (a medication used to treat excessive crying) 20-10 milligrams twice daily for dementia with behavioral disturbance. The nursing progress notes from 5/7/2024-7/22/2024 documented frequent behavioral symptoms including yelling, crying, [NAME], screaming, symptoms of anxiousness, and verbalizations of feeling lonely and sad. There were frequent unsuccessful attempts to determine the cause of behaviors or to successfully redirect the resident. The Comprehensive Care Plan documented: - on 1/24/2024 the resident had severe cognitive loss due to dementia. Interventions included allow ample time to absorb and respond to information; assess contributing factors to cognitive loss; consult with family as needed; explain all treatments and procedures; engage in conversation that was meaningful to the resident; monitor for changes in cognition; staff would not rush or show impatience; provide calm therapeutic environment and structured routine; and provide verbal/visual reminders as needed. - on 5/22/2024 the resident was diagnosed with depression and was prescribed medication to assist with symptom management. Interventions included consult with pharmacy and physician to consider dosage reduction when clinically appropriate, nursing staff would administer medications as ordered and monitor for any adverse side effects and report to physician and monitor for signs and symptoms of depression and report to physician and social worker. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335226	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vestal Park Rehabilitation and Nursing Center	1501 Route 26 South, Vestal, NY 13850

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident was observed on 7/22/2024 at 1:00 PM, in bed in their room hollering out indistinct words. There was no staff interaction with the resident. At 3:40 PM, in their room yelling out loudly and crying. No staff were observed interacting or attempting to soothe the resident. There was no documented evidence of person centered specific interventions used when the resident had behavioral symptoms and was crying out. During an interview on 7/26/2024 at 10:54 AM, Certified Nurse Aide #34 stated Resident #69 was overwhelmed a lot and if they were around too many people, they would cry out more than usual. They were unsure if there were specific care plan interventions for the resident. The certified nurse aide looked at the care log section of the electronic medical record system and stated none was listed for behavior interventions. During an interview on 7/26/2024 at 11:07 AM, Certified Nurse Aide #39 stated there were some behavior interventions listed in the care plans. They were unsure where in the new medical record system behaviors were found. Resident #69 could be whiney and felt lonely when left alone in their room. They found encouraging deep breathing, counting to 10, singing, and staying around other people helped to calm the resident. They were not aware of any specific care plan interventions that were in place for the resident. During an interview on 7/26/2024 at 11:27 AM, Registered Nurse #15 stated Resident #69 was anxious, yelled out, and cried a lot. They were not sure if the resident had a dementia care plan problem or if there were any specific interventions in place for the resident's behavioral symptoms. During an interview on 7/26/2024 at 11:49 AM, Licensed Practical Nurse Unit Manager #14 stated Resident #69 had difficulties dealing with their emotions and cried a lot. The resident was discussed many times at the weekly risk management meetings, had psychiatric consults, medical testing, and various medication changes to manage behavioral symptoms. Nudexta was most recently added and seemed to be working as what started as a regular behavior was now only an intermittent behavior. There was little in the care plan related to managing behaviors other than generic interventions. They felt there should be specific interventions tailored to the resident. 10NYCRR 415.11(c)(1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335226	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vestal Park Rehabilitation and Nursing Center	1501 Route 26 South, Vestal, NY 13850

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 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. 35045 Based on observations, record review, and interview during the recertification and abbreviated (NY00289910, NY00305753, NY00316721, NY00323929, and NY00339707) surveys conducted 7/22/2024-7/26/2024, the facility did not ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 2 of 7 Residents (Residents #88 and #127) reviewed. Specifically, Resident #88 was not assisted with shaving and Resident #127 was not assisted with showering and oral care. Findings include: 1) Resident #88 had diagnoses of age-related osteoporosis (weak/brittle bones), tremors, and depression. The 6/15/2024 Minimum Data Set assessment documented the resident had intact cognition, had no behavioral symptoms, did not reject care, and required supervision/touch assistance with personal hygiene. The Comprehensive Care Plan revised 3/2024 documented the resident had impairment with activities of daily living function/physical mobility related to weakness. Interventions required supervision/touch assistance of 1 for personal hygiene. The 7/2024 resident care instructions documented the resident required supervision/touch assistance of 1 for personal hygiene. The instructions did not include shaving preferences. During observations on 7/22/2024 at 11:14 AM and 7/23/2024 at 8:31 AM, the resident had dark facial hair on their upper lip and their chin. On 7/23/2024 at 12:31 PM, the resident had dark facial hair on their upper lip and their chin. The resident stated they did not like the facial hair and wanted it shaved. They stated they had their shower that day and the certified nurse aide did not have time to shave them. During an interview on 7/24/2024 at 10:21 AM Certified Nurse Aide #29 stated they were responsible for ensuring residents were clean, had their hair washed, had nail care, and were shaved on their shower day. They stated when care was completed, they documented it on the Point of Care activities of daily living sheet. Resident #88 had a shower the previous day and they did not shave the resident. If a resident was not shaved and wanted to be, it could be a dignity issue. The Point of Care History for performance of activities of daily living did not document personal hygiene was completed for the resident from 7/19/2024-7/26/2024. During an interview on 7/25/2024 at 12:55 PM Registered Nurse Unit Manager #16 stated resident care included washing, oral care, nail care, and shaving. The certified nurse aides were responsible for resident care and if the resident wanted to be shaved, they expected the certified nurse aides to shave them. It was a dignity issue if they were not shaved per their preference. During an interview on 9/28/2024 at 9:28 AM, the Director of Nursing stated the resident's personalized care plan should be followed regarding activities of daily living and the Unit Managers were responsible for checking that documentation was completed and rounding on the residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335226	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vestal Park Rehabilitation and Nursing Center	1501 Route 26 South, Vestal, NY 13850

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) Resident #127 had diagnoses of cerebral vascular accident (stroke), hemiplegia and hemiparesis (muscle weakness and paralysis affecting one side of the body), and depression. The 5/8/2024 Minimum Data Set assessment documented the resident had moderately impaired cognition, required substantial/maximum assistance of 1 for bathing/showering, and partial/moderate assistance of 1 for dressing. The comprehensive care plan initiated 5/22/2024 last reviewed 7/18/2024 documented the resident had impaired activities of daily living performance/physical mobility related to left sided hemiparesis (paralysis) and right sided weakness, decreased muscle strength and coordination, balance deficit and neurological impairment. Interventions included partial/moderate assistance of 1 for bathing/showering, set up assistance for oral hygiene and supervision/touch assistance with personal hygiene. The 7/2024 resident care instructions documented the resident required partial/moderate assistance of 1 for bathing or showering and partial/moderate assistance of 1 staff for oral hygiene. During an observation and interview on 7/23/2024 at 9:02 AM, Resident #127 was sitting in their wheelchair wearing a t-shirt, a flannel shirt, and sweatpants. They stated they had not had a shower in 3 weeks and needed assistance with brushing their teeth. Their teeth were yellow, and their breath had an unpleasant odor. They stated therapy used wipes to wipe them down, but they wanted a real bath or shower. At 1:38 PM, the resident was sitting in their wheelchair in the same clothing. They stated all they wanted was a shower on Sunday and did not want to smell bad when visitors came to see them. During an observation and interview on Wednesday, 7/24/2024 at 8:49 AM, the resident was dressed and sitting in their wheelchair. They stated they had not had their shower and it did not matter anymore. They stated they would get a shower on Sunday. The Point of Care History for activities of daily living did not include documentation of a shower or oral hygiene from 7/22/2024-7/26/2024. During an interview on 7/24/2024 at 12:38 PM, Certified Nurse Aide #40 stated resident care plans were printed and posted in their closets, so the aides knew how to care for them. The shower list was at the nursing station and included who was to be showered. If therapy showered a resident, they told the nurses. All rooms were private so showers could be performed. They stated it was unacceptable for Resident #127 to not have a shower and it was undignified. Agency certified nurse aides had no access to the electronic medical record system so they could not document a shower was given, but they would tell regular staff that one was completed. During an interview on 7/25/2024 at 2:17 PM Registered Nurse Unit Manager #24 stated they were not aware Resident #127 had not showered in 3 weeks. They stated the resident required assistance with oral hygiene and the certified nurse aides should have completed both tasks. If the resident had not received showers or oral hygiene in 3 weeks, it could lead to increased risk of infections, including dental caries (cavities). NY10CRR 415.12 46276 48446

