STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335600	A. Building B. Wing	12/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grand Rehabilitation and Nursing at Utica	1657 Sunset Ave Utica, NY 13502

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31623 35045 44838 Based on observation, record review and interview during the recertification survey conducted 12/13/21-12/21/21, the facility failed to ensure 1 of 2 residents (Resident #31) reviewed was free from physical restraints. Specifically, Resident #31's restraint was not released at least every 2 hours and at meals as care planned. Findings include: The 3/2020 Use of Restraints policy documented restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. Restraints shall only be used upon written order of a physician. Care plans for residents in restraints will reflect interventions that not only address the immediate medical symptom(s), but the underlying problems that may be causing the symptom(s). Care plans shall also include the measures taken to systemically reduce or eliminate the need for restraint use. Resident #31 was admitted to the facility with diagnoses of dementia with behavioral disturbance, restlessness, and anxiety. The 3/12/21 and 6/8/21 Minimum Data Set (MDS) assessments documented the resident used a trunk restraint daily. The 9/8/21 MDS assessment documented the resident was severely cognitively impaired; required extensive assistance with most activities of daily living (ADL), and restraints were not documented as used. A restraint assessment dated [DATE] was conducted by the interdisciplinary team (IDT) and documented the resident was to have a lap buddy (cushioned lap restraint) that was to be released every 2 hours for toileting, range of motion (ROM), and nourishment. The comprehensive care plan (CCP), updated 10/30/21, documented the resident was at risk to fall due to confusion, decreased mobility, and gait/balance problems. The resident used a physical restraint due to poor safety awareness and throwing self on floor. The resident had a lap buddy in place in wheelchair when out of bed, it was to be released every 2 hours for repositioning, ADLs, and feeding, beginning 6/15/20. Staff were to ensure restraint release was completed, evaluate restraint use including risk/benefit, alternatives and need; and report any adverse effects to medical doctor/nurse. (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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The certified nurse aide (CNA) care instructions, active 12/2021, documented the resident was to have a lap buddy in the wheelchair while out of bed, to be released every 2 hours for repositioning, ADLs, and feeding. The physician's orders, active 12/13/21, documented the resident had a lap buddy in wheelchair that was to be released every 2 hours for repositioning, ADLs, and feeding. The resident was observed sitting in their wheelchair with a lap buddy in place: - On 12/13/21 at 2:00 PM. Lunch trays were on the unit and the resident received assistance from staff with the meal. - On 12/14/21 at 9:15 AM, while CNA #59 was feeding/assisting the resident with their breakfast meal. - On 12/15/21 during a continuous observation from 11:53 AM to 2:38 PM. The resident was not offered personal care and the lap buddy was not released during the lunch meal by assistant nurse aide (ANA) #43. During an interview with CNA #59 on 12/17/21 at 1:28 PM, they stated the resident had a restraint, a lap buddy, to prevent them from tipping forward in their wheelchair. It would then be removed when the resident went back to bed. They were not aware it was to be removed at other times. They did not remove it at meals, and they fed the resident on 12/14/21 and did not remove it. They stated they signed off in the electronic record the restraint was removed every 2 hours when out of bed in wheelchair. During an interview with ANA #43 on 12/17/21 at 3:43 PM, they stated the resident could not walk or communicate their needs. The resident was to be repositioned every 2 hours to prevent pressure sores. They assisted the resident out of bed to their wheelchair on 12/15/21. They stated the lap buddy was to be used any time the resident was in the wheelchair to prevent them from falling forward. The electronic record documented to check lap buddy was in place every 2 hours. During an interview with registered nurse (RN) #30 on 12/17/21 at 1:45 PM, they stated the lap buddy was used when out of bed. When the resident was eating their meal, it was to be taken off, for comfort. During an interview with the Director of Rehabilitation on 12/20/21 at 3:27 PM, they stated physical or occupational therapy would assess need for a lap buddy and conduct quarterly screens to see if the restraint remained necessary and to maintain optimal safety. The resident was initially assessed in 6/2020 related to a fall from their chair. At that time, it was recommended a lap buddy be put into place. They reassessed the lap buddy on 6/8/21 and it was to remain as ordered. The resident was unable to rise from wheelchair and the lap buddy would be considered a restraint. The therapy department did not care plan for the release of the lap buddy. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Assistant Director of Nursing (ADON) #8 on 12/20/21 at 3:51 PM, they stated physical therapy determined whether a restraint was needed for a resident, determine its' safety, and discussed restraints with medical. Assessments were ongoing and all restraints were to be released at least every 2 hours to reposition. Unit Managers were responsible for communicating the plan to staff. The resident's unit had not had a Unit Manager for a while. If there was not a Unit Manager, the ADON would communicate this. It would be noted in the care plan and in the care instructions visible to the CNAs. The lap buddy would have instructions to release every 2 hours for ADLs and feeding. The lap buddy should not have been in place when the resident was being fed. 10NYCRR 415.4(a)(5)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 31623 40803 44838 Based on observation, record review, and interview during the recertification and abbreviated surveys (NY00281850, NY00270904, NY00269162 and NY00281169) conducted on 12/13/21-12/21/21, the facility failed to ensure 1 of 7 residents (Resident #2) reviewed received the necessary services to maintain good nutrition. Specifically, Resident #2 was not assisted with meals timely. Findings include: Resident #2 had a diagnosis including dysphagia (difficulty swallowing). The 11/26/21 Minimum Data Set (MDS) assessment documented the resident was severely cognitively impaired; required extensive assistance with eating; had a 5% weight loss in the last month; and was not on a prescribed weight-loss regimen. The 11/22/21 physician's orders documented the resident was on a regular diet with pureed texture and nectar thickened liquids. The 12/7/21 comprehensive care plan (CCP) documented the resident was at risk for malnutrition, needed an altered consistency diet, and required extensive assistance with eating. The care instructions, active 12/20/21, documented the resident required extensive assistance with eating, was on swallowing precautions, and received double portions at meals. During a meal observation on 12/13/21: - At 2:00 PM, the lunch trays arrived to the unit. - At 2:25 PM, the resident was sitting with their meal, not eating, with no staff assisting. - At 2:38 PM, a certified nurse aide (CNA) went into the resident's room to provide care. - At 2:48 PM, the resident remained seated with their meal tray in the room, untouched, and no staff had offered to assist. - At 2:55 PM, staff member went into the resident's room to assist them with their meal. The ADL report had no documentation eating assistance was provided by staff for the lunch meal on 12/13/21. During a meal observation on 12/14/21: - At 9:19 AM, a CNA was bringing the meal carts to the unit. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- At 9:45 AM, the resident's meal tray was brought to their room by CNA #58. The resident was sitting in the room at that time and was not offered meal assistance. - The resident remained seated in their room with meal untouched without staff assistance, through 10:30 AM. During an interview with CNA #58 on 12/14/21 at 10:35 AM, CNA #58 stated they went into the room and asked the resident if they were hungry at breakfast on 12/14/21. The resident did not respond, closed their eyes, and started to drift off to sleep. CNA #58 stated the resident was assigned to their care. They stated the meal cart arrived to the unit at 9:45 AM, and they passed the resident their meal tray. They could not recall what time they passed it. They stated 50 minutes was not a long time to wait for their meal as there was no way the staff could feed everyone that needed assistance on time. The ADL report had no documentation eating assistance was provided by staff for the breakfast meal on 12/14/21. During an interview with registered nurse (RN) #30 on 12/14/21 at 10:51 AM, they stated they helped assist residents with meals occasionally. They did not assist with meals that morning. They were unaware the resident had to wait for their meal, if they knew they would have helped. 10NYCRR 415.12(a)(3)

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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. 31623 40803 41591 44838 Based on observation, record review, and interview during the recertification and abbreviated (NY00269688 and NY00273974) surveys conducted on 12/13-12/21/21, the facility failed to ensure 2 of 13 residents (Residents #184, and 224) reviewed received adequate supervision and assistance devices to prevent accidents and/or their environments remained as free of accident hazards as possible. Specifically, - Resident #184 exited the secure unit (2S) undetected and made it to a non-resident area, and the incident was not thoroughly investigated, nor was a plan implemented to prevent further unsafe wandering. Resident #184 subsequently eloped from the facility and was found walking in the roadway by the local police after certified nurse aide (CNA) #24 did not appropriately respond when the wander guard system (to alert staff of resident wandering) alarmed. - Resident #224 had a fall in their bathroom on a wet floor. The accident hazard was not addressed timely to prevent falls and the incident was not investigated to ensure a plan was implemented to prevent reoccurrence. Findings include: The 1/2021 revised Elopement policy documented: - Staff shall investigate and report all cases of missing residents. Staff shall promptly report any resident who tries to leave the premises or who is suspected of being missing to the Charge Nurse or Director of Nursing (DON). - When a missing resident returns to the facility, the DON or Charge Nurse shall exam the resident for injuries, contact the attending physician and report findings, notify resident's legal representative, complete and file an incident report, and document relevant information in the resident's medical chart. The 1/2021 revised Wander Guard System policy documented: - The facility would provide and maintain a secure environment to prevent negative outcomes for residents who exhibit unsafe wandering and or elopement behaviors. - Residents identified at risk will be elevated for the benefit of wearing a wander guard bracelet (wearable alarm that emits a sound to alert staff if a resident is wandering into a potentially unsafe area. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The Wander Alert system will alarm when a wanderer or potential eloper attempts to leave the facility unaccompanied. - Alarms are placed on all exits on the first floor, on all exits on the units, and on the elevators. The revised 1/2021 Secured Dementia Unit policy documented: - The facility will maintain as needed a separate part of the building that is designated for residents who have Alzheimer's and other types of dementia, and special care. - All residents upon admission, readmission, change of condition will assessed by the interdisciplinary team (IDT). The assessment will include if a resident poses a risk to themselves or others, exhibits wandering behaviors that cannot be redirected, and where less restrictive measures have been unsuccessful. - All staff working will be trained on the protocols for entering and exiting the secured locations. Education will include but is not limited to protocols to check before and after exiting for residents that may have maneuvered through the exit, alerting superiors if a resident is noted to have left through an exit unauthorized, reporting a malfunctioning alarm, wander bracelet, or any other unplanned event. Prior to 4/1/21, the facility's Elopement Prevention and Management Training documented: - An elopement is the resident actually exiting the facility unsupervised, without permission and unobserved. All three components must be present to constitute an actual elopement otherwise it is considered an attempted elopement. - Preventions included care plan interventions and wander bracelet placement and function checked each shift. - Alert devices are checked for placement and function at least every shift by both certified nurse aides (CNA) and licensed practical nurse (LPN). The facility's revised 1/2021, Resident Accident and Incident policy documented all accidents or incidents shall be investigated and reported to the Administrator. The nurse Supervisor/Charge Nurse and/or the department director or Supervisor shall promptly initiate and document the investigation of the accident or incident. A complete accident and incident should included the date, time, injuries, circumstances surrounding the accident or incident, location of accident or incident, the individual's account of what happened names of witness and their account of the accident or incident, condition of the person, any corrective action taken, follow up information and the signature of the person completing the report. The DON shall ensure that the Administrator receives a copy of the Accident/Incident Report. Accident and Incident reports will be reviewed by the safety committee for trends related to accidents or safety hazards in the facility to analyze any resident vulnerabilities. