STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335471	A. BUILDING _____ B. WING _____	09/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
UTICA REHABILITATION & NURSING CENTER	2535 GENESEE STREET UTICA, NY 13501

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview during the recertification and abbreviated (NY 410) surveys the facility did not ensure each resident received adequate supervision and assistance devices to prevent accidents for 2 of 5 residents (Residents #56 and 87) reviewed. Specifically, Resident #56 was care planned to be out of bed for meals and was left in bed, received the incorrect food consistency, was not supervised during the meal, and was not assessed timely when it was discovered the wrong consistency had been consumed. Resident #87 had a physician order [REDACTED]. Residents will be identified as at risk for aspiration during meals in bold and capitalized on their meal tickets, as well as on their care plan and care guide. 1) Resident #56 had [DIAGNOSES REDACTED]. The 7/3/20 Minimum Data Set (MDS) assessment documented the resident had severe cognitive impairment, required extensive assistance of 2 for bed mobility, transfers, dressing, and hygiene, supervision with set up assistance for eating and the resident had a mechanically altered therapeutic diet. The comprehensive care plan (CCP) initiated 7/30/19 documented the resident had activities of daily living (ADL) self-care performance deficits, required set up for meals with intermittent supervision and must sit in a regular chair for meals. The 10/10/19 update documented the resident required set up, intermittent supervision, must sit in a scoot chair for meals and utilized a divided dish. The 9/6/19 CCP documented the resident had a nutritional problem related to a mechanical diet with chewing and swallowing difficulty. Interventions included pureed food with nectar thick liquids and a lip plate for meals. The 10/27/19 speech therapy discharge summary documented to facilitate safety and efficiency, recommended strategies during oral intake including guided bolus/utensil placement, alternation of liquids/solids, alternation of temperatures and tastes, rate modification and blous size modifications. The resident should be closely supervised. physician's orders [REDACTED]. The Kardex (care instructions) dated 7/12/20 documented the resident's diet was pureed, mildly thick/nectar liquids, and a lip plate for meals. The resident required set up by 1 staff, intermittent supervision to eat and was to be up in a scoot chair for meals. The second-floor assignment sheet for the 7/12/20 6 AM-2 PM shift documented there were 2 CNAs on that shift and neither was assigned to Resident #56. The Resident Accident/Incident report dated 7/12/20 at 9:45 PM, completed by registered nurse supervisor (RNS) #10 documented: - CNA #11 reported the resident was found to have regular consistency lunch tray on the overbed table that was partially eaten. Drink cups were thin liquids and were emptied. At 9:30 PM, the CNA came to get the RN to check on the resident who was coughing continuously and spitting up yellow sputum. Oxygen saturation was 80% on room air, oxygen on at 2 liters, the resident was sent out to hospital at 10:45 PM by oncoming RN #13. - Staff statements included LPN #15, who last saw the resident at 12:15 PM in bed; and CNA #12 last saw the resident at 9:45 PM. LPN#15's statement documented she worked 6 AM to 10 PM on 7/12/20, and was told around 9 PM the resident (#56) was aspirating and that had regular food consistency which was usually nectar consistency. The supervisor (RN#10) mentioned this to me, I asked her when the resident had the regular food, she said around lunch time that day. I was not aware of this. The undated Investigation Summary included with the Accident and Incident Report documented: - CNA #11 entered the resident's room early on the 2 PM-10 PM shift and noticed the resident with a tray on the table over the resident. The tray had empty drink cups, a couple of bites of ham loaf was eaten and a piece of pie including the crust was eaten. - CNA #12 assisted the resident with supper and reported they did not eat much, coughed once, and seemed congested. - At 9:20 PM, CNA #11 saw the resident had vomited, RNS #10 was notified and assessed the resident. The physician was notified, and RNS #13 assessed at the beginning of her shift (10 PM-6 AM) and noted the resident with further change of condition. The physician was updated again, and the resident was sent to the hospital and admitted with aspiration pneumonia. - The resident was to have pureed food with nectar thick liquids and received a regular consistency tray. The liquid consistency was unknown as the cups were empty, the meal ticket on the tray was correct. - The resident is set up for meals with intermittent supervision and to sit in a scoot chair for meals. - Although the resident was care planned for a scoot chair for meals and was not up, the resident was appropriately positioned in bed and therefore