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335226	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vestal Park Rehabilitation and Nursing Center	1501 Route 26 South, Vestal, NY 13850

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 35045 Based on observation, record review, and interview during the recertification survey conducted 7/22/2024-7/26/2024, the facility did not ensure the resident environment remained as free of accident hazards as is possible for 3 of 3 residents (Resident #127, #148, and #146) reviewed. Specifically, Residents #127, #148 and #146 had medications left unattended in their rooms. Additionally, there was no documented evidence Residents #127, #148 and #146 were assessed to determine their ability to safely administer medications or had physician orders to self-administer their medications. Findings include: The facility policy, Administration Procedures for All Medications, dated 8/2020 documented medications would be administered in a safe and effective manner. The facility policy, Self- Administering of Medications, dated 5/8/2015 documented each resident's ability to self-administer mediation would be assessed upon admission. The interdisciplinary team would meet and complete an assessment form to decide to trial a resident for self-administration of medications. The charge nurse would meet with the resident to review and sign the assessment form of when to self- administer medications and review the self- administration procedure. The medication administration record would be labeled to identify the resident able to self-medicate. 1)Resident #127 had diagnoses including cerebral vascular accident (stroke), hypertensive urgency (clinical situation in which the blood pressure is very high with minimal or no symptoms) and hemiplegia (muscle weakness or partial paralysis on one side of the body). The 5/28/2024 Minimum Data Set assessment (health assessment screening tool) documented the resident had moderately impaired cognition, required partial to maximal assistance for activities of daily living, and received insulin, antidepressant, and antiplatelet medications daily. The Comprehensive Care Plan initiated on 5/22/2024 documented the resident had moderately impaired cognitive skills for daily decision making. The care plan include documentation the resident was evaluated or capable for self-administration of medications. The 5/22/2024 physician orders included the following medications: - hydralazine 25 milligrams (for hypertension)1 tablet orally three times a day: 6:00 AM-10 AM, 1:00 PM - 3:00 PM, and 6:00 PM - 10:00 PM. - amlodipine 10 milligrams (for hypertension) 1 tablet oral once a day, due between 6:00 AM-10:00 AM. - aspirin 81 milligrams (for cerebral infarction, blood thinner) 1 tablet oral once a day, due between 6:00 AM-10:00 AM. - chlorthalidone tablet 25 milligrams (for hypertensive urgency) 1 tablet oral once a day, at 10:00 AM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335226	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vestal Park Rehabilitation and Nursing Center	1501 Route 26 South, Vestal, NY 13850

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- citalopram tablet 20 milligrams (antidepressant) 1 tablet oral once a day at 8:00 AM. - clopidogrel tablet 75 milligrams (blood thinner) 1 tablet oral once a day due between 6:00 AM - 10:00 AM. - ferrous sulfate 325 milligrams (iron supplement) 1 tablet oral once a day, 6:00 AM - 10:00 AM. - lisinopril tablet 20 milligrams (high blood pressure) 1 tablet oral once a day, 6:00 AM-10:00 AM. - pantoprazole 40 milligrams (for acid reflux disease) 1 tablet oral twice a day, due between 6:00 AM - 10:00 AM and 6:00 PM to 10:00 PM. - ascorbic acid 250 milligrams (vitamin C) oral once a day at 8:00 AM. - ezetimibe 10 milligrams (treats high cholesterol) 1 tab oral once a day between 6:00 AM - 10:30 AM. There was no physician order for self- administration of medications. During an observation and interview on 7/23/2024 at 8:59 AM, there were 9 pills in a plastic medication cup on Resident #127's bedside table. Resident #127 stated they did not know what they were, but the nurse put them there at 6:30 AM. They stated they did not take their medicine until they ate breakfast after 9:00 AM and the nurse should not have left them there. They stated they were a nurse, and medications should not be left with patients because someone else could take them or the patient may forget to take them. At 1:37 PM, the resident stated they took all their medications that morning after they ate their breakfast. They were not sure what the medications were for, they just took them. The nurses knew they would not take the medicine until after breakfast, but they still brought the medicine early. During an observation and interview on 7/24/2024 at 8:32 AM, there were several pills in a plastic medication cup on the resident's bedside table that was set up in front of the resident while they were sitting in their wheelchair. The resident stated they would take them after they ate their breakfast. During an interview on 7/24/2024 at 8:36 AM, Licensed Practical Nurse #22 identified the medications that were in the plastic cup in Resident #127's room. They stated they were amlodipine, chlorthalidone, hydralazine, and lisinopril for blood pressure, pantoprazole for reflux disease and vitamin C for anemia, citalopram for depression, clopidogrel, aspirin and ezetimibe for stroke prevention. They stated these medications were due between 6:00 AM- 10:00 AM. The resident did not have an order to self-administer medication. They should not leave the medications at the bedside, but the resident was good at taking them on their own. They stated they brought the medicine to the resident about an hour ago and there was no good reason the medications were left at the bedside. They should go back to the resident after they ate their breakfast and give their pills then. They stated they circled back around to make sure the resident took their medications and was not worried about the resident taking them. They stated leaving the medication in the resident room was a bad habit. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335226	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vestal Park Rehabilitation and Nursing Center	1501 Route 26 South, Vestal, NY 13850