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1) Resident #184 had diagnoses including vascular dementia and Schizophrenia. The 11/15/2020 Minimum Data Set (MDS) assessment documented the resident had moderately impaired cognition, did not wander, required supervision while walking in the room and in the corridor, and had a wander/elopement alarm used daily. The comprehensive care plan (CCP) documented: - On 9/13/19, the resident was at risk for wandering or elopement and the resident could be exit seeking. Interventions included medications as ordered, checking placement of the wander guard each shift, and determining the cause of behaviors. Staff were to distract the resident from wandering by offering pleasant diversions and activities of interest. All behaviors were to be documented and attempt made to identify patterns to target interventions. - On 10/25/19, resident required assistance with activities of daily living (ADL) related to confusion and dementia and required supervision with locomotion on and off the unit. On 9/15/20 psychiatric nurse practitioner (NP) #67's progress note documented the resident occasionally exhibited exit seeking behaviors but was noted to be redirectable most of the time. The resident was alert and ambulatory. At times, the resident was exit seeking and could be persistent with their demands. At the time of the exam, the resident was mostly focused on their desire to leave the long-term care (LTC) setting. However, their judgment was extremely impaired, and they are not able to live independently. The 11/15/20, registered nurse (RN)/Unit Manager (UM) quarterly assessment documented the resident was at risk for elopement related to being ambulatory, expressing a desire to leave, making prior attempts to leave, being difficult to redirect, and related to medications and diagnoses. The assessment documented residents at risk should have elopement prevention protocols followed and documented on the CCP. On 11/20/20 nurse practitioner (NP) #4's progress note documented per nursing staff, the resident continued to exit seek. On 11/23/20 at 2:41 PM, licensed practical nurse (LPN) #2's progress note documented the resident was exiting seeking all day and stated they were going to a city in another state. On 12/12/20 at 9:25 PM, LPN #61's progress note documented the resident was exit seeking at zone doors and elevator, resistive to redirection, cursing, and combative. Wander guard was intact and there were no further behaviors at this time. On 12/13/20 at 9:51 AM, LPN #2's progress note documented the resident was constantly exit seeking, trying to push the codes to the exits, and pushing on the doors. The resident was able to get off the unit and onto the 1st floor yesterday. Unit staff were unaware the elevator went down with the resident on it. The wander guard was intact. There was no documented evidence the 12/12/20 incident of the resident getting off the secured unit was investigated. There was no evidence the CCP was reviewed or updated following the incident to prevent further unsafe wandering or elopements. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 2/13/21 Annual MDS assessment documented the resident had moderately impaired cognition, wandered 1- 3 days during the assessment period, required supervision while walking in the room, in the corridor, was unsteady and required human assistance to stabilize during transitions and walking, and a wander/elopement alarm was used daily. On 3/14/21, psychiatric NP #67's progress notes documented the resident at times could be exit seeking, actually succeeded getting in getting out of the door, persistent with their demands, appeared anxious, had impaired short-term memory, was focused on leaving long-term care, their judgement was extremely impaired, and they were not able to live independently. On 4/1/21 at 3:53 PM, the local police department's report documented they responded to an intersection near the facility for a welfare check and located an individual who seemed disoriented, not dressed for the weather, and walking in the roadway. The individual was identified as Resident #184, and the resident was returned to the facility. On 4/1/21 at 4:11 PM, Director of Nursing's (DON) #7 assessment documented the resident was noted to have abrasions to bilateral knees, the left palm of their hand, and right pinky finger. All areas were cleansed, and Bactrian (antibiotic ointment) ointment was applied. The physician updated, there were no new orders, and staff would continue to monitor. The 4/1/21 facility Accident and Incident Report documented: - the resident eloped on 4/1/21 at 3:25 PM. After reviewing the camera footage, the door alarm on the secured 2S Unit was alarming at 3:25 PM. The resident had leaned on the delayed egress door for 15 seconds and exited. - CNA #24 cleared the alarm without checking the stairwell. - The resident was found by the local police walking down the sidewalk and was brought back to the facility. - The resident was assessed and medical was aware and the plan was to monitor the resident. - The resident had abrasions to their knees and reported they fell . - The resident's wander guard alarm was present and noted to be functioning properly. Statements included with the Accident and Incident Report documented: - CNA #24 documented on 4/1/21, the resident was not on their assignment and they last saw the resident lying in bed. The resident was independent with transfers. CNA #24 noted they were the only staff member on the unit at the time of the elopement. They were sitting behind the nurse's station desk when they heard the door alarm sound. They checked the door near the beauty salon and then realized it was the door alarm going off. They ran down the hallway and cleared the door alarm code. CNA #24 documented they were unaware they could leave the other residents unattended on the unit to check outside. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- LPN # 23 documented on 4/1/21, the resident was found by the local police department and brought back to the facility. LPN #23's statement did not include where they were at the time of the incident. The 4/2/21 (untimed), investigation summary written by the former Assistant Administrator documented they were notified that a local police officer was in the lobby with Resident #184. The cameras were reviewed, and it was discovered the resident approached the door at 3:25 PM and did not return. CNA #24 was noted to check the alarming door, cleared the code, and did not check the stairwell. During an interview with LPN #2 on 12/17/21 at 11:15 AM, they stated: - during 12/2020, they were not the Unit Manager but was a staff nurse on the unit. - If a resident was in the elevator on 2S and someone called the elevator to the 1st floor, the wander guard system would alarm but the elevator would move and go to the 1st floor. - In 12/2020, that was how the resident was able to take the elevator to the 1st floor and they were returned to the unit by staff. The unit staff were unaware the resident had left the unit until someone brought them back. - The incident happened at the end of their shift and they thought the nurse working the next shift would have handled the incident including notifying the Supervisor and completing an Incident Report. - LPN #2 documented a late progress note on 12/13/20 when they returned to work. - LPN #2 stated they were not employed by the facility when the resident eloped on 4/1/21. During an interview with LPN #23 on 12/20/21 at 8:52 AM, they reported: - the wander guard alarm sounded if a resident was close to the door or trying to exit through the door. - Staff were supposed to respond to any alarm going off. - If a resident pushing on the delayed egress fire door it would open after 15 seconds. - A code was needed to open the elevator door to get off the 2 South secured unit, but if someone took the elevator from the 1st floor to the second floor it would remain open for a few seconds and someone could get on the elevator. LPN #23 stated staff were supposed to remain the area to make sure no residents were able to get into the elevator while it was open. If a resident with a wander guard was able to get on the elevator, the wander guard alarm would sound but if someone called the elevator to the 1st floor, the elevator would move. LPN #23 stated this type of incident occurred with Resident #184 in 12/2020. They were able to take the elevator to the 1st floor and was brought back to the unit. A Supervisor should have been called when this happened, and it should have been documented. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 4/1/21, LPN #23 thought they were the only nurse working the unit. They were unaware the resident had left the building and the DON brought the resident to the unit after the incident sand they were unsure how long the resident was gone. During a telephone interview with CNA #24 on 12/20/21 at 10:50 AM, they stated: - if an alarm sounded on the secured 2 South secured unit, staff was supposed to respond, check the area, go outside if needed, and let a nurse know the alarm was sounding. - Resident #184 had exit seeking behaviors from time to time. - On 4/1/21, CNA #24 was the only staff member on the unit when the alarm sounded. All other staff were on breaks. They heard the door alarm sound, checked the door near the beauty salon, and then went to the fire exit door. They did not know Resident #184 was able to get out of the building and were unsure how long the resident was gone. They did not know they could leave the residents unattended and go outside to check to see if a resident was able to get outside. They did not tell anyone the alarm had gone off because there was no staff to tell as they were alone on the unit. - They were made aware Resident #184 had gotten outside when they were brought back to the unit. During an interview with the DON #7 on 12/20/21 at 11:24 AM, they reported if an alarm was sounding, staff should respond to the alarm. Typically, a resident was nearby and required redirection. If there was not a resident around and the alarm was sounding, staff should check the area, including the outside, let a nurse know if they are unaware, and a head count should be completed to determine if a resident missing. In 12/20, either the DON or Assistant Director of Nursing (ADON) were overseeing the 2 South secured unit. They stated residents with wander guard bracelets should not be able to leave the secured unit via the elevator. The DON stated they were unaware Resident #184 was able to leave the secured 2 South secured unit via elevator to the 1st floor in 12/2020. The DON stated the unit nurse should have let the Supervisor, ADON, or DON know when this happened and if they were made aware, they would have completed an Incident Report to determine how the incident had occurred. The DON also stated the resident's CCP would have been reviewed and possibly updated if needed. The DON stated on 4/1/21, when the video footage was reviewed, it was determined Resident #184 leaned on the delayed egress fire door for 15 seconds and the door opened. During this time, the alarm was sounding. CNA #24 cleared the code and did not check the surrounding areas to determine if any residents were able to exit the 2 South secured unit. The resident was brought back to the facility after being found outside by a police officer. They were unsure how much time had elapsed from when the resident was last seen on the video footage to being brought back by the police. They stated that information was not included in the investigation and it should have been noted to get a clear picture of the investigation. They also reported it was not determined if CNA #24's report of being left alone on the unit was looked into. The DON completed the 4/1/21 investigation and reviewed it with the facility's team. During an interview the former Assistant Administrator on 12/20/21 at 3:17 PM, they stated on 4/1/21, they received a call from the receptionist who reported the police had found a resident. They did not recall the time the police brought the resident back to the facility and did not document that information. The DON completed the facility investigation, and they wrote their summary after the investigation was completed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	investigation. 