STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335876	A. Building B. Wing	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delhi Rehabilitation and Nursing Center	41861 State Route 10 Delhi, NY 13753

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48744 Based on record review and interviews during a recertification survey, the facility did not ensure the facility conducted initially and periodically comprehensive, accurate, standardized reproducible assessments of each resident's functional capacity and completed not less than once every 12 months for 1 (Resident # 108) of 32 residents reviewed for Comprehensive Resident Assessments. Specifically, for Resident # 108, Comprehensive Resident Assessments was not completed to reflect changes in the resident's physical and medical conditions. This is evidenced by: A facility policy and procedure titled Minimum Data Set (MDS) - Resident Assessments dated 10/2017, documented that the assessment must accurately reflect the resident's status and be reflective of the resident's state at the time of assessment. Resident #108 was admitted with diagnoses including unspecified dementia (a neurological disorder affecting memory), hemiplegia and hemiparesis following cerebral infarction affection left non-dominant side (a clot in the brain causing one side of the body to be weak or nonfunctional), and gastro-esophageal reflux disease with esophagitis, with bleeding. The Minimum Data Set, dated dated dated [DATE], documented the resident was usually understood and could sometimes understand others and required extensive assistance for most activities of daily living. The Minimum Data Set, dated dated dated [DATE] documented Resident #108 did not have any symptoms and behaviors indicative of cognitive incapacity. The Minimum Data Set also did not document the gastro-esophageal reflux disease with esophagitis, with bleeding that the resident experienced which required medications to treat and minimize future similar gastric issues. Physician order dated 4/24/2024 documented Protonix 40 milligrams by mouth once daily for gastrointestinal bleeding prevention. (continued on next page)

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

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

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 7/29/2024 at 11:50 AM, Minimum Data Set Coordinator #1 stated the assessments were done telephonically. They stated when doing the Minimum Data Sets, the facility would inform them that a resident needed an assessment. Minimum Data Set Coordinator #1 stated if information was needed regarding a resident's assessment, they got assistance from the facility staff to help gather the needed information. They stated that the social work department, the Director of Nursing, and the therapy departments have provided information through emails and or phone calls. The Minimum Data Set Coordinator stated they had never been physically in the nursing home. 10 New York Code of Rules and Regulations 415.11(a)(2)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 48615 Based on record reviews and interviews conducted during the recertification survey, the facility did not develop and implemented comprehensive person-centered care plans for each resident that included measurable objective and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 2 (Resident #'s 124 and 150) of 32 residents reviewed for care plans. Specifically, (a.) Resident #124 had orders for congestion and fungal cream that were not care planned. (b.) Resident #150 had orders for 5 medications. There was no documented evidence that a comprehensive person-centered care plans was developed and implemented for their medication use. This is evidenced by: A facility policy and procedure titled Comprehensive Care Planning dated 12/05/2020, documented that the comprehensive care plan would include measurable objectives identified from admission assessment and the Minimum Data Set assessment. The interdisciplinary team would review and revised the care plan quarterly following Minimum Data Set completion, with a significant change, return following hospital admission, annually, and as needed. Resident #124 was admitted with diagnoses of unspecified dementia (a degenerative disease of the mind causing confusion and memory loss), toxic effect of methanol, intentional self-harm (intentionally ingested toxic amounts of alcohol- based chemical), type 2 diabetes (an endocrine dysfunction causing uncontrolled blood sugar levels). The Minimum Data Set (an assessment tool) dated 5/13/2024 documented the resident had significant cognitive impairment, could usually be understood, and