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/24/2024 at 1:42 PM, Registered Nurse Unit Manager #24 stated leaving medication at the bedside was not acceptable. The nurse should never leave medication at the bedside unless the resident had a medication self-administration medication order. It was a lengthy process that included an assessment by the nurse, a physician order, a daily evaluation, and an updated care plan. They were not aware the resident had medication at the bedside for the last 3 days. 2) Resident #148 had diagnoses including chronic obstructive pulmonary disease (lung disease), hypertension, and history of nicotine dependence. The 5/6/2024 Minimum Data Set assessment documented the resident had moderately impaired cognition, required partial/moderate assistance with activities of daily living, and received anticoagulation, antibiotic, diuretic, and opioid medications. The Comprehensive Care Plan initiated on 4/20/2024 documented the resident had moderately impaired cognitive skills for daily decision making. The care plan did not include documentation the resident was evaluated or capable of self-administration of medications. The 5/1/2024 physician orders documented the following medications: -Nicotine patch 24-hour, 7 milligrams/24 hour, 1 patch (to treat nicotine dependence) transdermal due between 6:00 AM - 10:00 AM. -Stioloto Respimat (inhalation spray for chronic obstructive pulmonary disease) 2.5-2.5 micrograms/actuation; 2 inhalations; inhale once a day between 6:00 AM - 10:00 AM. There was no physician order for self- administration of medications. During an observation and interview on 7/22/2024 at 12:10 PM, there was an unused nicotine patch and a Stioloto Respimat inhaler on the resident's bedside table. Resident #148 stated those medicines were not usually left at the bedside, but over the last four or five days things had changed. There were different nurses doing different things. They stated they used the inhaler for 5 years. At 12:51 PM, the nicotine patch remained on the table when staff brought the resident their lunch tray. The resident said they wanted to wait and put the nicotine patch on but was waiting to take a shower. The 7/22/2024 medication administration record documented Licensed Practical Nurse #26 administered the nicotine patch at 10:00 AM and it placed on the resident's left arm and administered the Stiolto Respimat inhaler between 6:00 AM and 10:00 AM. During an observation and interview on 7/23/2024 at 12:56 PM, there was a nicotine patch on the resident's tray table. The resident stated they never applied the patch on 7/22/2024 but the nurse had put the nicotine patch on them today. During an interview on 7/23/2024 at 1:05 PM, Registered Nurse #15 stated the patch on the resident's bed side table was from the previous day. They applied the nicotine patch at 7:30 AM this morning. The resident did not have a self-administration order for the nicotine patch or any of their medications. Medications should not be left at the bedside. A resident could forget to take the medication, medications could get thrown away accidently, and the resident may not get the effective dose of their medications. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335226	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vestal Park Rehabilitation and Nursing Center	1501 Route 26 South, Vestal, NY 13850

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/24/2024 at 9:33 AM, Registered Nurse #27 stated the resident did not have an order to self-administer any of their medications. If they did have an order, it would be listed on the for your information section in the electronic medication record. During an interview on 7/24/2024 at 1:50 PM, Registered Nurse Unit Manager #24 stated the resident did not have orders to self-administer any of their medication. If the resident did not want their patch at that time, they should reapproach the resident later to apply the patch. 3) Resident #146 had diagnoses including chronic obstructive pulmonary disease (lung disease) and paranoid delusions. The 4/18/2024 Minimum Data Set assessment documented the resident had intact cognition, was independent with most activities of daily living, and received an anticoagulant (blood thinner) and diuretic (water pill) daily. The Comprehensive Care Plan updated on 7/4/2024 did not document the resident was able to self-administer medications. The 7/17/2024 physician orders documented: - aspirin 81 milligrams one tablet oral, due between 6:00 AM- 10:00 AM. - bumetanide (diuretic) 1 milligram, one tablet oral every other day, due between 6:00 AM - 10:30 AM - Eliquis 5 milligrams (blood thinner)1 tablet oral, 6 - 10 AM twice a day. - ferrous sulfate 325 milligrams (iron supplement) 1 tablet oral due between 6:00 - 11:00 AM and 6:00 PM - 11:00 PM. - pantoprazole 40 milligrams (anti reflux), 1 tablet by mouth every day 6:00 AM- 11:00 AM. - vitamin C 250 milligrams, by mouth twice a day; due between 6:00 AM- 10:00 AM and 6:00 PM- 11:00 PM - fluticasone (allergy nasal spray) 250-50 microgram/dose; 1 inhalation, twice a day, 6:00 AM-10:00 AM, and 6:00 PM - 10:00 PM - Ventolin HFA (used to treat difficulty breathing) 90 micrograms/2 puffs/inhalation; every 4 hours as needed. There was no physician order for self- administration of medications. During an observation and interview on 7/22/2024 at 1:43 PM, the resident had a medicine cup on their bedside table with 4 pills. There was a round red tablet, 1 oval peach tablet, 1 round white tablet, and 1 round pink tablet. Resident #146 stated the pills had been there since early that morning. The resident sated they get the wrong medications sometimes and did not take all their medications if the nurses did not tell them what the medicine was. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335226	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vestal Park Rehabilitation and Nursing Center	1501 Route 26 South, Vestal, NY 13850

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A 7/23/2024 at 9:40 PM, Registered Nurse #10 progress note documented the resident was not to have their inhaler in their room and the physician told them they could have it at the bedside due to their chronic obstructive pulmonary disease. During an observation and interview on 7/23/2024 at 1:04 PM, Resident #146 had their albuterol inhaler at the bedside, labeled with directions to inhale two puffs every 4 hours as needed for shortness of breath. The resident stated they did not feel safe without their inhaler at the bedside. They had a stack of empty medicine cups on their bedside table. The resident stated this was what the nurses placed their medications in, and some nurses leave the pills with them because they did not like to take their medication until after they ate. They stated the pills in the cup the day before were Eliquis, and one for digestion, and vitamin C, potassium, and a cholesterol medication. They stated there was iron and a high blood pressure pill, and they did not have high cholesterol or high blood pressure and did not need the iron, so they threw those pills in the trash. During observation and interview on 7/23/2024 at 1:50 PM, Licensed Practical Nurse #9 stated the resident had a rescue inhaler at their besides and it was usually for asthma or chronic obstructive pulmonary disease. They stated they did not give the inhaler to the resident and assumed it was an as needed order and must have been left by another nurse. They reviewed the resident orders and there was no order for inhaler to be left at the bedside. During medication observation on 7/24/2024 at 11:13 AM, Registered Nurse #8 stated the resident has asked them to leave their medications on the table in the past, and they would not leave them as the resident did not have a medication self- administration medication order. The medications the nurse prepared to administer included aspirin 81 milligrams, ferrous sulfate 325 milligrams, Eliquis 5 milligrams, pantoprazole 40 milligrams, Vitamin C, fluticasone inhaler, and acetaminophen. The resident refused their iron pill. During an observation and interview on 7/25/2024 at 10:35 AM, the resident had an albuterol inhaler at their bedside inside a plastic bag- labeled with directions: 2 puffs every 4 hours as needed. The resident stated they the nurses kept trying to take their inhaler away. They told them they needed the inhaler because of their asthma and shortness of breath so the nurse left it at their bedside. During an interview on 7/25/2024 at 10:36 AM, Registered Nurse #8 stated the resident had their inhaler at the bedside, and they were aware they were not supposed to have it at the bedside. The physician was aware and there was a note in the medical record. The resident did not have a medication self-administration order for the albuterol inhaler. The resident refused to give the inhaler back to the staff. They did not notify the physician. They were told there was a note in the resident record about the physician talking with the resident and allowing the resident to keep the inhaler at bedside. During an interview on 7/26/2024 at 9:28 AM, the Director of Nursing stated they were not sure if there were any residents with a medication self- administration order. The facility policy for medications to be left at the bedside would include a registered nurse assessment to deem that the resident was safe for self-administration, then they would take this assessment to the physician who would place an order for self-administration. The care plan would be updated for medication self- administration. Nurses should not leave medication at the bedside if there was not a physician order for self- administration. This was not safe, and staff would not be able to ensure the medications were taken timely or safely. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335226	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vestal Park Rehabilitation and Nursing Center	1501 Route 26 South, Vestal, NY 13850