2) Resident #224 had diagnoses including chronic obstructive pulmonary disease (COPD), heart failure, and major depressive disorder. The 2/3/21 Minimum Data Set (MDS) assessment documented the resident was cognitively intact and required limited assistance of 1 staff member for toileting and walking in room. The 2/18/20 comprehensive care plan (CCP) documented the resident walked 10 feet in their room and was toileted with limited assistance of staff. The 1/6/21 at 6:45 PM, Assistant Director of Nursing (ADON) #8's progress note documented the resident fell on the floor coming out of the bathroom due to a puddle on the floor. It was reported to maintenance. The 1/6/21 at 10:07 PM, licensed practical nurse (LPN) #3's progress note documented the resident fell at 6:34 PM and LPN #3 notified the Nursing Supervisor. LPN #3 noted the resident had an abrasion to the left knee and the resident was provided an icepack and wound cleanser to the area. The resident complained of pain related to the fall and the Nursing Supervisor was aware. The 1/7/21 nurse practitioner (NP) #4's progress note documented the visit was related to a follow up post fall. The resident had complaints of some pain in the left leg, was ambulating without difficulty, but leg was slightly sore. There was no documentation an Accident/Incident report was completed for the fall to determine if the leak had been reported and addressed to prevent further falls. During an interview with Plant Operation Director on 12/16/21 at 1:46 PM, they stated there were no work orders found for the leak in the resident's bathroom. They stated this incident happened prior to their working at the facility, and they did not know anything about it. During an interview with LPN #3 on 12/17/21 at 10:03 AM, they stated they did not recall the resident or the incident. During an interview with ADON #8 on 12/17/21 at 10:07 AM, they stated they remembered an incident where there was water in a resident's room and a resident had an unwitnessed fall. They would expect an Accident/Incident report be completed and did not recall if they had completed one. They thought they had started one and did not think the resident was injured. During an interview with certified nurse aide (CNA) #5 on 12/17/21 at 1:17 PM, they stated the resident had an issue with the bathroom flooding at least daily/every other day. They remembered going into the resident's room to assist another CNA, but could not recall who the CNA was, who they could not recall, in assisting the resident off the floor. They stated they had found the resident on the floor and the resident had a bruise on their knee. They had retrieved towels, cleaned the water up on the floor, and notified maintenance. At the time of the event, there were maintenance folders available for reporting, but it was an emergency they would call maintenance and the Nursing Supervisor. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with CNA #6 on 12/17/21 at 1:27 PM, they stated when they entered the resident's room on the day of the incident, the resident was on the floor and the floor was wet with a lot of water, and there was another CNA whom they could not recall in the room. They did not recall if the resident was injured. They thought maintenance and the Nursing Supervisor were called by another staff person. There was a maintenance book to record any maintenance requests. However, when there was a maintenance emergency they were contacted on the phone. During an interview with the Director of Nursing (DON) on 12/17/21 at 1:58 PM, they stated an Accident/ Incident report should have been completed when the incident occurred. The nurse would have initiated the report and the RN Supervisor would have completed the assessment of the resident. The report would then be turned into the Unit Manager for any additional follow up. Lastly, the report would go to the ADON or DON for review in morning meeting. If there was overflowing water the receptionist and housekeeping should have been called immediately. If after an hour maintenance did not respond, the Director of Maintenance and Housekeeping should have been called. 10NYCRR 415.12 (h)(2)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 40803 Based on observation, record review and interview during the recertification survey conducted on 12/13-12/21/21, the facility failed to ensure 1 of 4 residents reviewed (Resident #145) maintained acceptable parameters of nutritional status. Specifically, Resident #145 had a significant weight loss which was not reassessed timely by clinical nutrition staff. Findings include: The facility's revised 1/2021, Weight Assessment and Intervention policy documented: - Nursing staff will weigh residents. - Weights will be recorded in each unit's weight book and in the resident's medical record. - Any weight change of 5% or more since the last weight assessment will be taken the next day for confirmation. If the weight is verified, nursing will immediately notify the registered dietitian (RD) in writing. Verbal notification must be confirmed in writing. - The RD will review the unit's weights by the 15th of the month. - Negative weight trends will be evaluated by the treatment team whether criteria for significant weight change has been met. - The threshold for significant unplanned weight and undesired weight loss is based on 5% loss at one month 7.5% loss at 3 months, and 10% loss at 6 months. - Assessment information shall be reviewed by the interdisciplinary team (IDT) and conclusions shall be made regarding the resident's target weight, estimated daily caloric and fluid needs compared to current intakes, the relationship medical conditions and weight, and whether weight can stabilize, or improvement can be anticipated. - The IDT will also look into whether medications, cognitive or functional decline, and environmental factors (such as noise and distraction related to dining) may have contributed to weight loss. - The resident's care plan shall address, if possible, the cause of weight loss, goals and benchmarks for improvement, and timeframe for monitoring and re-assessment. - Care planning interventions for undesirable weight loss shall be based on careful consideration including resident food choices and preferences, nutritional and hydration needs, functional factors that may inhibit the resident's inability to eat independently, environmental factors that may inhibit appetite or desire to participate in meals, the use of supplements and artificial nutrition. - The RD will discuss undesirable weight loss with resident or representative. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #145 had diagnoses including major depressive disorder and dementia. The 10/31/21 Minimum Data Set (MDS) assessment documented the resident was severely cognitively impaired; required extensive assistance with eating, weighed 131 pounds, and did not have any significant weight changes. The resident's weight record documented the resident weighed in pounds (lbs.): - On 7/23/21 - 147 lbs. - On 8/2/21 - 140 lbs. - On 9/3/21 - 140 lbs (7 lbs./4.7% loss in 2 months) On 9/20/21, the nurse practitioner's progress note documented the resident was down 7 lbs. in the past month and a half. The resident's diuretic medication would be discontinued as there was no evidence of edema at this time and they would start the resident on 2 Calorie HN at med pass and monitor the resident's weight in 2 weeks. The 9/2021 medical order documented the resident was started on 2 Calorie HN (oral nutrition supplement) at 120 milliliters (ml) twice daily on 9/21/21 and received a regular ground (mechanically altered) diet. The comprehensive care plan (CCP) documented on 9/20/21, 120 ml of 2 Calorie HN at medication pass was added. The resident's weight record documented on 10/3/21, the resident weighed 130.8 lbs. (9.2 lbs. loss/ 6.5% loss over 1 month). On 10/25/21, the NP's progress note documented they saw the resident for a routine follow up and nursing staff reported no new issues. They noted the resident's weight as 130.8 lbs. On 10/29/21, RD # 21 documented the resident was on a ground regular diet and received 4 ounces (oz.) of 2 Calorie HN twice daily, providing an additional 476 calories and 20 grams of protein to promote adequate intakes and weight gain. The resident's current weight was 130.8 lbs., the resident needed extensive assistance at meals, supplement intakes averaged 50 -75%, and meal intakes averaged 75% at meals. A re-weight was requested and pending. The resident had a potential weight loss of 9.2 lbs./ 6.6% since 9/3/21. The resident's nutritional needs would be reassessed once re-weight was obtained. The CCP, revised 10/29/21, documented the resident had a potential nutritional problem related to the past medical history of depression and dementia. Interventions included encouraging and monitoring oral intakes, they were an extensive assistance with meals, honor food preferences, monitor meal consumption, monitor weights, observe for chewing/ swallowing problems, provide a ground regular diet, and report any significant weight changes to medical and IDT team. On 10/30/21, the CCP was updated to reflect that the 2 Calorie HN at med pass provided an additional 476 calories and 20 grams of protein. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident's weight record documented on 11/3/21, the resident weighed 123.4 lbs. (7.4 lbs. loss/ 5.6% loss over one month and 16.6 lbs./ 11.8% loss over 3 months). On 11/6/21, The resident's attending physician's progress note documented the resident was a seen for a routine visit and weighed 123.4 lbs. The resident's appetite varied, which was a common side effect of the resident's advanced dementia. They were down 7 lbs. from last month, nutrition will follow closely, and unit staff will continue to encourage intakes at all meals and supplements. The resident's weight record documented the resident weighed in lbs.: - On 12/1/21 - 112.3 lbs. - On 12/10/21 - 113.8 lbs. (9.6 lbs. loss/ 7.7% loss over one month and 26.2 lbs. loss/ 18.7% loss over 3 months). The undated certified nursing assistant (CNA) care instructions (Kardex) documented the resident required extensive assistance at meals, received a ground regular diet, snacks were to be offered in the evening, intakes were to be monitored, and the RD and medical provider were to be notified if the resident had decreased intakes. Resident #145 was observed walking up and down the length of the 2S unit hallway on 12/13/21 at 10:53 AM, 11:08 AM, and at 11:24 AM. Resident #145 was observed eating lunch in the lounge area of the 2S unit with the assistance of CNA #27 on 12/13/21 at 1:40 PM. The resident ate 50% of their ground roasted chicken, 50% of their spinach, 100% of their vanilla pudding, 100% of their juice, and 50% of their milk. Resident #145 was observed walking up and down the length of the 2S unit hallway on 12/14/21 at 8:51 AM and 12/15/21 at 12:00 PM. Resident #145 was observed eating lunch in the lounge area of the 2 South unit with the assistance of CNA #27 on 12/15/21 at 12:57 PM. The resident ate 75% of their broccoli, 75% of their ground chicken tenders, 100% of their juice and 100% of their milk. Resident #145 was observed walking up and down the length of the 2S unit hallway on 12/16/21 at 12:03 PM, 12/17/21 at 10:14 AM, and 12/20/21 at 8:48 AM. During an interview on 12/17/21 at 12:39 PM, CNA #27 stated monthly weights were due by the 7th of the month and if a re-weight was needed, the nurse would let them know. During an interview on 12/17/21 at 12:49 PM, LPN #23 stated the CNAs obtained the residents' monthly weights by the 7th of the month. Any nurse could document the weights in the record. If re-weights were needed, the RD would let the Unit Manager know in morning report. Weights were also discussed during the CCP meetings. If a resident had a weight change of 5 lbs., a re-weight was obtained. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/17/21 at 12:55 PM, LPN #2 stated the RD provided the Unit Manager with a list of re-weights or missing weights. The RD informed the Unit Managers of this in morning report, via email, via phone call, or in CCP meetings. During an interview on 12/20/21 at 9:23 AM, LPN #2 reviewed the unit's weight book and stated the IDT team was aware of the resident's weight loss. They obtained the resident's re-weight in 10/21. The 10/21 re-weights for the resident were documented in the weight book as 132.6 lbs. and 132.5 lbs., which was a loss of 7.4 lbs. or 7.5 lbs. The 11/21 re-weight documented in the weight book was 123.4 lbs. During an interview with diet technician (DT) #19 on 12/20/21 at 10:12 AM, they stated the nursing department obtained the resident's weights and entered the information into the computer system. During an interview with RD #22 on 12/20/21 at 10:13 AM, they stated the RDs completed the high-risk nutrition assessment and weight notes. Nursing obtained and entered the weights. If a resident had a significant weight change of 5% or more at one month, 7.5% or more at 3 months, and 10% or more at six months, the RD should complete a weight note. The weight note should document if the significant weight change was planned or unplanned along with any interventions. Re-weights were requested on any resident that had a 5 lbs. weight change each month. Re-weights were requested in morning report, via email, or by calling the Unit Manager. If they requested a re-weight, they would document a re-weight was requested in the medical record. RD #22 reviewed Resident #145's weight record and stated the resident had a significant weight loss in 10/21 and they did not see a re-weight in medical record. The resident also had a significant weight change in 11/21 and a re-weight was not requested. They were unsure how the significant weight loss was missed. If a resident refused to be weighed nursing staff should document their refusal in the medical record. During an interview with Regional RD #43 on 12/20/21 at 10:29 AM, they stated initial weights were due by the 7th of the month. Weight notes were due by the 15th of the month. They expected staff to write a weight note documenting the significant weight change and along with any interventions. The resident's CCP should also be updated if there was a significant weight change. There should have been a weight note documented regarding Resident #145's significant weight loss. Weights were important because a clinical indicator of the resident's nutritional status. During an interview with the Director of Nursing (DON) #7 on 12/20/21 at 11:57 AM, they reported they were the RN who oversaw the resident's unit. The CNAs obtained the resident's monthly weights, and the nurses entered the resident's weights into the medical record. The nurses on the unit were made aware of the need for re-weights by the RD. They expected staff to document if a resident refused to be weighed. If a resident had a significant weight change, they would also expect a note to be documented and the CCP to be reviewed and if needed updated. 10 NYCRR 415.12(i)1