not a contributing factor in aspiration. Staff were disciplined and educated regarding following the plan of care. - During education with CNA #9, it was discovered the plan of care for CNAs does not have the Kardex button to display shortened care plan version. Roles checked and corrected to include Kardex button, permission of all CNAs was audited and corrected if necessary. Nursing progress notes documented: - On 7/12/20 at 10:48 PM, report received from previous supervisor (RNS #10) and CNA. The resident aspirated earlier today, upon immediate assessment resident was on oxygen 2 liters (L), was lethargic and minimally responsive, color was gray and lips dusky. The lungs were very diminished right side with coarse rhonchi and a harsh congested cough. Oxygen increased to 15 L non-rebreather, oxygen saturation on 15 L is 89. The physician was notified and order to send to emergency room obtained. The resident left the facility at 10:42 PM. - On 7/12/20 at 11:00 PM, RNS #10 noted she was asked to check on the resident who was continuously coughing. CNA #3 then told the RNS that she found a tray with a regular diet on the resident's over bed table. The tray was half eaten and the drinks, which were thin liquids, were empty. The resident was on a pureed diet. The resident's lung sounds had rhonchi to the right lung. The physician was notified and wanted a chest x-ray, oxygen put on at 2 L, and for the resident to be seen by the physician's assistant (PA) first thing in the morning. The oncoming supervisor (RNS #13) assessed the resident and sent to the hospital. - On 7/13/20 at 2:48 AM, the resident was admitted to the hospital with [REDACTED]. The resident was hypoxic on room air. The resident had shortness of breath, was not able to be relieved, coughing worsened it, oxygen and sitting up and changing positions was ineffective. The resident was admitted with aspiration pneumonia of the right lung. A Disciplinary Action Report dated 7/13/20 documented dietary aide #18 served a resident a tray that was not the proper consistency. The resident aspirated and was sent to the hospital. Tickets must be followed for resident safety. A Disciplinary Action Report dated 7/15/20 documented CNA #9 did not ensure the resident was up in the scoot chair for the meal as care planned, did not remove the tray from the room within 2 hours for prevention of food borne illness, and was re-educated. A Disciplinary Action Report dated 7/15/20 documented CNA #14 did not ensure the resident was up in the scoot chair for the meal as care planned, did not remove the tray from the room within 2 hours for prevention of food borne illness, and was re-educated. On 9/3/20 from 12:18 PM to 12:42 PM, Resident #56 was observed in a scoot chair, at a dining room table. The resident had a divided dish with pureed foods and thickened drinks. The resident ate independently, and consumed his food and drinks rapidly. On 9/8/20 at 11:27 AM, CNA #9 was interviewed and stated she and CNA #14 were the only 2 CNAs on the unit during the 7/12/20 6 AM-2 PM shift and there was one nurse. Resident #56 required 2 for care, she and CNA #14 provided the morning care and did not get the resident up. She was unaware the resident was supposed to be up for meals and was aware the resident was on a pureed diet with thickened liquids. Intermittent supervision meant the resident needed to be checked on during the meal. She did not check on the resident during the meal, as she left for a lunch break before the remaining trays were passed. She could not recall if she provided any care to the resident for the

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335471	A. BUILDING _____ B. WING _____	09/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
UTICA REHABILITATION & NURSING CENTER	2535 GENESEE STREET UTICA, NY 13501

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) remainder of the shift. She worked a double shift, and the second part of the shift worked on the other end of the hall. The CNA stated it was a very hectic day and she could not recall if she brought the resident the lunch tray. The only other staff passing trays was CNA #14, as LPN #15 was passing medications. During a telephone interview on 9/8/201 at 12:26 PM, CNA #14 stated she could not recall if she passed the lunch tray to the resident. When passing trays, dietary set up the tray and nursing staff brought them to the residents. At that time, all residents were in their rooms due to isolation precautions. The resident required assistance with set up and she could not recall the reason the resident was in bed, but it was probably because they were so short staffed. She could not recall providing any care to the resident or seeing the resident during or following lunch. During a telephone interview on 9/8/20 at 12:47 PM, LPN #15 stated she was the only nurse on the unit on 7/12/20 during the 6 AM-2 PM shift and worked until 10 PM that day. She had no knowledge the resident received a lunch tray with the wrong consistency until the CNA did rounds