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10NYCRR 415.12(h)(2) 46276

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335226	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vestal Park Rehabilitation and Nursing Center	1501 Route 26 South, Vestal, NY 13850

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 48895 Based on record review and interview during the recertification survey conducted 7/22/2024-7/26/2024, the facility did not ensure licensed nurses had specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care for 4 licensed nurses (Licensed Practical Nurses #22, #26, #35 and Registered Nurse #27); and did not ensure certified nurse aides were able to demonstrate competency in skills and techniques necessary to care for resident's needs, as identified through resident assessments, and described in the plan of care for 2 certified nurse aides (Certified Nurse Aides #12 and #36). Specifically: - Licensed Practical Nurse #22 left medications at a resident's bedside who did not have a physician order for medication self-administration. Licensed Practical Nurse #22 did not receive an annual competency evaluation for medication administration. (see F 689) - Certified Nurse Aide #12 was observed entering a resident's room who was on transmission based precautions, without proper personal protective equipment and without performing appropriate hand hygiene. There was no documented evidence Certified Nurse Aide #12 had competencies or education provided by the facility, specifically infection control practices. (See F 880) - Certified Nurse Aide #36 had no documented competencies or education provided by the facility - Licensed Practical Nurses #26, #27, and #35 had no documented competencies or education provided by the facility. Findings include: The 2/2016 facility policy, Nursing Policy, documented Staff Development/Nurse Educator was responsible for supervising the skilled training program for new nursing personnel. The 5/2022 facility policy, Orientation Program for Newly Hired Employee and Volunteers, documented the orientation program was separate from the role-specific training and/or in-service training of new and existing staff. The orientation included an introduction to resident care procedures, administration structure, infection control practices, and call light and intercom system. In addition to the general orientation, each department orients the newly hired employee/volunteer to their department's policies and procedures. Records of orientation were filed in the personnel file upon completion of orientation programs, and completed copies of the employee orientation checklists were filed in the employee's personnel file. The 3/19/2024-7/16/2024 Facility Assessment, documented skill nursing needs that included oxygen, suctioning, tracheostomy, intravenous medications, isolation, feeding tubes, mechanically altered diet, catheterization, ostomy, toileting programs, injections, immunizations, bariatrics, insulin, psychoactive medications, anticoagulants, antibiotics, diuretics. Competencies and training are conducted upon hire as part of general orientation, annually and as needed. There was no documented evidence of a policy and procedure for competency evaluations. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335226	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vestal Park Rehabilitation and Nursing Center	1501 Route 26 South, Vestal, NY 13850

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility used agency nursing staff to provide direct patient care to the residents from 7/22/2024 - 7/24/2024. - on 7/22/2024, the facility used 22 agency staff. - on 7/23/2024, the facility used 27 agency staff. - on 7/24/2024, the facility used 24 agency staff. Nursing personnel records were reviewed, for the following agency staff, all starting at the facility in 2024: - Certified Nurse Aide #12 had no documented competencies or education provided by the facility. - Certified Nurse Aide #36 had no documented competencies or education provided by the facility. - Licensed Practical Nurse #35 had no documented competencies or education provided by the facility. - Licensed Practical Nurse #26 had no documented competencies or education provided by the facility. - Registered Nurse #27 had no documented competencies or education provided by the facility. Licensed Practical Nurse #22's last medication administration competency was documented as 4/28/2022. An electronic communication from the Administrator dated 7/25/2024 at 10:18 AM, documented the agency staff were provided an on-floor orientation with the understanding that the agency was providing nursing competencies and education for common nursing practices prior to assignment. During an interview on 7/25/2024 at 11:03 AM, Licensed Practical Nurse Unit Manager #14 stated the agency did not receive competencies in the facility. They attended on the unit in-service trainings. They did not go to orientation. Agency staff came in and did the job. There were certified nurse aides and licensed practical nurses on their unit that were from an agency. The Director of Nursing might ask a nurse to walk agency staff around the unit, but there was no formal orientation. During an interview on 7/25/2024 at 2:46 PM, Registered Nurse Unit Manager #24 stated they had agency staff on their unit. They had never seen the facility complete a medication administration observation for agency staff and they did not get a formal orientation. They tried to give any new agency staff a walk around of the unit when they were assigned to their floor. During an interview on 7/25/2024 at 4:54 PM, the Staffing Coordinator stated the standard orientation and orientation packet was only for in-house (employed directly by the facility) staff. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335226	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vestal Park Rehabilitation and Nursing Center	1501 Route 26 South, Vestal, NY 13850

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 7/26/2024 at 11:12 AM, Nurse Educator #38 stated they completed the initial medication administration observation with new staff, when the nurse started at the facility, and then annually, usually in December. They did episodic training as needed. Agency staff received education if they did on unit in-service training when the agency staff member was working. Agency staff did not receive general orientation, and they did not complete competencies. The Nurse Educator was unsure how the facility ensured the agency staff were competent to provide direct care to the residents. They stated ensuring competency was important for the safety of the residents, and to ensure the nurses knew what they were doing before they went out and provided care. Licensed Practical Nurse #22's full training file was provided, everything they had completed was in the folder. During an interview on 7/26/2024 at 9:28 AM, the Director of Nursing stated agency staff did not get orientation. They showed up to the unit and got a brief report from the Unit Manager or the Assistant Director of Nursing. 10 NYCRR 415.26(c)(1)(iv)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335226	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vestal Park Rehabilitation and Nursing Center	1501 Route 26 South, Vestal, NY 13850

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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 48895 Based on observation and interview during the recertification survey conducted 7/22/2024-7/26/2024, the facility did not post daily at the beginning of each shift, the current resident census and the total number and the hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift, and accessible to residents and visitors for 4 of 5 days reviewed. Specifically, the nurse staffing was not consistently posted. Finding included: The facility did not have documented policy and procedures regarding daily posted staffing. The daily nursing staffing information was observed in a glass cabinet in the main lobby: - on 7/22/2024 at 10:10 AM, 11:35 AM, and 2:20 PM, the daily posted staffing document was dated 7/15/2024. - on 7/23/2024 at 9:08 AM, the daily posted staffing document was dated 7/22/2024 and did not have nurse staffing information for the evening and overnight shifts. - on 7/24/2024 at 4:02 PM, the daily posted staffing document was dated 7/24/2024, and did not have nurse staffing information for the evening shift. - on 7/24/2024 at 4:55 PM, there was no daily posted staffing document. - on 7/25/2024 at 8:08 AM, there was no daily posted staffing document. - on 7/25/2024 at 4:53 PM and 5:19 PM, the daily posted staffing document was dated 7/25/2024, and did not have nurse staffing information for the evening shift. During an interview on 7/25/2024 at 9:55 AM, receptionist #7 stated that either the building Supervisor or the Staffing Coordinator were responsible for posting the daily staffing in the cabinet. During an interview on 7/25/2024 at 11:46 AM, Staffing Coordinator #4 stated they made the schedule, and provided the information to the Director of Nursing and the building Supervisor. The Director of Nursing or the assigned building Supervisor posted the staffing. During a follow up interview on 7/25/2024 at 4:54 PM, Staffing Coordinator #4 stated it was important to have the staffing posted and it was required. They had provided the information to the Supervisor before they left for the day and did not know where the staffing document was posted in the lobby. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335226	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vestal Park Rehabilitation and Nursing Center	1501 Route 26 South, Vestal, NY 13850