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 35045 Based on observation, interview, and record review during the recertification survey conducted on 12/13/21-12/21/21, the facility failed to ensure the menu was prepared in advance, followed, and reflect, based on reasonable efforts, input from the residents for 4 of 35 residents reviewed (Residents #28, 91, 111, and 215). Specifically, Residents #28, 91, and 111 received a substitution of peas instead of spinach at the 12/13/21 lunch without documented rationale for the substitution. Resident #28 received incorrect items at 2 meals and Resident #215's meal preferences were not honored, and they received foods they did not like. Finding included: The 1/2021 Food Services policy and procedure documented individual food preferences will be assessed upon admission and communicated to the interdisciplinary team. Upon the resident's admission (or within 24) hours after his/her admission the dietitian or nursing staff will identify a resident's food preferences. MENU NOT FOLLOWED: 1) The 2021 Fall/Winter Menu Week 2 Menu documented the vegetable served for lunch meal on 12/13/21 was spinach. The vegetable to be served for dinner on 12/15/21 was steamed broccoli. There were no alternate options listed for the vegetables. The undated facility Test Tray audit form documented the meal tray should be checked that all food items reflect the portion, and the food item consistencies were accurate as stated on Mealtracker (tray ticket). Resident #28 was admitted to the facility with diagnoses including hyponatremia (low sodium level in the blood) and abnormal gait and mobility (difficulty walking). The 12/10/21 Minimum Data Set (MDS) assessment documented the resident was cognitively intact and required set-up only for meals. Resident #91 was admitted to the facility with diagnoses including pneumonia and chronic obstructive pulmonary disease (COPD). The 10/15/21 MD documented the resident was cognitively intact and required limited assistance for meals. Resident #111 was admitted to the facility with diagnosis including diabetes. The 10/23/21 MDS documented the resident was cognitively intact and required set-up only for meals. During an interview on 12/13/21 at 12:50 PM, Residents #28 and #111 stated the kitchen did not always send what they ordered, and their meal slip did not match what was on their trays. During the lunch meal observation on 12/13/21 at 1:03 PM, Residents #28, 91, and 111's meal tickets documented spinach and they were served peas. There was no signage or notification to indicate there was a menu item substitution at the lunch meal. During the observation, Resident #28 stated they did not like peas. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/15/21 at 1:34 PM, Resident #28 stated that the supper meal on 12/14/21 was supposed to be chicken salad sandwich, and they were provided two slices of white bread in a plastic baggie with a packet of peanut butter and packet of margarine. The resident did not eat the bread and it was observed on the resident's bedside tray table during the interview. During an interview on 12/16/21 at 8:45 AM, Resident #28 stated the supper meal on 12/15/21 had peas as the vegetable again. During an interview on 12/20/21 at 12:18 PM, the Food Service Director stated when changes were made to the menu, they let their Registered Dietitian (RD) know, and the Food Service Director would check to see what food item could be used as a substitute. If there was a change, the dietetic technician (DT) would notify the nursing staff on the units. The Food Service Director stated if there was something wrong with a meal tray, nursing staff would have to communicate that to the kitchen. The nursing staff did not usually call the kitchen about incorrect tray items. During an interview on 12/20/21 at 12:20 PM, dietary aide #39 stated they checked meal tickets for accuracy during the tray line. If there was a missing or incorrect item, they would let the rest of the line know to make the correction. Once the trays were corrected or changed, they were loaded into the carts and sent to the units. During an interview on 12/20/21 at 1:06 PM, dietary aide #40 stated they were working on 12/13/21 and but did not receive any call from the nursing staff that they need to make resident tray corrections or that any food items were missing. They had spinach for lunch and if the resident had spinach on their meal ticket, they should have received spinach, not peas. FOOD PREFERENCES: 2) Resident #215 had diagnoses including diabetes and anemia. The 11/23/21 Minimum Data Set (MDS) assessment documented the resident was moderately cognitively impaired and required supervision with eating. On 11/22/21 registered dietitian (RD) #22's progress note documented the resident was independent with eating after tray set-up and meal preferences were up to date and will be updated. An 11/22/21 RD #22's admission nutritional assessment documented the resident meal preferences were up to date and would be updated. The 12/6/21 comprehensive care plan (CCP) documented the resident had a nutritional problem and was at risk of malnutrition. Staff were to provide set up and assistance with feeding, monitor meal consumption records, and identify/honor food preferences. During an interview with the resident on 12/13/21 at 11:56 AM, they stated they did not like oatmeal, yet they received it almost daily. They were served meals they would not select themselves. The resident stated no one had taken their food preferences. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the resident on 12/14/21 at 9:27 AM, they stated they received oatmeal that morning. They told someone the first week they were at the facility they did not like it and could not recall who they told. The resident stated it was wasteful for them to receive foods they did not like, and they would want their preferences taken. The resident meal tickets documented the resident received oatmeal on 12/14, 12/18, and 12/21/21. During an interview with dietetic technician (DT) #19 on 12/21/21 at 11:27 AM, they stated themselves or the RD would interview residents on admission. At that time, they would note their preferences. They were not very familiar with the resident and they had not interviewed them. During an interview with RD #22 on 12/21/21 at 11:40 AM, they stated when a resident was newly admitted they would go to meet the resident; find out their dislikes and bring the menu and alternatives to them. They stated DT #19 could go over the menu items. Food preferences would be entered into the facility's meal tracker. They reviewed the resident's electronic medical record during the interview. RD #22 stated they did not see the resident. They stated it may have been a week they had a lot of admissions and the DT may have seen the resident. If the RD was unable to get to the resident, they would get information from the staff and that was probably what happened. They stated they were not aware the resident did not like oatmeal. 10NYCRR 415.14(c)(1-3)

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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. 35045 40491 40803 Based on observation, interview, and record review during the recertification survey conducted on 12/13/21 through 12/21/21, the facility failed to provide food and drink that is palatable and at a safe and appetizing temperature for 1 of 2 test trays reviewed. Specifically, a breakfast tray was served at unpalatable temperatures to Resident #2 and Residents #6, 28, #103, 111, and 133 reported receiving food at unpalatable temperatures. Findings include: The undated Test Tray Audit form documents acceptable temperatures of hot foods including entrees and hot cereals should be 140 degrees Fahrenheit (F) or above; and cold foods including beverages should be 40 degrees. Resident interviews included: - On 12/13/21 at 2:24 PM on Unit 2 West, Resident #28 stated the hot food was not served hot. - On 12/13/21 at 2:32 PM on Unit 2 West, Resident #111 stated the food did not arrive on time and was cold at times. - On 12/14/21 at 8:48 AM on Unit 7, Resident #133 stated the food was unbelievably bad, the hot food was not hot, and the cold foods were semi-warm. Ice cream was often melted by the time it was served. - On 12/14/21 at 8:41 AM on Unit 5, Resident #6 stated they could not get a hot meal at the facility. - On 12/14/21 at 10:35 AM on Unit 5, Resident #103 on Unit 5 stated the food was bad and not hot. On 12/14/21 at 9:25 AM, the meal trays for Unit 6 were being delivered. Resident #2 was served their breakfast meal at 9:45 AM. At 10:35 AM, certified nurse aide (CNA) #58 asked Resident #2 if they were hungry and went to assist the resident with their meal. The meal was taken for a test tray at that time. The nectar-thick orange juice was 70 degrees F, the pureed sausage with gravy was 107 degrees F, the oatmeal was 108 degrees F, and the nectar-thick milk was 67 degrees F. The food tasted lukewarm. CNA #58 stated 50 minutes was not a long time for a resident to wait for assistance with their meal as they had a lot of residents to assist. CNA #28 requested a new breakfast tray for Resident #2 at the time the food temperatures were being taken. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/20/21 at 12:31 PM, the Food Service Director stated the temperatures of the test tray on 12/14/21 were not acceptable including the orange juice at 70 degrees F, oatmeal at 108 degrees F, sausage at 107 degrees F, and milk at 68 degrees F. The Food Service Director stated the tray was out of their hands once it was delivered to the units and at that point, nursing was responsible for the food. 10NYCRR 415.14(d)(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 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33421 34459 Based on observation, interview, and record review during the recertification survey conducted on [DATE]-[DATE], the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety affecting the entire facility. Specifically, the facility failed to maintain a walk-in cooler in operating condition and was found to have an ambient air temperature above 45 degrees Fahrenheit (F). Milk from that walk-in cooler was found to be at 59.5 degrees F and was to be served to residents (required temperature: 45 F or less per New York State, NYS, code and 41 F or less per Food and Drug Administration, FDA, food code). Additional food product in a stand-up cooler that came from the improperly functioning walk-in cooler contained cottage cheese which was measured at 52 degrees F. The milk from the line was pulled at 12:45 PM. Unit 3 was called at 12:52 PM and the dairy products were not removed from the resident trays. Fifty-seven residents (Residents #6, 22, 24, 34, 38, 41, 49, 50, 54, 69, 71, 75, 76, 79, 86, 89, 96, 98, 100, 101, 102, 103, 105, 122, 123, 125, 129, 131, 143, 145, 147, 151, 152, 156, 161, 166, 168, 172, 178, 180, 184, 188, 198, 200, 202, 206, 208, 215, 216, 218, 221, 222, 223, 424, 425, 426, and 427) received potentially hazardous foods. The thermometer in the walk-in cooler was reading 39 F and there was not a process in place to calibrate the thermometer in the walk-in cooler. In addition, the seal to the cooler was ripped and torn. Adulterated food was found in the functioning walk-in cooler which included bags of spoiled lettuce and moldy garnishes. Hot food was not held at proper temperatures. During lunch service, meatballs, mashed potatoes, and