around 9 PM when the resident had a change of condition. She did not pass any trays that day and no staff reported to her the resident was in bed or received a tray of regular consistency good. She stated it was noted on the whiteboard at the nurse's desk if a resident was to be up for meals and on aspiration precautions. Intermittent supervision meant the resident should be checked on at least every 10-15 minutes while eating. During a telephone interview on 9/8/20 at 12:51 PM, CNA #11 stated she worked the evening shift, 2 PM-10 PM on 7/12/20. Near the beginning of her shift, she found the resident with a tray on the over bed table and the resident was in bed. The tray contained partially eaten food and empty drink cups. She removed the tray and immediately reported it to the nurses on the unit, there were 2 at the desk, she could not recall who was working then or what the response was. She did not see a supervisor after she reported the incident. The CNA knew as soon as she saw the tray it was wrong, as she was very familiar with the resident and knew they ate well, ate fast, and tended to guzzle drinks. The resident was to be monitored during meals, up in the scoot chair, and in view of staff. The CNA knew this due to her experience with the resident and it was on the care plan. She later checked the resident and found him to be coughing and sounded congested, she reported it to a nurse and could not recall to whom it was reported. LPN #21 was interviewed via telephone on 9/9/20 at 9:30 AM and stated she could not recall any events on 7/12/20 related to Resident #56 aspirating, if any staff reported any concerns to her, or the condition of the resident. During a telephone interview on 9/11/20 at 9:03 AM, SLP #6 stated she screened the resident on 6/30/20, noting no changes to the current plan of pureed food and nectar thickened liquids. The last evaluation was 10/27/19, when the resident was discharged from therapy services. The resident required close supervision for oral intake. There were no other SLP evaluations after 10/27/19 and the resident remained at risk of aspiration and required supervision with meals. The level of supervision or risk could not be reduced without another SLP evaluation. The resident was not safe to eat in bed unsupervised due to aspiration risk, cognitive decline, and the tendency to gulp drinks and eat rapidly. With isolation precautions in place, the resident should have at least been up in a chair in the doorway to the room in order for staff to monitor meal consumption. If the resident remained in bed, staff should have remained to supervise. During a telephone interview with RNS #10 on 9/15/20 at 3:33 PM, she stated she worked 6 PM to 10 PM on 7/12/20. Upon arrival, there was no report of Resident #56 having received the wrong consistency food or having any symptoms of aspiration (coughing, vomiting, difficulty breathing). At approximately 9:00 PM, staff reported the resident did not look well. Upon assessment, CNA #11 was in the room speaking to the supervisor as she was assessing the resident's condition, and mentioned she found a regular tray with some items eaten and the thin liquids gone. The CNA did not say she reported it to anyone prior to that time. Had it been reported earlier, the RNS would have assessed the resident immediately During an interview on 9/17/20 at 12:00 PM, the Director of Nursing (DON) stated there was a care plan violation due to the CNAs not getting the resident out of bed, providing the wrong tray, and not supervising the meal. She was unable to determine who brought the tray to the resident and both CNAs were disciplined. Intermittent supervision meant the resident required some assistance and she expected staff to have checked on the resident throughout the meal. The DON stated during the education, she discovered CNA #9, who had been employed for approximately 2 months at the time, did not have the ability to view the Kardex based on permissions settings in the electronic system. She stated she expected the CNA to have reported that she was unable to view care instructions. The LPN would typically monitor meals in the dining room, and with all residents in their rooms, it was difficult to monitor, as she was also passing medications. When CNA #11 arrived on the second shift and found the tray, she did not report the findings to a nurse. It was not until later when the resident was found vomiting, the CNA was in the room with RNS #10 and mentioned finding the tray while the RNS assessed the resident. She stated the assessment was not timely because the CNA did not report finding the tray with the wrong consistency until hours later. The resident should have been assessed, monitored, and the physician notified immediately when the it was discovered the resident consumed the wrong consistency food and drinks. 