understand others. The Comprehensive Care Plan initiated 10/31/2022, and last revised on 5/31/2024, did not document the resident's medical conditions of congestion and fungal infection) that required 2 medications, the use of the medications, and the signs and symptoms of adverse reactions to the medications, the adverse effects of the medical issues that required or any signs or symptoms of resolution or abatement of the medical condition requiring the ordered medications. There was no documented evidence that acare plan was developed or implemented for antifungal cream and Claritin medication use. Physician order dated 10/31/2023 at 9:00 AM documented Claritin 10 milligrams by mouth daily for congestion. There was no end date for this medication order. Physician order dated 6/24/2024 at 8:00 PM documented Clotrimazole antifungal cream for an infection on their genitals. There was no end date for this medication order. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #150 was admitted with diagnoses of schizoaffective disorder, bipolar type (a mental health disorder causing extreme mood swings), type 2 diabetes (a dysfunction of the endocrine system causing inability to regulate blood sugar), and hypertension (high blood pressure). The Minimum Data Set, dated dated dated [DATE] documented the resident had significant cognitive impairment, could usually be understood, and understand others. The Comprehensive Care Plan initiated 4/23/2024, last revised 6/12/2024, did not document the resident's medical conditions that required 5 medications, the use of the medications, and the signs and symptoms of adverse reactions to the medications, or the adverse effects of the medical issues that required them. Physician orders dated 4/24/2024 documented Hydrochlorothiazide 25 milligrams once daily for hypertension, Aspirin 81 milligrams once daily for coronary artery disease, Protonix 40 milligrams once daily for gastroesophageal reflux disease, Flomax 0.4 milligrams once daily for an enlarged prostate, and Atorvastatin 20 milligrams daily for cholesterol. Review of the Comprehensive Care Plan did not have documented evidence of care plan developed and implemented for Hydrochlorothiazide, Aspirin, Protonix, Flomax, and Atorvastatin use. During an interview on 7/30/2024 at 10:38 AM, Assistant Director of Nursing #1 stated care plans should be updated as things change. Sometimes care plans were updated at care reviews which were done every 3 months. For example, if a resident was receiving antibiotic therapy and the infection was resolved, the care plan should have been updated to read completed or resolved. Care plans should not have outdated therapy or treatments listed on it. During an interview on 7/20/2024 at 10:49 AM, Director of Nursing #1 stated that care plans were supposed to updated at least quarterly and anytime there were changes. They stated when a resident's condition change or medications added or removed, the care plan should be updated to reflect that. When asked why a care plan might not be updated to reflect resident medications or changes. Director of Nursing #1 stated that the facility tries to focus the care plans more on diagnoses and what the diagnoses required, not just medications. 10 New York Codes, Rules, and Regulations 415.11(c)(1) 48744

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48413 Based on record review, and interviews conducted during a recertification and abbreviated (NY00344171) survey, the facility did not ensure Comprehensive Care Plans were reviewed and revised to reflect f resident current conditions for 2 (Resident #'s 33 and 108) of 32 residents reviewed. Specifically, for (a.) Resident #33's Comprehensive Care Plan for accidents and abuse was not revised after the resident was involved in a resident-to-resident altercation; (b.) Resident #108's, Comprehensive Care Plan for medications was not reviewed and revised to include completion of treatment and resolution of medical issues. This is evidenced by: Resident #33 was admitted with diagnoses of sensorineural hearing loss (hearing loss in the inner ear), chronic obstructive pulmonary disease, and major depressive disorder. The Minimum Data Set (an assessment tool) dated 5/16/2024, documented the resident had moderate cognitive impairment, could be understood, and could understand others. The Comprehensive Care Plan for Behavior and Aggressive tendencies last updated on 5/13/2024 documented the resident would demonstrate appropriate coping skills. The Comprehensive Care Plan was not updated after an altercation had occurred between Resident #33 and another resident resulting in an injury to Resident #33 on 