red sauce were held at ,d+[DATE] F. (Required temperature: 140 F or above per NYS code and 135 F or above per FDA food code). The facility was unaware and informed by the surveyor. A leaking pipe from the compressor in the freezer was causing ice to build up and contaminate food products. A pan of leftover corned beef (wrapped in foil) was adulterated when the ice came in contact with the food. The facility's failure to properly maintain the kitchen puts 212 of the 216 residents at immediate risk for serious illness caused by consumption of potentially contaminated food and drink. This resulted in Immediate Jeopardy to resident health and safety. Findings include: Review of the undated test tray audit tool noted acceptable delivery temperatures must be 40 degrees Fahrenheit (F) (cold) and 140 degrees F or above for (hot). Review of the undated Food Receiving and Storage Policy documented refrigerated foods must be stored below 41 degrees F unless otherwise specified by law. Review of the undated Food Preparation and Service policy documented foods should be held above and out of the danger zone between 41 degrees F and 135 degrees F to prohibit the rapid growth of pathogenic organisms that cause food born illness. Review of the undated sanitization policy noted under bullet 1 all kitchen, kitchen areas and dining areas shall be kept clean. Under bullet 2 all utensils, counters, shelves and equipment shall kept clean and good repair. (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Food temperature concerns: Kitchen: The daily refrigerator temperature logs for the facility's large walk-in coolers for the month of ,d+[DATE] documented temperatures should be maintained at or below 40 degrees F, temperatures should be checked and recorded once a day (at the opening of the operation or during other stable time) and should be checked using the accurate internal probe. All temperatures recorded were within acceptable range. When observed on [DATE] at 11:50 AM, walk-in cooler #2's ambient air temperature was measured to be 50 degrees F. Butter, that was in the cooler, measured 53 degrees F. When observed on [DATE] at 12:06 PM, the following food items were removed from walk-in cooler #2, had temperatures that were out of range (over 41 degrees F), and were voluntarily discarded by the Food Service Director: - Cold cut turkey and ham was 55 degrees F. - A tray of egg salad was 53 degrees F. - A 6 inch tray of ham salad was 53 degrees F. - A tray of ground sausage was 55 degrees F and was labeled and dated on [DATE]. - A container of tomato sauce was 52 F and was dated [DATE]. - A large tray of stewed tomatoes, labeled and dated [DATE], measured 47 degrees F. - A box of cubed cheese was 55 degrees F. - A 4 inch deep hotel pan of hard boiled eggs was 52 degrees F. - A 4 inch deep hotel pan of rigatoni was 51 degrees F. - A case of shell eggs was 47 degrees F. - 7 boxes of shredded cheddar and mozzarella cheese were 44 degrees F. When interviewed on [DATE] at 11:30 AM, the Food Service Director stated they thought they had 8 hours to fix the temperature issues with the foods in walk-in cooler #2. The State surveyor intervened and stated food may be out of temperature for up to 2 hours for preparation, or service. The Food Service Director then stated they would discard the foods that were out of temperature because they were not sure how long the cooler was out of temperature. (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	When observed on [DATE] at 12:43 PM, whole milk was in a glass in a standup cooler at the end of the tray line in the kitchen. The doors to the stand up cooler were open and the milk was 59.5 degrees F. At 12:44 PM, the surveyor informed the Food Service Director of the milk temperature and the Food Service Director stated they were going to remove milk from the meal service. At 12:45 PM, the milk in the standup cooler was removed from the cooler and a nectar-thick milk was checked and was 50 degrees F. At that time, milk from the standup cooler had been delivered to the nursing units and the Food Service Director stated they would ask the registered dietitian (RD) to call the units to remove the milk from the resident meal trays that had been delivered. The Food Service Director stated it was the first time they were aware of issues with milk temperatures and when they did test trays, the milk was usually around 43 degrees F. At 12:50 PM, the Food Service Director was observed removing items from the standup cooler at the tray line. The stand up cooler also contained cottage cheese which was measured at that time to be 52 degrees F. At 12:55 PM, the Food Service Director stated in an interview, Units 2S, 2W, 4, 5, and 7 had been served lunch trays already and Units 3 and 6 had not been served yet. When interviewed on [DATE] at 12:58 PM, dietary aide #49 stated the milk in the standup cooler during the tray line had been poured before 11 AM or maybe 10 AM that day and was moved from walk-in cooler #2 to the standup cooler. They stated after the trayline was done, the milk went from the standup cooler back into walk-in cooler #2. Additionally, at the time of the interview, the Food Service Director(who was present) stated walk-in cooler #2's door did not seal, but it could be pushed closed. During interview on [DATE] at 1:01 PM, the Administrator and Assistant Administrator were notified by the surveyor of the issues with the dairy products' temperatures and they stated they would call the units to ensure the items were removed from service on Units 2S, 2W, 4, 5, and 7. At 1:29 PM, a ham sandwich in walk-in cooler #2 was measured at of temperature of 53 degrees F. A turkey sandwich from a pan at the top of walk-in cooler #2 was measured at 76 degrees F. These were placed in the cooler after lunch service by a staff member. Unit 4 Observations on Unit 4 on [DATE] included: - at 12:39 PM, a milk from Resident #71's tray was 64 degrees F. - At 12:41 PM, a milk from Resident #105's tray was 65 degrees F. Unit 3: When observed at 12:49 PM, the residents on Unit 3 had milk on their meal trays and staff were not observed to remove milk from the meal trays. - At 12:52 PM, Resident #178 was assisted by certified nurse aide (CNA) #32; the resident consumed two sips of milk. Licensed practical nurse (LPN) #14 answered a telephone call and hung up the phone. (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	- No milk was observed to be removed from residents' trays. - At 1:01 PM, Resident #178's milk was taken for a temperature and was 64 degrees F. On [DATE] at 1:08 PM, the meal trays were removed from the resident rooms on Unit 3. The surveyor told the unit staff to ensure no milk products were left in the resident's rooms. When interviewed on [DATE] at 1:15 PM. LPN #14 stated the telephone call they received at 12:52 PM was to tell them to remove all milk from the residents' trays but at the end of the call, the person on the other end of the phone told LPN #14 to forget about it and not to remove the milk. LPN #14 stated Residents #75, 123, 22, 54, and 129 had consumed all the milk on their lunch trays. LPN #14 stated they did not know who the person was on the other end of the phone. Unit 2S: When observed on [DATE] at 12:56 PM, the lunch meal cart arrived to Unit 2S. At 1:01 PM, a carton of milk was removed from Resident #168's lunch meal tray by the surveyor. The temperature of the milk was 73.1 degrees F. At that time, the surveyor asked LPN Manager #2 to remove all milk products from the residents' meal trays. An additional 14 residents (Residents #98, 100, 122, 145, 151, 152, 166, 168, 184, 188, 202, 206, 216, 218) had milk and milk products on their meal trays, which were removed prior to being served to residents (at the surveyor's direction). LPN Manager #2 stated in an interview at that time, they were not aware there was an issue with the temperature of milk and milk products in the building until the surveyor informed them. Unit 6: When observed on [DATE] at 1:29 PM, lunch meal was delivered to Unit 6. Included with the lunch meal were 2 ham sandwiches for residents, the temperature between the ham slices was measured to be 78.8 F. Staff were notified, and both sandwiches were disposed of. On [DATE] at 1:43 PM, the Administrator and Food Service Director were notified by the surveyor of the ham and turkey sandwich temperatures. They stated the sandwiches would be removed from service. On [DATE] at 2:06 PM, the Director of Nursing (DON) provided a list of residents who consumed dairy products from lunch. The DON stated the residents would be assessed by the registered nurse (RN) and nurse practitioner (NP). When interviewed on [DATE] at 2:46 PM, dietetic technician (DT) #19, stated the Food Service Director asked them to call Unit 2S at 1 PM to determine if they had received their lunch meals yet. DT #19 stated they called Unit 2S, were unsure who they spoke to, and was told the unit had not received their lunch meal cart at that time. They let the Food Service Direct know Unit 2 South had not received their meal cart yet at the time that they called. DT #19 stated they were unsure why they were asked to call Unit 2S, but did overhear discussions regarding milk product temperatures. They stated after lunch, they attended a care plan meeting until 2 PM and after the meeting, they informed the registered dietitians (RD) about the Food Service Director asking them to call Unit 2 South and about the discussions they overheard regarding the milk product temperatures. (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	When interviewed on [DATE] at 2:49 PM, RD #21 stated they were not asked to call any of the units at lunch today and was informed by DT #19 at 2 PM, about the discussion in the main kitchen regarding milk product temperatures. When interviewed on [DATE] at 2:50 PM, RD #22 stated they were not asked to call any units during lunch that day and were informed by DT #19 at 2 PM about the discussion in the main kitchen regarding milk product temperatures. RD #22 stated the RDs completed a basic monthly main kitchen sanitation audit which included observing if the cooler and freezer temperature logs were filled out. They did not check or take any temperatures of food items in the coolers or freezer. RD #22 stated the last monthly audit completed was in , d+[DATE] and the ,d+[DATE] audit was due [DATE]. When interviewed on [DATE], the Food Service Director stated: - at 2:53 PM, walk-in cooler temperatures were recorded daily around 7 AM. Staff constantly open and close refrigerators, but occasionally will leave the cooler open for a short time when they are busy. Temperatures were read off a similar thermometer as is in the walk-in cooler, located in the back on the bottom. - At 2:55 PM, the Food Service Director stated they randomly checked the cold food including thickened drinks, salad, and cold sandwiches. They stated they did not record any of the random temperatures that were measured of cold food items. When interviewed on [DATE] at 4:26 PM, nurse practitioner (NP) #4 stated it was a concern if residents had consumed items that were served at a suboptimal level. The residents who had been identified as consuming the dairy products were assessed on that day. The milk could have bacteria depending on how warm it got. If a resident had an adverse reaction from the milk, they would likely exhibit gastrointestinal symptoms such as diarrhea. The symptoms were likely to occur within 24 hours and the facility would continue to monitor. When interviewed on [DATE] at 4:39 PM, the Medical Director stated the impacts of dairy products being out of temperature depended on how long they were out of temperature. Typical side effects would be gastrointestinal issues such as nausea and diarrhea. They stated NP #4 was onsite everyday and would follow up with the residents involved. The Medical Director was not made aware of the issues with the consumed dairy products on [DATE]. Thermometer concerns: When interviewed on [DATE] at 11:30 AM and 11:57 AM, the Food Service Director stated they usually record the walk-in coolers' internal temperatures each morning approximately at 7 AM. They go by the temperature reading on the hanging manual thermometer maintained in the walk ins. That morning, they stated they recorded a temperature of 38 degrees F. When observed on [DATE] at 12:45 PM, the internal ambient air temperature of walk-in cooler #2 was measured to be 55 degrees F. The prepared milks in cups stored within the tray line holding refrigerators were measured to be between ,d+[DATE] degrees. The hanging manual thermometer within walk-in cooler #2 indicated the temperature of the cooler was 39 degrees F. The internal temperature of ham cold cut was measured to be 51 degrees F, located in walk-in cooler #2. (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	When interviewed on [DATE] at 2:55 PM, the Food Service Director stated they do not calibrate the hanging thermometers in the coolers, nor do they check the temperature of any products in the coolers. Adulterated Food: When observed on [DATE] at 11:40 AM, there was a case containing lettuce that appeared rotten and partially liquefied, located on top shelf of the rack on the left side in walk-in cooler #1. The bagged lettuce was stamped by the manufacturer with