2) Resident #87 was admitted to the facility with [DIAGNOSES REDACTED]. The 8/21/20 Minimum Data Set (MDS) assessment documented the resident had moderate cognitive impairment, required supervision with one-person assistance for eating and had complaints of difficultly or pain with swallowing. Physician orders [REDACTED]. On 7/17/19 the physician order [REDACTED]. The comprehensive care plan (CCP) revised on 7/16/19 documented the resident received a mechanical diet alteration related to dysphagia. Interventions included aspiration precautions and monitor/document/report any signs or symptoms of dysphagia during meals. The CCP initiated on 7/24/19 documented the resident required set up and supervision by staff to eat, was on aspiration precautions and required verbal cues at meals to double swallow to clear residue and throat clears if vocal quality was wet or gurgled. A speech language pathologist (SLP) progress note dated 12/24/19 documented the resident should alternate liquids and solids, modify rate and bolus size, ensure effortful swallow in upright posture during meals. The resident required close supervision for oral intake. The SLP discharge summary for dates of service 5/6/20-8/24/20 documented intake protocol included maximal upright positioning, slow rate, alternating liquids/solids, effortful swallow and small bites/sips. The resident required distant supervision for oral intake. The resident Kardex (care instructions) active on 9/17/20 documented aspiration precautions and the resident required verbal cues at meals to double swallow to clear residue and throat clears if vocal quality was wet or gurgled. The resident was observed eating unsupervised in the back corner of their room, located at the end of the hallway, during the following times: -On 9/14/20 at 12:27 PM; -On 9/15/20 from 12:28 PM to 12:40 PM; -On 9/16/20 at 12:15 PM the resident received the lunch tray. At 12:20 PM an unidentified staff looked in the resident's room and stated, I just wanted to make sure you got your tray and walked down the hall. At 12:21 PM the resident was heard coughing briefly and remained sitting in the corner of the room. The resident's meal ticket did not include information about aspiration precautions. At 12:23 PM an unidentified staff member came to the resident's door, said hello to the resident and walked away. The resident continued to eat alone until completion of the meal at 12:28 PM. During an interview with certified nursing assistant (CNA) #1 on 9/17/20 at 10:43 AM she stated Resident #87 was on a mechanical soft diet with thick liquids and had worked with the SLP on and off. She did not think the resident was on aspiration precautions as there was not a suction machine in the resident's room. If a resident were on aspiration precautions they should be supervised and someone should sit with them during the entire meal, while they ate. She stated the resident used to eat in the dining room until COVID-19 kept them from using the dining room. There would always be staff around in the dining room to provide supervision. During an interview with licensed practical nurse (LPN) #3 on 9/17/20 at 11:00 AM she stated Resident #87 required nectar thick liquids, was noncompliant and would drink water from the tap in the bathroom. The resident was on aspiration precautions. If a resident was on aspiration precautions, they should be monitored with supervision during eating. She stated the resident would often eat in the doorway of the room and staff would keep an eye out. Staff would usually drop off the tray and peek in during meals. During an interview with registered nurse (RN) Unit Manager #4 on 9/17/20 at 11:10 AM she stated she was the manager on a different nursing unit and was overseeing Resident #87's unit for now. She stated if a resident was on aspiration precautions they were at risk for aspirating food or fluid into their lungs or choking. If a resident were on aspiration precautions someone would have to watch the resident during feeding since the dining rooms were closed on the second floor. The resident should sit in the doorway with supervision or with someone in the room. During an interview with SLP #6 on 9/17/20 at 11:35 AM she stated aspiration precautions were used when a resident was at risk for aspirating food or fluid. The resident should be out of bed, supervised either distance or close, and be in eyesight of someone. She stated when she made recommendations it would be forwarded to the resident unit and dietary and translated to the meal ticket. When the resident was eating someone should be in the doorway, distant supervision and walking around to make sure the resident was not coughing. She stated the resident was independent with their swallowing strategies. It has been difficult with isolation on the resident's unit and no dining room. Resident #87 should be eating in the doorway with staff supervision. During an interview with diet technician/Food Service Director #7 on 9/17/20 at 12:42 PM she stated the resident was on aspiration precautions and required supervision at all meals. Someone should be with the resident during meals. Close

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335471	A. BUILDING _____ B. WING _____	09/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