6/04/2024. During an interview on 7/25/2024 at 12:22 PM, Social Worker #1 stated Resident #33 did not have any issues or problems since the initial altercation on 6/04/2024 and the care plans should have been updated. During an interview on 7/29/2024 at 1:01 PM, Registered Nurse #1 stated the Comprehensive Care Plans should be person-centered and include non-pharmacological interventions and monitoring. The Comprehensive Care Plan should be reviewed and changed as necessary, based on changing goals, preferences, and needs of the resident and in response to current interventions reviewed and revised by the interdisciplinary team after each assessment. Resident #108 was admitted with diagnoses including unspecified dementia (a neurological disorder affecting memory), hemiplegia and hemiparesis following cerebral infarction affection left non-dominant side (a clot in the brain causing one side of the body to be weak or nonfunctional), and gastrointestinal hemorrhage (bleeding in the digestion track, stomach and/or intestines). The Minimum Data Set, dated dated dated [DATE], documented the resident was usually understood and could sometimes understand others. The Minimum Data Set did not document resident's cognition status. The Comprehensive Care Plan for Infection initiated 3/29/2023 and last updated on 4/22/2024 documented the resident had a history of cellulitis to their left hand and required antibiotics twice a day for 10 days. The completion of the antibiotic therapy and resolution of the infection was not documented on the care plan. Physician order dated 3/20/2024 documented Doxycycline 100 milligrams twice a day for 10 days. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Comprehensive Care Plan for infection initiated 4/23/2023 and last revised on 4/26/2024 documented the resident had a history of a urinary tract infection and required antibiotics for 7 days. The completion of therapy and resolution of the infection was not documented on the care plan. Physician order dated 4/23/2024 documented Cephalexin 500 milligrams twice a day for 7 days for Urinary tract infection. There was no documented evidenced on the care plan that the care plan was updated or revised when the resident completed the antibiotic use. During an interview on 7/30/2024 at 10:38 AM, Assistant Director of Nursing #1 stated care plans should be updated as things change. They stated care plans were updated at care reviews which were done every 3 months. For example, if a resident was receiving antibiotic therapy and the infection was resolved, the care plan should have been updated to read completed or resolved. Care plans should not have outdated therapy or treatments listed on it. Assistant Director of Nursing #1 stated that care plans were based more on medical management than individual treatments. 10 New York Codes of Rules and Regulations 415.11(c)(2)(i-iii) 48744

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48615 Based on observations, record review, and interviews conducted during a Recertification and Abbreviated (Case #NY00330031) Survey, the facility did not provide needed care and services that were resident centered and in accordance with professional standards of practice to meet each resident's physical, mental, and psychosocial needs for 2 (Resident #'s 24 and 87) of 32 residents reviewed for quality of care. Specifically, for (a.) Resident #24 missed two scheduled specialist appointments. Resident #24 had multiple co-morbid conditions and subsequently underwent amputation of 5 toes. (b.) Resident #87 went on a 3-day Leave of Absence without supplies for daily wound care. Resident returned on day #3, and on day #4 dressings were still unchanged. This is evidenced by: The Facility's Transportation Policy dated July 2023; documented facility would assist residents in arranging transportation to/from outpatient clinic appointments/diagnostic appointments when necessary. In the event that the transportation company canceled transportation for a consult, alternative means of transportation would be made, if possible. If alternate transportation was not available, medical provider would be informed and consult would be rescheduled. A virtual consult or alternative medical review (i.e. In-house provider/contract vendor) would be pursued to the extent possible in the event that alternate transportation arrangements were not available. The Facility's Out on Pass (OOP) Therapeutic Leave Policy effective 7/13/2023, documented Nurse would order necessary medications from pharmacy for Out on Pass as needed. Nurse would provide education to resident/responsible party regarding any medication that is sent Out on