the date of [DATE]. When interviewed on [DATE] at 11:40 AM, the Food Service Director stated the bagged salad was dated [DATE] but may have been frozen in transport. They voluntarily discarded the entire box. This produce box also contained unwrapped herbs that were wilted and rotting and pre-bagged salad mixes. The Food Service Director stated in an interview at that time, the cooks and food preparation staff usually notified the Food Service Director when foods were spoiled or rotten, and then they throw the food away. When interviewed on [DATE] at 2:55 PM, the Food Service Director stated the food service supervisors were responsible for food inspections in the cooler to make sure nothing was rotten and/or expired. They stated supervisors go through to check and make sure things are dated, and the Food Service Director will go through and check to make sure all items were dated. The Food Service Director stated they also made sure everything was labeled and added that there were no calibration or accuracy checks being done prior to today. They stated they had never taken random food temperatures of items in the walk-in coolers. Hot holding violations: When observed on [DATE] at 11:30 AM, the following food temperatures were measured on the service line, and were out of acceptable range for hot holding: - Red sauce was 128 degrees F. - Meatballs were 123 degrees F. - Mashed potatoes were 129 degrees F. - The steam table units were on and water within the steam tables measured at 158 degrees F. At the time of the observation, the Food Service Director stated the facility recorded food temperatures when items were put into the steam tables. Review of the temperature recordings documented by the facility at the start of meal service revealed each item measured had a temperature recorded as greater than 160 degrees F. After these temperatures were brought to the attention of the Food Service Director, for correction, the items were removed from service and reheated to 165 degrees F. When interviewed on [DATE] at 11:30 AM, the Food Service Director stated that the initial cooking temperatures were logged by the cook who was also doing the reheating. They thought that maybe these items being uncovered could have affected their temperatures. They stated the probe thermometers used by the cook's were calibrated daily. (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	When interviewed on [DATE] at 2:55 PM, the Food Service Director stated they did random hot food checks and hot food should be at least 140 degrees F for hot holding. The Food Service Director stated if the foods were not 140 degrees F but were close, they would reheat the food item. The Food Service Director stated today they did their random check on the tuna noodle casserole and the peas. They stated there was not a policy for taking food product temperatures. Staff monitored temperatures on tray line periodically, but the Food Service Director will usually check them as well. They stated they did not record any of the random temperatures they took. The Food Service Director stated they did not check food temperatures again during the tray line or when food left the kitchen. The steam tables were turned on in the morning at 5:30 AM and they stayed on all day. The steam tables were set to high which was 10. The staff did not check the temperature of the water in the wells, they looked for the presence of steam from the steam table. Physical Contamination and Cleanliness: Review of the monthly kitchen audits documented on [DATE], the ice machine was clean with no lime, rust or mildew, ice scoop was stored appropriately outside of the machine. The [DATE] audit was completed by Regional RD #43. The [DATE], [DATE] and [DATE] kitchen audits did not mention the ice machine or the ice scoop storage. The [DATE], [DATE], and [DATE] audits were completed by RD #22. The weekly cleaning audits documented there was a different area or item of the kitchen cleaned each day on weekly rotations. The ice machine was not included in this rotation. When observed on [DATE] at 10:28 AM, the ice machine adjacent to the kitchen showed signs of dark spotty mold like substance on the inside on both sides of upper section of the unit. The top and outside of ice machine was unclean with food spills and was sticky. The ice scoop was noted to be in a plastic holder attached to the wall adjacent to the ice machine. The wall and the scoop holder attached to the wall that the scoop was in contact with was unclean and soiled. At the time of the observation, the Food Service Director stated daily cleanings were done by food service workers and then monthly deep cleans were performed. The walk-in freezer was observed on [DATE] at 10:34 AM, and the following was present: - frost was puddling under the condenser fans unit. - A 3 foot x 3 foot sheet of ice was present on the floor below the storage racks and main aisle between the racks. - Four boxes of food product were wet from dripping condensate on the outside and there was ice buildup. - There were 2 large sheet trays under the fans collecting condensate water and the water was frozen solid and spilling over the trays. (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	At the time of the observation of the walk-in freezer on [DATE] at 10:34 AM, the Food Service Director stated in an interview, the walk-in freezer had been in the condition it was in for about ,d+[DATE] weeks. The Food Service Director stated they replaced the sheet pans each day when they were full of ice build-up from the dripping condensate. An HVAC (heating ventilation and air conditioning) vendor came in initially and the Food Service Director stated they hoped they would be back today ([DATE]). The Food Service Director stated the vendor stated they needed to wrap the line with installation to stop the condensation from dripping from the condenser unit. Observations in the kitchen on [DATE] at 10:44 AM, included: - Floors and walls in the food preparation areas and underneath and in front of the stoves/ovens were unclean and soiled with food debris. - Black soiled flooring was present in several areas and all the grout between flooring tiles was blackened. - Improper air drying and storage was observed behind the 3 bay sink area. The Food Service Director stated in an interview at that time, that section was a clean drying area for dishware. Numerous sheet trays and deep trays were present in this section and were being improperly air dried with water droplets on the outside and inside surfaces. These items were stored tight together. - Floors in front of and underneath the dish machine were not smooth and easily cleanable. The floor was missing tiles and grout and a 10 foot x 10 foot section contained standing water with unclean food debris and spillage under and between tiles. - The juice machine was unclean with juice spills on the lines. Under the machine was sticky and juice was draining into a cut plastic bucket. - Walk-in cooler #2 had pieces of sliced cold cut turkey on the floor, racks, and shelves. The floor also contained other food debris and was unclean. At the time of the observation on [DATE] at 10:44 AM, the Food Service Director stated in an interview, all items on the racks should be clean and air dried before moving them to be stacked and stored in that area. He further stated the spray gun and juice machine were cleaned every night. The tiles in the dish machine area have been black in color for at least three months. The grout gets filled and it wears away and needed to be done again. The Food Service Director stated maintenance replaced the grout when needed. Observations on [DATE] at 11:37 AM, (one day after initial inspection) included: - the kitchen floors remained unclean and soiled with food debris and black grout, including under and behind major appliances on the cook lines. - The stored dishware, behind the 3 bay sink section, including the pans and trays were stored wet and stacked together without being fully air dried. All items were stacked with water collecting inside and in between one another. (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	- The dish washing area contained broken, missing floor tiles, and grout had food debris and milk spillage in the grout spaces and under floor. - The walk-in freezer contained a large sheet of ice formation on the floor under the storage racks approximately 8 feet x 4 feet. The sheet pans were full of ice under condenser fans. There were two 10 pound (lb) boxes of sausage, a 10 lb box of strudel, and a 14 lb box of pizza crusts covered in dripping refrozen unclean condensate ice water. When observed on [DATE] at 12:11 PM, the hand washing sink did not have paper towels in the dispenser. In addition, the can opener was unclean and soiled with a black sticky substance. The can holder and the blade were also unclean and soiled with the black sticky substance. When interviewed on [DATE] at 12:50 PM, the Food Service Director stated they were planning to move the food products that were wet and encased in the ice dripping from the compressor lines. The Food Service Director stated they were planning get the food out of the walk-in freezer today and the food had been there for about a week. The Food Service Director stated the majority of the facility's food stock turned over within one week to 9 days. At the time of the interview, there was corned beef in a foil pan wrapped in aluminum foil and labeled with a date of [DATE] and 2 cases Italian sausage (ground) heavily encased in ice and affecting the packaging. Meatballs and similar product cases were also compromised and encased in ice. The foil pan of corned beef wrapped in foil was voluntarily discarded due to the ice encasing it, the aluminum foil covering was partially ripped open and the condensate ice/water was in contact with the food product. When interviewed on [DATE] at 2:53 PM, the Food Service Director stated a HVAC repair person should be coming tonight ([DATE]) to look at the walk-in cooler #2 and the walk-in freezer. The freezer issues have been going on for 3 months and started approximately [DATE]. On [DATE], the condensation lines were wrapped on the roof and more was needed. They were not aware of the walk-in cooler #2 having issues with holding temperature. Review of kitchen maintenance log confirmed the dates of [DATE] for reporting freezer leak and HVAC vendor coming out. It also identified the condensation lines were wrapped on the roof. --- Immediate Jeopardy was identified, and the facility Administrator was notified on [DATE] at 5:43 PM. The Immediate Jeopardy was removed on [DATE] at 4:42 PM, based upon the following corrective actions taken: - The freezer was repaired on [DATE] at approximately 7:00 PM. - Walk-in cooler #2 was found by the vendor to be cooling properly. The door/seal was broken and repair was planned. Use of walk-in cooler #2 was stopped until the repair could be made. - The facility implemented a plan to check accuracy of the thermometers in the walk-in coolers. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grand Rehabilitation and Nursing at Utica	1657 Sunset Ave Utica, NY 13502

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	- Drinks were maintained cold on the trayline in a pan with ice and the facility was no longer using the stand-up coolers during service. - Sandwiches were transported to the units in an Igloo cooler to the units instead of on a tray in the Cambro/hot box. - Kitchen staff were educated on hot holding temperatures and temperatures in the cooler. 100% of currently working staff were educated. - Education signage was placed throughout the kitchen on hot holding temperatures, refrigeration, and proper storage of food. - The heat to the kitchen was turned off which improved the ambient temperature of the kitchen. - A detailed cleaning schedule was posted and to be followed. - Monitoring of residents who consumed dairy products: with shift-to-shift report for 5 days and on the 24 hours report. 10NYCRR 415.14(h) 40491 40803 44838

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. 31623 Based on observation and interview during the recertification survey conducted on 12/13/21-12/21/21, the facility failed to operate and provide services in compliance with all applicable Federal, State, and local laws, regulations and codes affecting 1 of 7 units (Unit 2S) reviewed. Specifically, the Unit 2S dining room's heat was not working, residents were displaced to their rooms and hallways for meals, and the facility did not report the heat outage to the New York State Department of Health (NYS DOH) as required. Findings include: On 12/13/21 at 10:38 AM, the Unit 2S dining room was observed to be locked. On 12/13/21 at 10:40 AM, licensed practical nurse (LPN) Manager #2 stated the dining room was closed because the heat was not working. Residents were to eat in their rooms or the hallways. At 12:25 PM, LPN Manager #2 stated there were 16 residents who typically ate in the dining room that were currently eating in the hallway due to the closed dining room. LPN #2 stated the dining room had been closed for 2 to 3 weeks. When observed on 12/13/21 at 4:10 PM, the Unit 2S dining room was locked and cold. The packaged terminal air conditioner (PTAC, heating/cooling system) unit was not in operation and not functioning. During an interview with Director of Plant Operations #50 on 12/14/21 at 9:18 AM, they stated they had been having a problem with the heat and temperatures in the Unit 2S dining room since the end of 10/2021. The heat and temperatures were all over the place and would not stay constant. They contacted a vendor who confirmed there were issues with the heat exchangers, and they needed to be replaced. They ordered new heat exchangers on 11/19/21. They were told it would take 5 weeks as they were on back order. They were notified this date the part would arrive in 10-17 days. The Administrator was present during the interview and stated they did not deem the incident reportable as the facility was still providing services and feeding residents. Per request, an itemized receipt dated 11/19/21 was provided and it documented 2 heat exchangers were ordered. During an interview with the Administrator on 12/20/21 at 2:17 PM, they stated they did not have a policy for reporting environmental incidents and they used the New York State (NYS) reporting manual as guidance. They did not feel the change in service warranted a report to the NYS DOH. 10NYCRR 400.2 40491 40803