UTICA REHABILITATION & NURSING CENTER	2535 GENESEE STREET UTICA, NY 13501

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) supervision would mean sitting at the same table and distant supervision would mean in eyesight. Aspiration precautions would be listed on the resident Kardex and meal ticket. She was unsure why the resident's meal ticket did not indicate aspiration precautions. 10 NYCRR 415.12(h)(2)
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review during the recertification and abbreviated (NY 494) surveys the facility did not ensure each resident maintained acceptable parameters of nutritional status for 1 of 8 residents (Resident #24) reviewed. Specifically, Resident #24 had a significant weight loss and was not reassessed timely to address the weight loss, decreased meal intakes, and difficulty chewing. Findings include: There was no documented facility policy addressing subsequent nutritional assessments after the completion of an intitial assessment. Resident #24 had [DIAGNOSES REDACTED]. The 8/28/20 Minimum Data Set (MDS) assessment documented the resident had moderate cognitive impairment, required supervision and set up assistance with meals, had no weight loss or gain of over 5% in the last 30 days and did not have signs or symptoms of possible swallowing disorder. The oral/dental status section was not completed. The 1/13/20 dietary progress note documented the resident's recommended diet was NAS (no added salt), whole and thin liquids and preferences were obtained (no pork, no orange juice). The comprehensive care plan (CCP) initiated 1/23/20 documented the resident had a nutritional problem related to therapeutic diet restriction and need for mechanically altered consistency of solids. Interventions included monitor intake, record every meal, and monitor for signs of malnutrition. The residents weight record documented: - 5/1/20: 167.2 pounds (lbs.) - 6/3/20: 177.1 lbs. (5.92% increase in one month); - 6/9/20: 176.4 lbs. - 6/10/20: 178 lbs. - 6/18/20: 178.2 lbs. - 6/23/20: 179 lbs. - 7/14/20: 163.3 lbs. (8.36% decrease in one month); - 7/27/20: 165.3 lbs. - 8/3/20: 164.2 lbs. - 8/11/20: 163.4 lbs. Meal consumption records documented: - In 6/2020, intake amounts for 26 out of 90 meals were not recorded, the resident consumed 76%-100% of most meals. - In 7/2020, intakes for 57 out of 93 meals were not documented, the resident consumed 0-25% of 17 meals, 26-50% of 2 meals, and over 51% of 17 meals. - In 8/2020, intakes for 50 of the 93 meals were not recorded, the resident consumed 0-25% of 3 meals, 26-50% of 11 meals, and over 51% of 29 meals. Dietary progress notes documented: - On 6/10/20, the resident's weight was 176 lbs. a significant gain of 5.5% in 1 month. The interdisciplinary team (IDT) was alerted of the weight gain and requested assessment of the resident for possible [MEDICAL CONDITION] (fluid retention) and an order for [REDACTED]. Dietary would watch weights weekly at that time. - On 8/10/20, the monthly weight was 164 lbs. stable, continue with the current plan of care. - On 8/14/20, aware of consistency change, regular solids to mechanical soft, changes were made to the meal profile and care plan. There were no documented dietary progress notes regarding the 6/23-7/14/20 weight loss or the multiple undocumented meal intakes. There was no documented evidence a nutritional assessment was completed to address the resident's significant weight loss from 6/23/20-7/14/20. The nurse practitioner (NP) progress note dated 7/9/20 documented the resident was refusing bath/shower, did not want food, and had not eaten in a few days per nursing staff. The NP was unaware, offered options, the resident adamantly declined, became agitated, and wanted to be somewhere else. Nursing progress notes documented: - on 7/8/20, the resident had been refusing meals on the 6 AM-2 PM shift; - on 7/9/20, refused to be weighed and refused dinner; - on 7/15/20, the resident refused breakfast and all fluids; - on 7/27/20, the resident was not getting out of bed and eating meals as they had before, weight started to decrease as the resident was not eating; and - on 7/30/20, the resident's appetite was poor that morning. There was no documentation from 6/4/20-7/8/20 regarding the resident's loss of appetite or meal refusals. The SLP (speech language pathology) Evaluation and Plan of Treatment dated 8/14/20 documented the resident was referred for chewing and swallowing difficulties. Nursing progress notes documented: - On 8/14/20, a skilled dysphagia (difficulty swallowing) evaluation was completed. The recommendation was to downgrade to mechanical-soft solids, maintain thin liquids; - On 8/20/20, the resident complained of having difficulty with swallowing food and medications; The physician's orders [REDACTED]. The 8/31/20 quarterly nutrition assessment documented: - from 6/3-6/23/20 the resident's weight was 176-179 lbs. - from 7/14 - 7/27/20, the resident's weights were 163 and 165 lbs. - from 