Pass. Resident #24 was admitted to the facility with diagnoses of diabetes type 2 (a problem in the way the body regulates and uses sugar as a fuel), diabetic foot ulcers leading to osteomyelitis (inflammation or swelling that occurs in the bone usually as a result of infection), and peripheral vascular disease (a slow and progressive circulation disorder caused by narrowing, blockage or spasms in a blood vessel). The Minimum Data Set (an assessment tool) dated 10/11/2023, documented resident had severe cognitive impairment, could be understood, and understand others. Based on review of complaint NY00330031, the complainant stated Resident #24 had repeated cancellations of appointments related to the nursing home not having transportation. The resident ended up having to have a full amputation. Wound Care progress note dated 10/19/2023 documented Resident #24 was seen on follow up for left 3rd toe wound. Resident had left partial hallux and second digit amputation for presumed infection and osteomyelitis on 8/1/8/2023. Wound status: worsening. Size: Size: 1 centimeter x 1 centimeter x u.1 centimeter. ca1cu1atect area 1s 1 sq centimeter. Exudate: Moderate amount of serous drainage. Wound Care progress note dated 12/19/2023 documented Resident #24 rescheduled for amputation of left 3rd toe on 12/21/2023, secondary to transportation needs. Left 3rd toe showed exacerbation and deterioration. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/25/2024 at 11:28 AM, Licensed Practical Nurse #5 stated Resident #24 was admitted to the facility with diabetic foot ulcers and a history of osteomyelitis. Resident was hospitalized for foot infections in August, September, and October of 2023. Thereafter, Resident was seen by infectious disease in November of 2023, along with orthopedics every two weeks in November of 2023. In December 2023 resident underwent amputation of left 5 metatarsals (toes). Resident had been stable since amputation in 2023. During an interview on 7/25/2024 at 11:54 AM, Transportation Scheduler #1, stated orthopedic appointment on 10/25/2023 for Resident #24 was re-scheduled to 11/08/2023. They stated the facility had two residents with appointments for same day. The facility did not have transportation because both were non-Medicaid and had no transportation benefit. Therefore, the facility was to provide transportation. Transportation Scheduler #1 stated the new admission resident had a post-op appointment which took priority. They stated on 11/16/2023 orthopedic appointment for Resident #24 was re-scheduled due to COVID positive and Resident #24 had an appointment on 11/24/2023 of the following week. During an interview on 7/26/2024 at 11:17 AM, Director of Nursing #1 stated Resident #24 was admitted in July of 2023 with history of gangrene and osteomyelitis. They stated Resident #24 was sent to hospital on the following dates: -8/12/2023 - 8/24/2023 after seen on wound rounds with left great toe red and warm to touch. -9/2/2023 - 9/6/2023 diagnosis of Altered Mental Status, oxygen desaturation and sepsis. -9/13/2023 - 9/14/2023 replaced peripherally inserted central catheter (PICC) line. -10/1/2023 - 10/5/2023 Sepsis -12/21/23 - 12/27/23 Amputation left 5 metatarsals (toes). Director of Nursing #1 stated Resident #24 had scheduled orthopedic appointments. The 10/25/2023 appointment was rescheduled to 11/08/2023 because facility was unable to provide transportation for two residents appointments on the same day. The 11/16/2023 orthopedic appointment was canceled because Resident #24 was COVID positive, and the resident had another scheduled appointment on 11/24/2023. They stated the two appointments were rescheduled at their discretion and the facility physician and or Nurse Practitioner were not notified. they stated moving forward, physician and or Nurse Practitioner would be notified according to facility's policy and procedure. During an interview on 7/29/2024 at 2:34 PM, Nurse Practitioner #1 stated if a resident missed an appointment the protocol was to notify the provider. The provider would then make an assessment and determine what alternative could be done for missed appointments or if appropriate for appointment to be rescheduled. Resident #87 was admitted to the facility with diagnoses of cervical region radiculopathy (inflammation of any of the nerve roots of your cervical spine (neck), contracture left wrist (a deformity caused by injury to the muscles), and adjustment disorder (a group of symptoms, such as stress, feeling sad or hopeless, and physical symptoms that could occur after you go through a stressful life event). The Minimum Data Set, dated dated dated [DATE], documented resident had intact cognition, could be understood, and understand others. (continued on next page)