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. 40491 Based on observation, interview, and record review during the recertification survey conducted 12/13/21-12/21/21, the facility failed to furnish services by a person or agency outside the facility if the facility does not employ a qualified professional to furnish a specific service for 2 of 3 residents (Residents #6 and 175) reviewed. Specifically, Resident #6 missed a virtual medical appointment; and Resident #175's outpatient nephrology appointment was canceled, the cancellation was not communicated, and the resident went to the canceled appointment with a family member. Findings include: The 1/2021 Consultations policy documents the facility is responsible to provide consultation services for any resident as needed. The facility assumes responsibility for obtaining services that meet professional standards. The attending physician will write an order for a consult and the reason in the medical record. Designated staff will schedule the consult; if using outside consultant, the employee will arrange the appointment, transportation, and notification of resident designated representative. The facility will provide escort to an appointment if a designated representative declines to attend. The policy did not document a process for virtual consults. 1) Resident #6 was admitted to the facility with diagnoses including Parkinson's disease (a degenerative neurological disease) and seizures. The 11/24/21 Minimum Data Set (MDS) assessment documented the resident was cognitively intact, required limited assistance or supervision for most activities of daily living (ADL), and was in frequent pain. The 8/17/21 comprehensive care plan (CCP) documented the resident required assistance with ADLs related to musculoskeletal impairment. The 10/4/21 provider order documented the resident had a neurology appointment scheduled on 12/9/21 at 2:00 PM. The 11/23/21 nurse practitioner (NP) #4's progress note documented the resident had questionable Parkinson's and reported pain. The plan was for the resident to continue to see neurology and had an upcoming appointment in 12/2021. The 12/9/21 psychiatric NP #47's progress note documented the resident had a neurology appointment later that day; the resident was looking forward to speaking with the neurologist and was hopeful it would help with their tremors. There was no documentation the resident attended the 12/9/21 neurology consult appointment. The 12/2021 nursing progress notes did not document the resident had or attended a neurology appointment. (continued on next page)

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/14/21 at 8:42 AM, the resident was observed in a recliner in their room. The resident was noticeably tremoring in their upper extremities and leg throughout the 5-minute interview. The resident stated their tremors had been worse for the previous 3 days and they were in pain because of the tremors. During an interview on 12/20/21 at 1:15 PM, the outpatient neurology receptionist #45 stated the resident had a virtual appointment scheduled for 12/9/21 to address their tremors. The neurologist was present on the virtual appointment and the facility never logged on to have the resident participate. The neurologist was ready, the appointment did not occur, and was rescheduled for12/27/21. During an interview on 12/21/21 at 8:43 AM, licensed practical nurse (LPN) Nurse Manager #46 stated they helped set up outpatient appointments and kept track in an appointment book. An order was entered in the electronic record, so staff were aware. Unit clerk #48 was notified, and they updated the calendar for appointments for the whole facility. The resident had a virtual appointment set up for 12/9/21 and the order had been entered by the Assistant Director of Nursing (ADON). On 12/9/21, the LPN waited with the resident for the virtual appointment to start with the outpatient neurology office and the resident was not contacted for the appointment. The LPN found out after the missed appointment that the link had been sent to the ADON and the LPN stated they did have access to that link. The LPN rescheduled the appointment with their email as the contact. The resident was having issues with their tremors and they had a diagnosis that required attention. NP #4 had been following the resident and requested the neurology appointment. During an interview on 12/21/21 at 9:05 AM, ADON #8 stated they had been providing registered nurse (RN) Unit Manager coverage for the resident's unit. If NP #4 scheduled the appointment, the nurses entered the order and let the ADON know. If the consult was being completed via video, the consultant's office would email the ADON or the Unit Manager with the video link that could be accessed on the tablets or laptop for the resident. The resident had an in-person appointment scheduled at first, which was changed to virtual due to transportation and a long commute. The ADON did not think they were working at the facility the day of the scheduled virtual appointment but had heard the appointment had been missed. The resident was aware they had a virtual appointment. The ADON thought LPN Manager #46 may not have had access to the appointment. The ADON stated if the LPN and the resident were waiting for the neurology office virtual appointment someone should have called when they were not contacted. It was a system breakdown for the resident. During an interview on 12/21/21 at 9:19 AM, unit clerk #48 stated they would set up appointments for residents upon request. They kept a calendar of all the appointments for residents, the reason for the appointment, and kept track of any canceled appointments. The unit clerk looked at the calendar for 12/9/21 for the resident, which noted the appointment had been changed from in person to virtual on 12/9/21. The nurses typically set up the virtual appointments and the unit clerk had not been notified the appointment had been missed. 2) Resident #175 was admitted to the facility with diagnosis including diabetes mellitus and chronic kidney disease. The 9/16/21 Minimum Data Set (MDS) assessment documented the resident was cognitively intact and required supervision for most activities of daily living (ADLs). The 10/2021 Treatment Administration Record (TAR) documented the resident had a nephrology appointment on 10/28/21 at 11:30 AM and the resident would be going to the appointment with their family member. (continued on next page)

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 10/28/21 licensed practical nurse (LPN) Manager #46's progress note documented the resident had left for an appointment. The appointment was canceled on 10/25/21 due to high risk of exposure/quarantine at the facility. The resident's family member called the facility to confirm the cancellation upon arrival to the outpatient office. The office would call to reschedule the appointment. There was no other documentation the appointment had been canceled. During an interview on 12/13/21 at 2:43 PM, the resident stated they went to an appointment with their family member on 10/28/21. When they arrived at the appointment, they found out it had been canceled 4 days earlier. The resident stated they had not been told the appointment had been canceled prior to arriving at the office. During an interview on 12/16/21 at 3:43 PM, nephrology receptionist #52 stated the office did not have a notation about the appointment on 10/28/21 and did not know who had cancelled the appointment. The resident was seen on 12/9/21 via telehealth as the office was not seeing nursing home residents in person due to the pandemic. During an interview on 12/21/21 at 8:43 AM, LPN Unit Manager #46 stated they helped set up outpatient appointments and kept track in an appointment book. An order was entered in the electronic record, so the staff were aware. Unit clerk #48 was notified, and they updated the calendar for appointments for the whole facility. Resident #175 had gone on an appointment with their family member and discovered the appointment was canceled when they arrived at the appointment on 10/28/21. The LPN stated they were working at the facility at that time and had no information that the appointment had been canceled. If the office called the facility when the LPN was not at the desk, there was no tracking of who took the call. During an interview on 12/21/21 at 9:05 AM, ADON #8 stated they had been providing registered nurse (RN) Unit Manager coverage for the resident's unit. If NP #4 scheduled the appointment, the nurses entered the order and let the ADON know so they could set up transportation. If the appointment was canceled, the office would call the facility; many offices had the ADON's phone number, or they would contact unit clerk #48 to notify the nurses and the resident. The ADON was not aware the resident had an appointment that was canceled. During an interview on 12/21/21 at 9:19 AM, unit clerk #48 stated they would set up appointments for residents upon request. They kept a calendar of all the appointments for residents, the reason for the appointment, and kept track of any canceled appointments. The unit clerk looked at the calendar for the resident on 10/28/21, which documented an outpatient appointment where the resident's representative was providing transport. The calendar did not document the appointment had been canceled and the unit clerk was not aware the resident had shown up to the appointment to discover it had been canceled. The Unit Clerk stated that the nephrology office had switched to telehealth visits from in person after the appointment had been scheduled due to the pandemic. The unit clerk stated they should have been notified the appointment was canceled, which would have saved the resident from going out. 10NYCRR 415.26(e)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 44838 Based on observation, record review and interview during the recertification and abbreviated surveys (NY00272513) conducted 12/13/21-12/21/21, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 1 of 2 residents (Resident #83) reviewed. Specifically, registered nurse (RN) #30 did not change gloves after removing an old dressing and cleansing a wound and did not perform hand hygiene between glove changes during wound care for Resident #83. Findings include: The facility policy Wound Care reviewed 1/2021, documented the following procedural steps; arrange supplies, wash, and dry hands thoroughly, put on exam gloves, remove dressing, pull glove over dressing and discard into appropriate receptacle, wash, and dry hands thoroughly, put on gloves, apply treatment as indicated, discard all soiled laundry in soiled laundry container, remove disposable gloves and discard into designated container, wash, and dry hands thoroughly. Resident #83 was admitted to the facility with diagnoses including type 2 diabetes, peripheral vascular disease (PVD, impaired circulation), and chronic ulcer of the right lower limb. The 10/10/21 Minimum Data Set (MDS) assessment documented the resident had intact cognition had two Stage 2 pressure ulcers (partial thickness loss of skin layers), one venous ulcer, and received daily wound care with the application of nonsurgical dressings. The comprehensive care plan (CCP) initiated 11/12/21, documented the resident had an alteration in skin integrity with an actual pressure ulcer. Interventions included to apply treatment as ordered by provider, monitor dressing daily to ensure it is clean, dry, and intact, and monitor wound daily for signs and symptoms of infection. The physician order dated 10/8/21 documented to cleanse right outer ankle wound with wound cleanser, apply Anasept (wound cleanser) to wound bed, sprinkle collagen packet onto wound bed, apply calcium alginate (absorbent dressing for wound healing), cover with an abdominal binder pad, wrap with bulky wrap and secure with tape and change the dressing daily. The physician order dated 11/7/21 documented to cleanse left lower leg wound with wound cleanser, use silver alginate to pack wound and tunnel, cover with a DPD (wound dressing) every day. The 11/2021 Treatment Administration Record (TAR) documented cleanse right outer ankle wound with wound cleanser, apply Anasept to wound bed, sprinkle collagen packet onto wound bed, apply calcium alginate, cover with an abdominal binder pad, wrap with bulky wrap and secure with tape, change the dressing daily with a start date of 10/8/21. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 12/14/21 at 11:20 AM, RN #30 performed wound care treatment for Resident #83's right outer ankle wound and left below-knee amputation (BKA) wound. RN #30 put on clean gloves and placed a barrier on the resident's bed. The RN removed the old dressing from the right ankle wound then removed their gloves. The RN put on a clean pair of gloves and did not perform hand hygiene between glove changes. The RN cleansed the ankle wound, applied wound powder, covered the wound with alginate, applied an abdominal pad and wrapped the ankle in gauze dressing. The RN then taped and dated the dressing, removed their gloves, and put on a clean pair of gloves to treat the second wound on the left leg. The RN did not perform hand hygiene between changing gloves. The RN removed the dressing to the left leg wound, cleansed the area with wound spray and applied skin prep to the wound edges and did not perform hand hygiene or change gloves after removing the old dressing. The RN removed their gloves and applied new gloves without performing hand hygiene and applied alginate to the wound base, wrapped the wound with gauze and taped and dated the dressing. During an interview with RN #30 on 12/14/21 at 11:40 PM, the RN stated they had performed hand hygiene before gathering supplies but did not wash their hands in between glove changes. The RN stated they should have washed their hands or disinfected them in between the old and new glove change and hand hygiene should be performed before beginning a treatment. The RN stated after removing old dressings, gloves should be removed, and hand hygiene performed before putting on new gloves. The RN stated hand sanitizer was allowed if the gloves or hands were not visibly soiled. The RN stated if these practices were not followed the risk of infection would be increased. During an interview on 12/20/21 at 10:00 AM, Infection Control RN #9 stated they were new to the facility and not thoroughly familiar with all the facility policies. They stated that during wound care hand hygiene should be performed after removing dirty gloves and before applying clean gloves. They also stated hand sanitizer could be used if hands were not visibly soiled. 10NYCRR 415.19(b)(4)

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F 0886 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Perform COVID19 testing on residents and staff. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33421 Based on observation, record review, and interview during the recertification survey conducted on 12/13/21-12/21/21, the facility failed to conduct testing based on parameters set forth by the Secretary for 3 of 4 residents (Residents #76, 132, and 156) reviewed. Specifically, Residents #76, 132 and 156 were identified as having a close contact with a COVID-19 positive staff member (certified nurse aide, CNA, #54) and were not tested per the outbreak testing guidelines on Day 2. Findings include: The 9/10/21 Centers for Disease Control (CDC) Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes documents residents with close contact with someone with SARS-CoV-2 infection, regardless of vaccination status, should have a series of two viral tests for SARS-CoV-2 infection. In these situations, testing is recommended immediately (but not earlier than 2 days after the exposure) and, if negative, again 5-7 days after the exposure. During an interview on 12/16/21 at 10:30 AM, the Administrator stated they had one COVID-19 positive staff member who had resulted positive on 12/15/21 around 9:30 PM. The staff member had worked during the day shift on 12/14/21 and 12/15/21, was vaccinated and asymptomatic, and they believe they were exposed in the community. The Administrator stated Infection Control/Registered Nurse (IC/RN) #9 was following up for the next steps. The 12/16/21 electronic mail communication at 10:44 AM, from New York State (NYS) Epidemiologist #55 addressed to Infection Control registered nurse (IC RN) #9, COVID-19 Tracker/Coordinator #15, IC RN/Staff Educator #10, and 2 facility regional staff documented there were 4 potentially exposed residents, and they should be tested for COVID-19 on Day 2 from the date they were exposed. During an interview on 12/16/21 at 12:10 PM, IC RN #9 stated certified nurse aide (CNA) #54 worked on 12/15/21 and tested positive for COVID-19 after their shift. The facility determined 4 residents were potentially exposed to CNA #54 having been within 6 feet of the staff member for more than 15 minutes during a 24-hour period. Those residents were Residents #76, 103, 132, and 156. CNA #54 and the residents had been asymptomatic. IC RN #9 stated the facility communicated with the state epidemiologist, who recommended they monitor the residents for any COVID-19 symptoms. There was no documentation Residents #76, 132, and 156 were tested for COVID-19 from 12/16/21 through 12/19/21. During an interview on 12/21/21 at 9:12 AM, COVID-19 Tracker/Coordinator #15 stated Residents #76, 132, and 156 were not tested for COVID-19 on 12/17/21. IC RN #9 let them know when residents needed to be tested and they tracked the COVID-19 data for resident testing. During an interview on 12/21/21 at 10:10 AM, IC RN #9 stated Residents #76, 132, and 156 were exposed to CNA #54 on 12/15/21. The residents were not tested on [DATE] or Day 2 after their exposure as they were asymptomatic, fully vaccinated, and had low exposure. When asked about the electronic communication from NYS Epidemiologist #55, they stated it was an oversight that the residents were not tested . (continued on next page)

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F 0886 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10NYCRR 415.19 40491

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 34459 Based on observation, interview, and record review during the recertification and abbreviated surveys (NY00273974) conducted from12/13/21-12/21/21, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public for 1 of 7 resident units (2S Unit). Specifically, the 2S Unit (secured dementia unit) elevator was not disabled by the presence of a wander alert bracelet (used to alert staff of resident wandering). Subsequently, Resident #184 was able to take the elevator to the first floor, unsupervised, while wearing a wander alert bracelet. Findings include: The facility policy Wander Guard System revised 1/2021 documented: - The facility would provide and maintain a secure environment to prevent negative outcomes for residents who exhibit unsafe wandering and or elopement behaviors. - The Wander Alert system will alarm when a wanderer or potential eloper attempts to leave the facility unaccompanied. - Alarms are placed on all exits on the first floor, on all exits on the units, and on the elevators. - Maintenance or designee will check at least daily that all points of the wander guard alarm system are functioning properly. The revised 1/2021 Secured Dementia Unit policy documented: - The facility will maintain as needed a separate part of the building that is designated for residents who have Alzheimer's and other types of dementia, and special care. - All staff working on this unit will be trained on the proper way for entering and exiting the secured locations. Education will include but is not limited to protocols to check before and after exiting for residents that may have maneuvered through the exit, alerting superiors if a resident is noted to have left through an exit unauthorized, reporting a malfunctioning alarm, wander bracelet, or any other unplanned event. Resident #184 had diagnoses including vascular dementia and schizophrenia. The 11/15/2020 Minimum Data Set (MDS) assessment documented the resident had moderately impaired cognition, did not wander, required supervision while walking in the room, in the corridor, and a wander/ elopement alarm was used daily. The comprehensive care plan (CCP) initiated 6/26/17 and revised 9/13/19 documented the resident was at risk for wandering into unsafe areas or for elopement out of the building without supervision and could also be exit seeking. Interventions included check placement of Wander Guard each shift. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335600	A. Building B. Wing	12/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grand Rehabilitation and Nursing at Utica	1657 Sunset Ave Utica, NY 13502

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

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 11/15/20, Registered Nurse/Unit Manager (RN/UM) Quarterly Assessment documented the resident was at risk for elopement. The undated Kardex (care instructions) documented the resident required supervision while ambulating on the unit and to check the placement of the resident's Wander Guard each shift. On 12/13/20 at 9:51 AM, licensed practical nurse (LPN) #2's progress note documented the resident was constantly exit seeking, trying to punch the code in at the exit doors and pushing on them. The resident was able to make it off the unit and down to the 1st floor yesterday (12/12/20) at 2 PM. The resident was retrieved by staff. Unit staff were unaware the elevator went down to the 1st floor with the resident on it. The resident's wander guard was intact. During an observation on 12/13/21 at 11:45 AM the surveyor entered the elevator on 2S and traveled to the first floor without a code for activation. Resident #184 was observed on 12/13/21 at 2:03 PM wearing a wander alert device on their left ankle. During an interview with LPN #2 on 12/17/21 at 11:15 AM they stated, residents with wander guards could enter the elevator when the door was open. If someone on the 1st floor called for the elevator, the elevator would move. LPN #2 stated that was how Resident #184 was able to get downstairs via the elevator in 12/2020. The LPN stated the elevator alarmed and continued to alarm while traveling to the 1st floor and would not stop alarming unless someone entered the code to clear it. On 12/20/21 at 8:52 AM, during an interview with LPN #23, they stated residents had left the 2S Unit previously. When resident #184 got off the unit, the resident had entered the elevator and traveled down to the 1st floor when someone on the 1st floor called the elevator. The elevator did not stop movement while the resident was on it and the Wander Guard alarm bracelet was in place. The resident was able to take the elevator to the 1st floor unnoticed and staff did not realize they were gone until they were brought back to the unit. On 12/20/21 at 11:24 AM, during an interview with the Director of Nursing (DON), they stated residents should not be able to leave the 2S Unit via the elevator. The elevator should not allow residents with a Wander Guard bracelet to get down to the 1st floor. They were unaware Resident #184 was able to take the elevator to the 1st floor while wearing their Wander Guard alarm bracelet. The DON stated if they were aware, they would have notified the maintenance department and the Wander Guard alarm system should have been checked to ensure it was working properly. During an observation on 12/21/21 at 9:30 AM the elevator went from the main floor (1st floor) to the 2S secured unit. On the 1st floor the elevator opened into a non-resident area. The Maintenance Supervisor's office and staff lockers were adjacent to the corridor at the elevator bank. During an observation on 12/21/21 at 9:48 AM, Maintenance Supervisor #65 tested the 2S Unit elevator door alarm. The Wander Guard alarm sounded when a wander guard entered the elevator. After 45 seconds to 1 minute, the elevator was able to move to the 1st floor. The wander guard alarm continued to sound when the elevator was called to the 1st floor. Maintenance Supervisor #65 stated they were unaware the elevator would go to the 1st floor when a Wander Guard alarm bracelet was present in the elevator and the alarm was sounding. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/21/21 at 10:09 AM, during an interview with Director of Plant Operations #50, they stated they were unaware that the elevator would travel to the 1st floor with a Wander Guard. At 10:19 AM, Director of Plant Operations #50 was observed to call the Wander Guard alarm vendor. After the telephone conversation, Director of Plant Operations #50 stated the Wander Guard alarm did not have a time out feature (the amount of the time the door remains open before it closes automatically when not in use) and the vendor recommended the facility contact the elevator vendor. On 12/21/21 at 10:20 AM, during an interview with certified nurse aide (CNA) #62 they stated they were unaware the elevator would go down to the 1st floor from the 2S Unit with a resident who wore a Wander Guard. On 12/21/21 at 10:25 AM, during an interview with Director of Plant Operations #50 they stated they were unaware that a resident had been able to get to the 1st floor from the 2S Unit in the elevator with a Wander Guard on. 10NYCRR 415.29 40803