8/3-8/28/20, the resident's weights were 163-166 lbs. - suggested body weight was 166 lbs. actual weight; - meal acceptance was approximately 70%; and - the resident made changes with the diet technician (DT) frequently. There was no documentation to address the 6/23-7/14/20 weight loss, undocumented meal intakes, or difficulty with chewing or swallowing. The 8/26/20 SLP Discharge Summary documented the resident received treatment due to difficulty with mastication (chewing) of soft solids, decreasing overall oral intake and interest in eating. When interviewed on 9/14/20 at 10:14 AM, the resident stated they were dissatisfied with most of the food provided. The food was often cold, was a ground textured diet but the vegetables often came pureed and ran into the other food on the plate. The resident reported they felt weak, had lost weight, and often refused meals. The resident could not recall anyone checking in about meals or to update preferences. On 9/14/20 at 12:48 PM, the resident's lunch was observed. The meal included spaghetti with ground meat balls and sauce, pureed broccoli and vanilla pudding. The pureed broccoli was on the same plate as the spaghetti and running into the spaghetti. The resident stated the meal would not be consumed. Meal temperatures taken at that time were not palatable. The meal ticket included bread and butter, which was not provided on the tray and the resident stated they would have liked to have the bread. On 9/15/20 at 12:40 PM, the resident was observed in their room with the lunch meal. The resident stated they were not going to eat the meal, and no one had offered an alternative. When interviewed on 9/17/20 at 11:50 AM, CNA #22 stated the resident did not like to eat much, did not like the food, sometimes got alternatives, and did not like the pureed foods. Typically, the resident would eat crispy rice cereal and milk. All meal intakes were supposed to be completed in the CNA documentation and it was often not completed by agency staff. She told nursing staff when the resident did not eat and did not see any dietary staff on the floor to check menu preferences. When interviewed on 9/17/20 at 12:45 PM, the DT stated the weight difference from 6/2020-7/2020 was significant, however it was the resident's usual weight range prior to the weight increase from 5/2020-6/2020. She was unable to determine the reason the resident gained weight and the resident returned to the weight range in the 160's that was the prior normal. Residents should be assessed immediately when there was a significant weight gain or loss. Assessments included review of meal intakes, updating preferences, and discussing with the nursing staff and resident other contributing factors. There was no assessment following the weight loss as the DT was waiting on re-weights and thought there may have been differences in the scales on the different floors, or a scale was not functioning properly. She stated the resident used to come see her often and make requests, get cookies, and visit the vending machine. She could not recall how long it had been since the resident last visited her to get the snacks or request menu changes. It had been at least a couple of months. Since the noted weight loss, the DT had not visited the resident to inquire about preferences, dietary concerns, or other possible factors to address the weight loss. She had not reviewed the resident's intakes and was not aware of the missing intake documentation. She stated based on the weight change, missing intake documentation and questions regarding the scales, she should have reassessed to determine what was going on. She was not aware the resident was unhappy with meals and refusing meals. 10NYCRR 415.12 (i)(1)
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview during the recertification survey the facility did not ensure drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable for 1 of 3 (Unit 4) medication carts and 1 of 2 (Unit 2) medication storage rooms observed. Specifically, the Unit 4 medication cart and the Unit 2 medication storage room refrigerator had open vials of medications/biologicals that were not labelled with the date opened. Findings include: The ,[DATE] facility Storage and Maintenance of Medication Policy documented medications with expiration dates must be dated when opened. If a medication is past the time frame, the medication will be discarded. Medications must be checked regularly, and expired or deteriorated medications must be disposed of. Refrigerated medications are kept in closed labeled containers. During a medication cart observation on [DATE] at 10:50 AM, the Unit 4 medication cart contained an open vial of [MEDICATION NAME] (used for numbing) 1% solution 200 mg/ml for injection. There

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335471	A. BUILDING _____ B. WING _____	09/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
UTICA REHABILITATION & NURSING CENTER	2535 GENESEE STREET UTICA, NY 13501