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

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48744 Based on record review and interview conducted during a recertification survey, the facility did not ensure that residents who used psychotropic drugs received gradual dose reductions, unless clinically contraindicated, in an effort to discontinue these drugs for 2 (Resident #s108 and #150) of 32 residents reviewed for unnecessary medications. Specifically, for (a.) Resident #108 was ordered 3 psychotropic medications (Seroquel, Mirtazapine, and Zoloft) and (b.) Resident #150 was ordered 3 psychotropic medications (Trileptal, Olanzapine, and Clonazepam). There was no documented evidence that a gradual dose reduction was attempted. The Policy titled Psychotropic Medications -Unnecessary use effective 10/24/2022 documented the faculity would ensure that psychotropic medications were prescribed appropriately and were routinely evaluated and monitored; each resident's drug regimen would be free from unnecessary medications. The Policy further documented Gradual Dose Reduction (GDR) as the stepwise tapering of a dose to determine if symptoms, conditions, or risk could be managed by a lower dose or if the dose or medication could be discontinued. Resident #108 was admitted to the facility with diagnoses of heart failure (dysfunction of the heart muscles to contract properly), unspecified dementia (a degenerative memory disease), post traumatic stress disorder (an emotional disorder caused by a traumatic experience), and depression. The Minimum Data Set (an assessment tool) dated 6/03/2024 documented resident had significant cognitive impairment, could sometimes be understood, and sometimes understand others. A Physician order dated 2/28/2024 at 8:00 PM documented Resident #108 was to receive Seroquel 50 milligrams by mouth twice a day. No end date was documented. A Physician order dated 2/28/2024 at 10:00 PM documented Resident #108 was to receive Mirtazapine 7.5 milligrams by mouth at bedtime. No end date was documented. A Physician order dated 2/29/2024 at 8:00 AM documented Resident #108 was to receive Zoloft 100 milligrams by mouth daily. The Minimum Data Set, section N (Medication), dated 6/03/2024 documented Resident #108 received antipsychotic medication on a routine basis. Section N0450 antipsychotic review documented no gradual dose reduction (GDR) attempted. Review of Resident #108's medical record on 7/25/2024 did not have documented evidence that a gradual dose reduction was attempted for the resident. (continued on next page)

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	335876	A. Building B. Wing	07/30/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #150 was admitted to the facility with diagnoses of schizoaffective disorder / bipolar type (a mental disorder causing variable mood swings), depression nspecified, and disruptive mood disorder /dysregulation disorder (a mental disorder that increases the chance of the resident reacting inappropriately to situations). The Minimum Data Set, dated dated dated [DATE], documented the resident had a fluctuating cognitive pattern with disorganized thinking /behavior present, could sometimes be understood, and sometimes understood others. During an observations of the Aspen unit on 7/22/2024 at 12:53 PM, Resident #150 was observed in their room yelling loudly and banging their hand on the bed. A Physician Order dated 4/23/2024 at 8:00 PM documented Resident #150 was to receive Trileptal 600 milligrams by mouth twice a day. No end date was documented. A Physician Order dated 4/23/2024at 8:00 PM documented Resident #150 was to receive Olanzapine 15 milligrams by mouth twice a day. No end date was documented. A Physician Order dated 7/19/2024 at 8:00 AM documented Resident #150 was to receive Clonazepam 0.5 milligrams by mouth daily No end date was documented. The Minimum Data Set, section N (Medication), dated 4/30/2024 documented Resident #150 received antipsychotic medication on a routine basis. Section N0450 antipsychotic review documented no gradual dose reduction (GDR) attempted. Review of Resident #150's medical record on 7/25/2024 did not have documented evidence that a gradual dose reduction was attempted for the resident. During an interview on 7/29/2024 at 7:57 AM, Administrator #1stated a local psychiatric facility sent a large number of residents to the facility prior to the current administrator's hiring. Administrator #1 further stated that the Nurse Practitioner that was used by the facility had just received psychiatric