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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/26/2024 at 10:13 AM, Registered Nurse Supervisor #5 stated they worked 7:00 AM to 3:00 PM, and they updated the glass cabinet with the day shift staffing when they came in for the day. They stated the staffing document should be completed on the evening and night shifts. They were not able to complete the full document in the morning, as they did not know the staffing past the day shift. During a telephone interview on 7/26/2024 at 10:58 AM, Registered Nurse Supervisor #6 stated they usually worked 11:00 PM to 7:00 PM, and they did not make the schedule and were not responsible for posting it. They stated they did not post the schedule anywhere, they just told staff where to go. During an interview on 7/26/2024 at 9:28 AM, the Director of Nursing stated the Nursing Supervisor on duty was responsible for posting the daily nursing staffing. They stated they or the Assistance Director of Nursing might also post it. 10 NYCRR 415.13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335226	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vestal Park Rehabilitation and Nursing Center	1501 Route 26 South, Vestal, NY 13850

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 - Few	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** 48895 Based on observation, interview, and record review during the recertification survey conducted [DATE] through [DATE], the facility did not ensure drugs and biologicals were labeled and stored in accordance with currently accepted professional principles and included the appropriate accessory and cautionary instructions when applicable for 1 of 4 medication carts (Brookside Garden medication cart), 1 of 1 treatment cart (Brookside Terrace cart), and 1 of 2 medication rooms (Brookside Terrace medication room) reviewed. Specifically, the Brookside Garden medication cart contained 3 insulin pens without opened dates; and the Brookside Terrace medication refrigerator did not have a complete record of refrigerator temperatures, and the treatment cart was unlocked. Findings include: The pharmacy services policy, Storage of Medications, dated ,d+[DATE] documented medications and biologicals were to be stored safely, securely, and properly, and followed manufacturer's recommendations. Refrigerated medication should be stored between 36- and 46-degrees Fahrenheit with a thermometer for temperature monitoring. The facility should maintain a temperature log in the storage area to record temperatures at least once a day or in accordance with facility policy. Certain medications or package types, such as multiple dose injectable vials, required an expiration date shorter than the manufacturer's expiration date once opened to ensure medication purity and potency. When the original seal of a manufacturer's container or vial was initially broken, the container or vail was to be dated. The nurse should place a date opened, sticker on the medication and record the date open and the new date of expiration. Manufacturer instructions for insulin aspart and insulin glargine documented to dispose of the insulin after 28 days, even if there was insulin remaining in the pen or vial. Insulin Pens: During an observation on [DATE] at 11:53 AM with Licensed Practical Nurse #13, the Brookside Garden, D cart contained a basaglar (insulin glargine, long-acting insulin) pen for Resident #83 without an opened date documented on the medication or the pharmacy labelled bag. Resident #83 also had a Fiasp (Insulin aspart, rapid-acting insulin) flex pen without an opened date documented on the medication and did not have a pharmacy labelled bag and was placed in the bag with the Basaglar pen. Resident #20 had a levemir (basal insulin, long-acting) flex pen without an opened date on the medication or the pharmacy labelled bag. The levemir pen was in a pharmacy labelled bag for insulin lispro (rapid-acting insulin) with another insulin pen. During an interview on [DATE] at 12:09 PM Licensed Practical Nurse #13 stated that insulin needed to be dated with an opened date because the medication was only good for 24 or 28 days. There was potential to give the resident an expired insulin. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335226	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vestal Park Rehabilitation and Nursing Center	1501 Route 26 South, Vestal, NY 13850

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 - Few	During an interview on [DATE] at 11:03 AM, Licensed Practical Nurse Unit Manager #14 stated the responsibly for checking medications in the medication care fell on them. The medication nurses on the carts should also be checking during their medication passes. They did not expect agency nurses to do anything but pass medications. They stated there was no routine schedule for checking the medication carts, but it would be useful. Insulin should be labeled with an opened date. If it did not have an open date, it would have to be discarded. Insulin was only good for 30 days, without a labeled opened dated a resident could be given expired insulin. Medication Refrigerator Temperatures: During an observation on [DATE] at 10:42 AM, the Brookside Terrace Medication Room medication refrigerator log sheet was missing temperatures for [DATE], [DATE], [DATE], and [DATE]. The refrigerator temperature was 46 degrees Fahrenheit. During an interview on [DATE] at 12:29 PM, Registered Nurse Unit Manager #16 stated that the medication refrigerator log sheet was missing temperatures. It was the responsibility of the overnight nurses to check the refrigerator temperatures and complete the log, but anyone who went into the refrigerator could document the temperature. It was important to monitor the temperature to ensure they did not go out of range. If the refrigerators went out of range, it could cause the medications to go bad. The Registered Nurse Manager put up a new reminder paper on the double lock box to help with medication room responsibilities, but they could monitor everything. Treatment Cart: During observations on [DATE] at 10:37 AM, [DATE] at 2:50 PM, and [DATE] at 8:53 AM the treatment cart on Brookside Terrace was unlocked. The treatment cart contained nystatin (anti-fungal) powder, aspercream (pain relief) cream, estrodial (estrogen hormone) cream, Volteran (pain relief) gel, sunscreen, medicated menthol patch, no rinse cleanser, thera gel shampoo (treats psoriasis/dry skin), and a spray cleaner. During an interview on [DATE] at 8:25 AM, Licensed Practical Nurse #17 stated there were creams in the treatment cart. It should be locked for safety reason as residents that wander could get into the cart. During an interview on [DATE] at 8:33 AM, Registered Nurse Unit Manager #16 stated the treatment carts had creams and other medications, such as anti-fungal and antibiotic creams. It should always be locked so residents could not get into it. During an interview on [DATE] at 9:28 AM, the Director of Nursing stated treatment carts should be locked when not in use as they might have prescription medications for wounds. Locking the cart could prevent people from getting into the contents, and there was the potential for the residents to get into the wound care supplies. Insulin pens should be labeled in the medication cart with the bag, pharmacy label, and the date it was opened. The date the insulin was opened was important to monitor the proper expiration date. The night shift licensed practical nurses typically checked the temperature of the medication refrigerator. It was important to monitor the temperature to ensure that it was within an acceptable range. If the medication refrigerator was out of range, there was potential for medications to go bad. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335226	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vestal Park Rehabilitation and Nursing Center	1501 Route 26 South, Vestal, NY 13850

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 - Few	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
	335226	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vestal Park Rehabilitation and Nursing Center	1501 Route 26 South, Vestal, NY 13850