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) was no date documenting when the vial had been opened. During a medication storage room observation on [DATE] at 11:14 AM, the Unit 2 medication refrigerator contained an open vial of [MEDICATION NAME] Purified Protein Derivative (used for detecting [MEDICAL CONDITION]) 5 TU/0.1 ml. There was no date documenting when the vial had been opened. During an interview [DATE] at 10:55AM licensed practical nurse (LPN) #23 stated once a vial of [MEDICATION NAME] was opened, the policy was to discard it after 72 hours. If the vial was not dated when opened it should have been discarded. LPN #23 was unsure of who was responsible for stocking and checking medications in the cart. During an interview [DATE] at 11:19 AM LPN #25 stated she was unsure of the policy regarding dating an open medication vial, but it should be discarded after 28 days. She stated the vial needed to be discarded it was not dated. 10NYCRR 415.18(d)(e)(,[DATE])
F 0804 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.** Based on observation and interview during the recertification and abbreviated (NY 494) surveys, the facility did not provide food and drink that was palatable, attractive, and at a safe and appetizing temperature for 2 of 2 meal trays tested . Specifically, food was not served at palatable and safe temperatures. Findings include: The facility policy Food Temperature effective 7/2018 did not include required serving temperatures for hot and cold food. The following was observed during the lunch meal on 9/14/20: - At 12:46 PM, a small uninsulated cart was brought down the hall near Resident #24's room; - At 12:48 PM, a lunch tray was brought to Resident #24 in their room. The resident's tray was tested , and a replacement tray was requested. - At 12:49 PM, food temperatures on the meal test tray were as follows: - spaghetti with meat sauce was measured at 125.8 degrees Fahrenheit (F); - pureed broccoli was measured at 95.2 degrees F; and - milk was measured at 53.7 degrees F. When interviewed on 9/14/2020 at 12:49 PM, Resident #24 stated the food was cold to the touch. The resident stated they rarely received food that was very warm and did not usually receive all the items on the meal ticket. When interviewed on 9/14/2020 at 10:00 AM, food service aide #3 on the 3rd floor stated residents in their rooms were served first and then the dining room residents were served last. When observed on 9/15/2020 at 12:15 PM, the following temperatures were measured to be outside acceptable ranges during a randomly selected test tray during the 3rd floor lunch dining room service: - Seafood Newburg was measured at 123 degrees F. - cooked carrots were measured at 121 degrees F. When interviewed on 9/15/20 at 11:45 AM, the Food Service Director stated the kitchen was called if there were any issues with food temperatures on the units and the kitchen staff would reheat the foods to 165 degrees F and send the food back up to the floor. Residents in their rooms were served first, then the dining rooms. Service would begin at about 12:00 PM and was expected to finish around 12:45 PM. Food should be held in the steam tables and the temperatures should be at least 140 degrees F. When interviewed on 9/15/20 at 12:11 PM, food service aide #4 stated steam tables were turned on around 11:00 AM and food was served at about 12:00 PM. Food service aides then took temperatures and recorded them for each meal. If the temperatures were not in range, they were to call the kitchen to have them reheat the food. 10NYCRR 415.14(d)(1)(2)
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation, record review and interview during the recertification survey, the facility did not store, prepare, distribute and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen (main kitchen) and 2 of 3 nourishment refrigerators (3rd and 4th floor). Specifically, the walk-in cooler and the dry food storage room in the main kitchen were soiled and unclean. The 3rd and 4th floor nourishment refrigerators were soiled and the 3rd floor nourishment refrigerator contained unlabeled food. Findings include: The facility policy Food Brought in by Families/Visitors effective 3/19/20 documented perishable foods must be stored in re-sealable containers with lids or sealable bags in the refrigerator. All containers will be labeled with the residents' name and date. These items are good for 48 hours only and will be discarded after such time. There was no facility policy for kitchen or food storage cleaning procedures. 1) Main kitchen: During observations on 9/14/2020 at 9:30 AM and 9/15/2020 at 11:30 AM, the floor in the walk-in cooler was unclean and soiled with food debris under the shelving units on the left when entering the cooler. There was spilled sticky liquids on the floor. During observations on 9/14/2020 at 9:34 AM and 9/15/2020 at 11:30 AM, there was approximately a 1-foot long section of a black substance along the floor meeting at the bottom of the wall under a baker's rack in the dry food storage room. In addition, the commercial #10 can opener was soiled with black sticky food debris. 