certification 3 weeks ago and would be reviewing the plans for the psychiatrically challenged residents at the facility. During a subsequent interview on 7/30/2024 at 12:25 PM, Administrator #1 stated telehealth psychiatric services were used and residents with psychiatric care were set up with telehealth psych appointments 2 days per week. The psychiatric provider had never been physically in the building. New York Codes of Rules and Regulations 415.12 (1)(2)(ii)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48615 Based on observation, record review, and interviews conducted during the recertification survey, the facility did not ensure drugs and biologicals were labeled and stored in accordance with professional standards of practice for 3 of 3 medication carts, and 2 (Elm and Aspen units) of 3 medication storage rooms reviewed. Specifically, (a.) opened medications had no open and/or expiration dates; (b.) stock medication open and expiration dates were not legible; (c.) personal items were stored in double locked cabinet with controlled substances; (d.) a pre-poured medication cup was noted in medication cart; and (e.) a narcotic was not signed out correctly when administered. This is evidenced by: The facility's Storage -Labeling - Maintenance of Medications Policy effective [DATE], documented all medications maintained in the facility would be properly labeled in accordance with current state and federal guidelines and regulations. Medications with shortened expiration dates (i.e. Insulin's, injections, ophthalmic drops, etc.) must be dated when opened. See Recommended Minimum Storage Parameters for specific information. Only drugs (and supplies necessary for their administration) were to be kept in medicine cabinets and carts. Medication must be checked regularly for expiration dates and deterioration. Medication labels must be legible at all times. The facility's Administration of Medication - General Policy effective ,d+[DATE], documented it was the facility's policy that medications would be administered to residents in a timely and accurate manner by a licensed nurse or physician. Nurse should check expiration dates on packaged containers. Nurse Administers medication at the time it was prepared. Never pre-pours medications. Nurse should immediately chart medications administered in the proper time and date square via initials and identified initials by signature in designated space on the administration record. During an observation on [DATE] at 12:35 PM, the Elm Unit Medication room [ROOM NUMBER] refrigerator contained an open bottle of purified protein derivative (PPD) with no open and or expiration date. During an observation on [DATE] at 1:15 PM, Elm Unit Medication Cart #1 contained a cup of pre-poured medications for Resident #62. Licensed Practical Nurse #2 stated they poured medication for Resident #62, but they were not in their room. Licensed Practical Nurse #2 stated they placed the cup of pills in medication cart and planned to give medications when resident returned. The following had no expiration dates after opening: 2 Humalog insulin Kwik pens, 1 Basaglar insulin Kwik pen, and 1 opened Breo Ellipta inhaler had no open date. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on [DATE] at 10:33 AM, the Aspen Unit medication cart #2 contained: an opened bottle of nitroglycerin pills with no open and or expiration date, 1 bottle of zinc stock medication where the open and expiration dates were not legible. Licensed Practical Nurse #3 discarded the bottle of zinc. The Narcotic count for Resident #19 oxycodone 10 milligrams count was 104, sign out book reflected 103. Licensed Practical Nurse #3 stated Resident #19 was also prescribed oxycodone 5mg as well and they signed medication out on the incorrect page. Oxycodone 5mg count was 11, and book reflects 12. Licensed Practical Nurse #3 made the correction. During an observation on [DATE] at 10:40 AM, the Aspen unit medication #2 room narcotic lock box contained a wallet and $2 cash. Licensed Practical Nurse #3 stated they belonged to a resident and was kept for safe keeping. During an observation on [DATE] at 11:00 AM, the Birch Unit medication cart #1 contained the following with no expiration dates after opening: 1 vial Fiasp insulin; 1 Degludec insulin kwik pen; 1 Humalog insulin kwik pen; 1 Timolol eye drop; and 1 bottle artificial tears. During an interview on [DATE] at 11:00 AM, Licensed Practical Nurse #4 stated, pharmacy placed expiration dates on medication. Insulin expired 30 days after opening and they were not aware of Medications with shortened expiration dates (i.e. Insulin's, injections, ophthalmic drops, etc.). During an interview on [DATE] 11:13 AM, Director of Nursing #1 stated all residents had a locked drawer in their room to keep personal items. There was also a safe to keep valuables. Director of Nursing #1 did not know where the safe or key to the safe was located. Director of Nursing #1 stated Activities generally assisted residents with accessing personal needs account and ordering out when needed. During a subsequent interview on [DATE] at 2:52 PM, Director of Nursing #1 stated nursing staff were to date medications upon opening and check expiration date with each medication pass. Nurses should not pre-pour medications. 10 New York Codes, Rules, and Regulations 415.18(d)