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 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. 35045 Based on observation, interview, and record review during recertification survey conducted 7/22/2024-7/26/2024, the facility did not provide each resident with a nourishing, palatable, well-balanced diet that meets their daily nutritional needs, taking into consideration the preferences of each resident for 2 of 4 residents (Resident #107 and #148) reviewed. Specifically, Residents #107 and #148 were missing food items on their meal trays. Findings include: The undated facility policy, Meal Tray Accuracy Audit Report Policy, documented the Food Service Director was responsible for completion of the meal tray accurracy form at least three times a week. The meal tray accurracy form was used to improve accuracy of tray service, resident satisfaction, and resident diet. The week 1 Summer/Spring menu was observed hanging in the hallway in front of the Sunrise Garden nursing station on 7/22/2024 at 10:30 AM. The week 1 lunch menu choices for Monday included barbeque chicken, zesty pork chop, roast beef sandwich on wheat bread, or egg salad sandwich on wheat bread, capri vegetable, broccoli, vegetarian baked beans, steamed rice, and rocky road chocolate pudding. 1) Resident #107 had diagnoses including multiple sclerosis (a central nervous system disease), depression, and dysphagia (difficulty swallowing). The 6/27/2024 Minimum Data Set assessment documented the resident was cognitively intact, was independent with eating. and weighed 131 pounds. The comprehensive care plan initiated 3/8/2022 and revised on 4/18/2024 documented the resident was at risk for an alteration in nutritional status related to anxiety, hyponatremia (low sodium levels in the blood), multiple sclerosis, depression, Barrett's esophagus (damage to the esophogus), and gastroesophageal reflux disease (stomach acid backs up into the esophagus). Interventions included a regular diet with yogurt and milk at breakfast and estimated 1640 kilocalories day. A 2/10/2022 Physician #20 order documented a regular diet with no change in consistency. During an interview on 7/22/2024 at 11:39 AM, Resident #107 stated the food was not good and they were often missing items on their tray that were on their meal ticket. They stated one example was soup with crackers, the crackers would be missing even though they were on their meal ticket. During an observation and interview on 7/22/2024 at 1:04 PM during the lunch meal, Resident #107's meal ticket documented BBQ chicken, vegetarian baked beans, steamed rice, and rocky road chocolate pudding. Rocky road chocolate pudding and steamed rice were not included on the meal tray. Resident #107 stated they would have eaten the pudding and rice if it was on their tray. 2) Resident #148 had diagnoses including fractured left femur (thigh bone), diabetes, and hypertension (high blood pressure). The 5/6/2024 Minimum Data Set assessment documented the resident had moderately impaired cognition, required setup assistance with eating, and required a therapeutic diet. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335226	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vestal Park Rehabilitation and Nursing Center	1501 Route 26 South, Vestal, NY 13850

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 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 4/30/2024 physician order documented the resident was to receive a carbohydrate controlled diet, regular solids and thin liquids. The comprehensive care plan dated updated on 5/13/2024 documented the resident was at risk for altered nutrition/dehyration related to hypothyroidism (under active thyroid), hypertension, hip fracture, and diabetes. Interventions included regular controlled carbohydrate diet and supplement with Glucerna (nutritional supplement) at lunch and yogurt and milk at breakfast. During an interview on 7/22/2024 at 11:57 AM, Resident #148 stated the kitchen staff would offfer them food items and then the food did not come as they ordered. They stated staff did not follow the menu and at times there was food missing on their meal tray. During an observation on 7/22/2024 at 12:49 PM, Resident #148's lunch meal ticket documented a tuna sandwich on wheat, an egg salad sandwich on wheat, and broccoli. The resident received a tuna sandwich on white bread, no egg salad sandwich, and mixed oriental vegetables in place of broccoli. The resident stated they preferred wheat bread. During an interview on 7/25/2024 at 12:02 PM, the Food Service Director stated they were not out of wheat bread. They may have run short but if a resident had a preference for wheat bread for their sandwich they should be provided with wheat bread. If a resident requested broccoli as their vegetable they should have gotten that. There was a subustitute on Monday of capri mixed vegetables and the residents should have been notified of the substitution. They ran out of diet jello pudding and this should have been substituted with diet jello. The residents' meal trays were checked by several staff members prior to being brought to the unit. All food service staff was responsible to make sure the food items were accurate. 10NYCRR 415.14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335226	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vestal Park Rehabilitation and Nursing Center	1501 Route 26 South, Vestal, NY 13850

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 43754 46276 48446 Based on observation and interview during the recertification and abbreviated (NY00339707) surveys conducted 7/22/2024-7/26/2024, the facility did not ensure each resident received food and drink that was palatable, flavorful, and at an appetizing temperature for 2 of 2 meals reviewed (the 7/23/2024 lunch meal and the 7/24/2024 lunch meal). Specifically, food was not palatable or served at palatable and appetizing temperatures during the lunch meals on 7/23/2024 and 7/24/2024. Additionally, Residents #36, #88, #107 and #136 stated the food was not palatable. Findings include: The facility policy, Maintaining Food Temperatures, revised 4/2012 documented food would be prepared, stored, and transported in a manner that would ensure proper serving temperatures. During an interview on 7/22/2024 at 11:11 AM, Resident #88 stated the food was cold and lacked flavor. The chicken and rice casserole was the least flavorful of all dishes. During an interview on 7/22/2024 at 11:39 AM, Resident #107 stated the food lacked flavor and was often cold and had to be heated in the microwave. During an interview on 7/22/2024 at 11:41 AM, Resident #36 stated the food was not palatable. Tea and coffee were always cold. The food was often cold and had to be heated in the microwave. During an interview on 7/22/2024 at 2:35 PM, Resident #136 stated the pork chop was so tough they could not cut it and they had to pick it up and eat it with their fingers. During an observation and interview on 7/24/2024 at 8:31 AM, Resident #136 stated their eggs were cold and the banana was too ripe to eat. The banana peel appeared mostly brown and black. During a lunch meal observation on 7/23/2024 at 12:51 PM on the First floor Unit D, the last meal tray was selected as a test tray and a replacement tray was ordered for the resident. The temperatures were measured as follows: - pork 120 degrees Fahrenheit - stuffing 143 degrees Fahrenheit - carrots 126 degrees Fahrenheit - gelatin dessert 52 degrees Fahrenheit - Ensure (nutritional supplement) 57 degrees Fahrenheit (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335226	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vestal Park Rehabilitation and Nursing Center	1501 Route 26 South, Vestal, NY 13850