2) Nourishment refrigerators: During observations on 9/14/2020 at 10:13 AM and 9/15/2020 at 12:15 PM, there was sticky spilled yellowish liquid on the bottom of the 3rd floor nourishment refrigerator. There were two brown paper bags in the bottom of the refrigerator that contained resident food wrapped in tin foil. One bag had a resident name on the outside and one had no labeling. Neither bag was labeled with the date the food was received or the food contained in the bags. During observations on 9/14/2020 at 10:25 AM and 11:43 AM and 9/15/2020 at 1:26 PM, the inside of the 4th floor nourishment refrigerator was unclean with food debris and spilled sticky liquids on the bottom and on the shelves and drawers. When interviewed on 9/15/2020 at 3:00 PM, the Food Service Director stated she was not aware of the food being held in the 3rd floor refrigerator. Staff should be labeling the food with a name, date, and what the food was. Food service staff was responsible for the cleaning of the nourishment refrigerators and the labeling was the responsibility of the staff that placed the food to be stored. She stated the 4th floor refrigerator was unclean and soiled, and she needed to have a work order put in because the seals were hanging off and not in good working order. She stated there were no cleaning schedules or procedures in place. She expected that floors were cleaned daily to include the walk-in cooler floors and storage rooms. Counters and equipment should be cleaned throughout the day. 10NYCRR 415.29 (j)(1)
F 0919 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that a working call system is available in each resident's bathroom and bathing area.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview during the recertification survey, the facility did not ensure they were adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area for 1 of 1 resident (Resident #7) reviewed. Specifically, the call system unit at the bedside for Resident #7 was not operational and there was no call system cord installed on the unit for resident access. Findings include: Resident #7 had [DIAGNOSES REDACTED]. The 9/1/20 Minimum Data Set (MDS) assessment documented the resident had moderate cognitive impairment, required supervision and set up help for walking in the room, toileting, and personal hygiene. The comprehensive care plan (CCP) initiated 3/2/20 documented the resident was at high risk for falls. Interventions included to ensure the call light was in reach, encourage the resident to use it, and promptly respond to all requests for assistance. The resident required a safe environment with a working and reachable call light. The 8/19/20 nursing progress note documented the resident was transferred to a new room on the third floor. The Kardex (care instructions) dated 9/15/20 documented the resident required limited assistance of one staff for dressing and walking with a quad cane, and extensive assistance of one staff for toileting. On 9/14/20 at 10:40 AM, the resident's room was observed to have no call bell cord at the wall. The resident had no tap bell in the room. When interviewed on 9/14/20 at 10:41 AM, the resident stated they never had a call bell in the room, they would use it if there was one, they took them self to the bathroom, and did not use a bedside urinal. If the resident needed assistance, they would walk to the hall and get someone. When asked what the resident would do if they were unable to get to the doorway and needed assistance, they shrugged their shoulders. The resident stated it bothered them to not have the call bell. When observed on 9/14/20 at 12:25 PM and 2:12 PM, there was no nurse call system cord installed on the beside unit within the resident's room. At 2:12 PM the call bell unit was not functional (no activation or communication with panel) when tested by the Director of Environmental Services. When interviewed on 9/15/20 at 2:12 PM, The Director of Environmental Services stated they perform random room audits and they check call bells and their function. He stated he was unaware the call cord was missing and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335471	A. BUILDING _____ B. WING _____	**09/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
UTICA REHABILITATION & NURSING CENTER	**2535 GENESEE STREET UTICA, NY 13501**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0919 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 4) that the unit was not functioning. He stated there was a work order book behind each nursing station that staff could add any issues that needed to be addressed. When interviewed on 9/15/20 at 2:14 PM, registered nurse (RN) unit manager #4 stated she was unaware the resident had not had a call cord or that the call bell unit did not work. She stated the resident moved from the 4th floor during the second half of last month. The third-floor work order binder had no documentation regarding the call bell for Resident #7's room. 10NYCRR 415.29