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

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 21414 Based on observation, record review, and interviews during the recertification survey, the facility did not store, prepare, distribute, and serve food in accordance with professional standards for food service safety. Specifically, the automatic dishwashing machine was not in good repair and did not provide a sanitizing final rinse, and equipment required cleaning. This is evidenced by: During observations on 7/22/24 at 11:19 AM, the thermometer on the automatic dishwashing machine was not functioning, and the concentration of sanitizing chemical in the final rinse of the automatic dishwashing machine final rinse was zero parts per million of available chlorine. The directions on the bottle of sanitizing chemical concentrate state the concentration is to be between 50 and 100 ppm. During observations on 7/22/2024 from 11:19 AM, the following equipment in the Elm Unit, Fir Unit, Birch Unit, Aspen Unit, Chestnut Unit, and/or Dogwood Unit nourishment rooms and servery kitchens were soiled with food particles or food drips: microwave oven K-rated fire extinguisher microwave ovens refrigerators cabinetry During observations on 7/24/2024 at 1:21 PM through 2:31 PM: In the main kitchen, the floor drains were soiled with food debris and/or a black residue, the floor and drain below and behind the dishwashing machine were heavily soiled with a black build-up, and dead insects were found above the suspended ceiling and in ceiling light fixtures. In the Aspen/Birch Servery, dead insects were found above the suspended ceiling, and the floor was caked with a black build-up and food debris along the wall and under the steamtable, worktable, and dishwashing machine. In the Chestnut/Dogwood Servery, food debris and dead insects were found on the floor under the steamtable, worktable, and dishwashing machine. During an interview on 7/22/2024 at 12:22 PM, Food Service Director #1 stated that the vendor would be contacted to repair the automatic dishwashing machine. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/25/2024 at 12:27 PM, Administrator #1 stated that they would speak to the Food Service Director regarding training staff to monitor the dishwashing machine final rinse and maintaining the cleanliness of the nourishment rooms. 10 New York Codes, Rules, and Regulations 415.14(h) Chapter 1 State Sanitary Code Subpart 14-1

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F 0923 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have enough outside ventilation via a window or mechanical ventilation, or both. 21414 Based on observation and interviews during the recertification survey, the facility did not provide adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. Specifically, components of the heating and air conditioning system were not repaired or replaced as necessary. This is evidenced by: During observations on 7/24/2024 from 8:00 AM through 3:00 PM and on 7/25/2024 at 10:25 AM, the air quality in the Family Conference Room was humid and stuffy. During an interview on 7/25/2024 at 10:27 AM, Director of Maintenance #1 stated for about one year, the closed loop air handler servicing the Family Conference Room had a clogged water line which interfered with the functioning of the system. Director of Maintenance #1 stated several air conditioning heat pumps (approximately 10 of 300) were failing and required replacement; the facility had purchased and had onsite, 3 replacement heat pumps that would be installed by facility staff, and in the interim, window air conditioning units were placed in the rooms affected. During an interview on 7/26/2024 at 11:09 AM, Administrator #1 stated the air handling system servicing the Family Conference Room would be diagnosed and repaired if necessary, and all heat pumps not functioning properly would be repaired or replaced as necessary. 10 New York Codes, Rules, and Regulations 415.29(h)