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The pork was overcooked and tough and the stuffing tasted bland. During a meal observation on 7/24/2024 at 12:02 PM meal carts for Second floor Unit C temperatures were measured on the service preparation and the fish measured at 125 degrees Fahrenheit. During a lunch meal test tray observation on 7/24/2024 at 12:38 PM on the Second floor Unit C the fish was measured at 96 degrees Fahrenheit, hot water was 118 degrees Fahrenheit, and juice was 40 degrees Fahrenheit. The fish was not hot, and the noodles lacked flavor. The juice was opened and had an ice block in the middle of the container. During an interview on 7/23/2024 at 3:32 PM, Certified Nurse Aide #28 stated residents often told them the food did not taste good, hot food was cold, and cold food was warm. Residents told them numerous times items were missing from their trays. They observed items missing from trays such as Magic Cups (nutritional supplement), fruit, and even silverware. They saw items on trays that were not listed on the resident's meal ticket and diabetics had missing items on their trays, especially Ensure. When they noticed inaccuracies or had complaints from the residents they told the kitchen staff in the kitchenette area. During an interview on 7/24/2024 at 10:21 AM, Certified Nurse Aide #29 stated residents often complained about the hot food being cold and the meal not looking appetizing. They had observed missing items from trays on several occasions like coffee, a sandwich, and thickening powder (used to thicken liquids). They observed sandwiches on white bread when the meal ticket documented wheat bread. If a resident did not eat the food because it was cold or not appetizing the resident could get upset, lose weight, and not receive the proper nutrition. During an interview on 7/24/2024 at 1:17 PM the Food Service Director stated juice came in frozen and was put in the cooler. Test trays were supposed to be completed three times a week and the results were documented. It should take 7-10 minutes to get the trays prepared and delivered to the resident. Trays should look appetizing and be served at the correct temperatures. Hot food should be above 135 degrees Fahrenheit and cold food should be between 33-41 degrees Fahrenheit. They stated 96 degrees Fahrenheit was not an acceptable temperature for fish, and the hot water for tea should be 125 degrees Fahrenheit and not 118 degrees Fahrenheit. Ensure should usually be served cold. 10NYCRR 415.14(d)(1)(2) 48895

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335226	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vestal Park Rehabilitation and Nursing Center	1501 Route 26 South, Vestal, NY 13850

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 - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43754 Based on observation, record review, and interview during the recertification survey conducted 7/22/2024-7/26/2024, the facility did not ensure food was stored, prepared, distributed, and served in accordance with professional standards for food service safety in the main kitchen. Specifically, food was not maintained at proper temperatures and the dishwasher was not maintaining the proper temperature. Findings include: The Food Service Department policy, Maintaining Food Temps, last reviewed 4/2012 documented food would be prepared, stored, and transported in a manner that would ensure proper serving temperatures. Food Temperatures: During an observation in the main kitchen on 7/23/2024 at 11:18 AM, chicken salad was observed in the walk-in cooler. The chicken salad was covered and was in a large plastic hotel sized pan that was 6 inches deep. The chicken salad contained 10 pounds of chicken, 1 gallon of mayonnaise, and additional ingredients. The chicken salad's temperature was measured at 52 degrees Fahrenheit. During an interview on 7/23/2024 at 11:19 AM, Prep Cook/Dietary Aide #55 stated they prepared the chicken salad about 10 minutes ago. The chicken was pre-cooked, and they added mayonnaise and celery and mixed it all together. They stated food could be out of temperature for up to 10 minutes for meal preparation. During an interview on 7/23/2024 at 11:21 AM, the Food Service Director stated the chicken salad was being served for the dinner meal and was served on whole wheat bread. They stated potentially hazardous food could be left out of temperature during necessary preparation for 2 hours. They stated the chicken salad would be completely cooled by the dinner meal. During an interview and observation on 7/23/2024 at 1:05 PM, the chicken salad was measured at 47 degrees Fahrenheit. The Food Service Director stated the chicken salad was moved from the bigger pan to four shallow pans because it was not cooling timely. The chicken salad had only cooled 5 degrees in nearly 2 hours, therefore was placed in the walk-in freezer to cool rapidly. After 20 minutes the temperature was measured again and was at or below 41 degrees Fahrenheit. Dishwasher Temperatures: During an observation on 7/23/2024 at 1:24 PM, the mechanical dishwasher required specifications documented on the side of the machine were as follows: - wash temperature 160 degrees Fahrenheit - final rinse temperature 180 degrees Fahrenheit (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335226	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vestal Park Rehabilitation and Nursing Center	1501 Route 26 South, Vestal, NY 13850

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 - Many	The dishwasher was observed with a wash temperature of 157 degrees Fahrenheit and a final rinse temperature of 171 degrees Fahrenheit. During an observation and interview on 7/23/2024 at 1:27 PM, Dietary Aide #56 checked the dishwasher and recorded the following in the log, wash temperature 163 degrees Fahrenheit, final rinse temperature 157 degrees Fahrenheit. They stated they got the temperatures from the digital display on the front of the dishwasher. During an interview on 7/23/2024 at 1:40 PM the Food Service Director stated the wash temperature was between 150-160 degrees Fahrenheit and the rinse temperature was between 180-194 degrees Fahrenheit. They stated they observed staff daily to make sure the temperatures were completed and documented in the log. The log documented several days of recorded temperatures that were below the required temperatures. The Food Service Director stated they did not do anything about it as they went by the wash temperatures on the log sheet. During an observation and interview on 7/24/2024 at 1:46 PM the dishwasher wash temperature read 151 degrees Fahrenheit, and the rinse temperature read 181 degrees Fahrenheit. The Food Service Director stated the machine was not serviced because the service people came and stated it was working fine and just took time to reach the temperature. 10NYCRR 415.14(h)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335226	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vestal Park Rehabilitation and Nursing Center	1501 Route 26 South, Vestal, NY 13850

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 46276 Based on observation, record review, and interviews during the recertification survey conducted 7/22/2024-7/26/2024, the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 certified nurse aide and 1 registered nurse (Certified Nurse Aide #12 and Registered Nurse #15) observed. Specifically, Certified Nurse Aide #12 did not wear a gown and gloves as required in a room requiring transmission based precautions and did not perform appropriate hand hygiene before exiting the room; Registered Nurse #15 did not perform hand hygiene or change their gloves during wound care. Findings include: The facility policy, Contact Isolation Precautions for Clostridium Difficile, revised 3/2024 documented all employees were to follow isolation precaution signage on the resident's doors; residents diagnosed with Clostridium Difficile (an easily transmitted bacteria that causes diarrhea) were to be immediately placed on isolation precautions with signage on the door and a personal protective equipment cart placed outside of the door containing masks, gowns, gloves, and clear plastic bags. Certified nurse aides were to don (put on) gown and gloves, bring only supplies needed into the room to care for the resident, perform care last if possible, and wash hands upon exiting the room. Alcohol based hand sanitizer was not effective for removing Clostridium Difficile spores from the hands. The facility policy, Skin and Wound Management, revised 4/2020 documented pressure injury treatment program should focus on managing bacterial colonization and infection. The facility policy, Standard Precautions, revised 7/2019 documented clean gloves should be used before touching mucous membrane and non-intact skin and gloves would be changed between tasks and procedures on the same resident and after contact with material that may contain a high concentration of microorganisms such as wound drainage. 1) Resident #53 had diagnoses of enterocolitis (inflammation of the intestines) due to Clostridium difficile, diarrhea and pneumonia. The 7/11/2024 Minimum Data Set assessment documented Resident #53 had intact cognition, was frequently incontinent of bladder and bowel, and required partial/moderate assistance of 1 for toileting hygiene. The comprehensive care plan, initiated 5/2024, documented Resident #53 was on contact precautions due to Clostridium difficile. Interventions included administer antibiotics as ordered, keep call bell within reach, post sign on door, obtain cart with personal protective equipment, explain contact precautions to resident and family, and monitor for loose bowel movements, nausea, abdominal pain, or cramping. The 5/2024 resident care instructions documented the resident was on contact precautions; post sign on door and obtain care with personal protective equipment. The 7/2024 physician order documented the resident was on isolation precautions due to Clostridium difficile. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335226	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vestal Park Rehabilitation and Nursing Center	1501 Route 26 South, Vestal, NY 13850

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 7/23/2024 at 7:18 AM nursing progress note by Licensed Practical Nurse #41 documented Resident #53 was the 24-hour nursing report due to contact precautions for Clostridium difficile and was taking antibiotics. During a continuous observation on 7/24/2024 beginning at 8:51 AM: - An unidentified certified nurse aide entered the resident's room without donning the appropriate personal protective equipment, picked up the resident's breakfast tray, exited the room, and did not wash their hands after removing the tray. - At 8:52AM, Certified Nurse Aide #12 entered the resident's room with towels and washcloths and did not don personal protective equipment. - At 9:08 AM, Certified Nurse Aide #12 exited the resident's room without performing appropriate hand hygiene. - At 9:18 AM, Certified Nurse Aide #12 re-entered the resident's room, donned gloves, and assisted the resident in the bathroom. Certified Nurse Aide #12 disposed of the resident's dirty brief in the trash receptacle outside of the bathroom, doffed their gloves, exited the room, and used alcohol-based hand sanitizer to clean their hands. During an interview on 7/24/2024 at 9:57 AM, Registered Nurse #8 stated the resident was on contact precautions and the surveyor would need a gown and gloves to enter the room. The gown and gloves were in the plastic tower of drawers next to the room door. During an interview on 7/24/2024 at 9:57 AM Certified Nurse Aide #12 stated they cared for Resident #53 on another unit when they had Clostridium difficile. Certified Nurse Aide #12 stated contact precautions meant they had to wear a gown and gloves, but they did not use gown and gloves when they entered the resident's room. They did not know what kind of hand hygiene was required with Clostridium difficile. They used the hall hand sanitizers and did not want to transmit disease to their family. During an interview on 7/25/2024 at 9:28 AM, the Director of Nursing stated certified nurse aides received infection control education when they were hired; as needed if there was an outbreak of COVID-19; if they were unsure how to don/doff (put on/take off) personal protective equipment; or if they needed to know what the sign on the door meant. They should ask Registered Nurse #3 or their Unit Managers if they did not know. Staff should not enter a contact precaution room without gowns and gloves to prevent the spread of infection. During an interview on 7/26/2024 at 12:51 PM, Registered Nurse #3 stated a resident should have a physician order if they required contact precautions. Certified nurse aides were educated on infection control during orientation and had handwashing education yearly or with an outbreak. Certified nurse aides should don a gown and gloves when they entered a room with precautions to prevent the spread of infection. There was a competency fair last fall with a video and handwashing for infection control. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335226	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vestal Park Rehabilitation and Nursing Center	1501 Route 26 South, Vestal, NY 13850

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) Resident # 142 was admitted to the facility with diagnoses of dementia, peripheral vascular disease (reduced blood flow in extremities), and morbid obesity. The 5/23/2024 Minimum Data Set assessment documented the resident had severely impaired cognition, required moderate assistance with most activities of daily living, and had a Stage 3 pressure ulcer (full thickness tissue loss). The 7/22/2024 physician wound care order documented to cleanse right heel Stage 3 pressure ulcer with wound cleanser, apply a skin protectant to peri wound (skin surrounding the wound) and apply Pluragel (a wound treatment used to create a moist wound environment) to the wound bed, cover with border gauze (protective gauze covering) daily and as needed. During a wound care observation on 7/25/2024 at 9:36 AM, Registered Nurse #15 applied a pair of clean gloves, removed Resident #142's sock from their right foot, removed the soiled dressing from the right heel, opened a clean gauze packet, moistened the gauze with the cleansing agent, cleansed the right heel wound, applied Pluragel using a cotton tipped applicator, and covered the wound with border gauze. Registered Nurse #15 did not change their gloves or perform hand hygiene after removing the soiled dressing and before applying the clean dressing. During an interview on 7/25/2024 at 1:32 PM, Registered Nurse #15 stated they would have changed their gloves if the new dressing they were applying was ordered as a sterile dressing. Resident #142s dressing was not ordered as a sterile dressing. They stated gloves would be dirty if they touched the soiled dressing and if the same gloves touched a clean, new dressing then cross contamination of the clean dressing could occur. This could result in infection. During an interview on 7/25/2024 at 4:31 PM, Licensed Practical Nurse Unit Manager #14 stated after removing an old dressing gloves should be removed, and hands should be washed. New gloves should be put on before applying a new dressing. It was important to change gloves to prevent contamination of the clean dressing that could result in wound infection or worsening of the wound. 10 NYCRR 415.19(a)(b) 48895 50561

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335226	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vestal Park Rehabilitation and Nursing Center	1501 Route 26 South, Vestal, NY 13850

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. 46276 Based on observation, record review, and interview during the recertification survey conducted 07/22/2024-7/26/2024, the facility did not ensure call bells were adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from each resident's bedside, toilet, and bathing facilities for 1 of 1 resident (Resident #28) reviewed. Specifically, Resident #28's call bell was not within reach. Findings include: The facility policy, Call Light System Policy, reviewed by the facility 6/2024 documented when finished providing care to residents be sure to position the call light in their reach for ease of resident use. Tell the resident where the call light is and show them how to use the call light. Resident #28 had diagnoses including epilepsy (seizure disorder), cerebral vascular accident (stroke), and aphasia (difficulty speaking). The 8/10/2023 Minimum Data Set assessment documented the resident had severely impaired cognition and was dependent for all activities of daily living. The comprehensive care plan revised 3/2024 documented the resident had difficulty making themselves understood and understanding others related to aphasia following a cerebral vascular accident. The resident had impaired activity of daily living performance/physical mobility related to weakness. The resident was at risk for falls due to inability to maintain their position. Interventions included anticipate resident needs and keep call bell in reach and answer it promptly. The resident was observed: - On 7/22/2024 at 11:55 AM with their call bell behind the bed and out of reach; - On 7/24/2024 at 10:11 AM with their call bell behind the bed and out of reach; - On 7/25/2024 at 10:49 AM and 12:06 PM with their call bell on the floor and out of reach. During an interview on 7/25/2024 at 12:06 PM, Certified Nurse Aide #43 stated Resident #28 did not always have their call bell and was unable to communicate their needs. Call bells should always be kept near the resident so they could communicate their needs to the staff. If the call bell was not accessible, the resident could need emergency help, have a fall, or obtain an injury and staff would not be aware and able to respond. During an interview on 7/25/2024 at 12:34 PM, Registered Nurse #8 stated they noticed residents with call bells out of reach and they would move them within reach. Resident #28 was not able to verbalize their needs and was a high fall risk, so it was important for them to always have their call bell within reach. If the call bell was in reach it could result in falls or other serious events. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335226	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vestal Park Rehabilitation and Nursing Center	1501 Route 26 South, Vestal, NY 13850

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/26/2024 at 9:28 AM, the Director of Nursing stated it was not appropriate for a call bell to be out of reach or behind a bed. Staff should check for call bell placement when they did rounds on their residents and when they left the residents' room. 10NYCRR 415.29