STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335378	A. BUILDING _____ B. WING _____	09/23/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SODUS REHABILITATION & NURSING CENTER	6884 MAPLE AVE SODUS, NY 14551

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 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews conducted during the Recertification Survey, it was determined that for one of two residents reviewed the facility did not thoroughly investigate injuries of unknown origin to rule out abuse, neglect, or mistreatment. Specifically, Resident #92 had bruises of unknown origin that were not investigated. This is evidenced by the following: Resident #92 had [DIAGNOSES REDACTED]. The Minimum Data Set Assessment, dated 9/5/20, revealed that the resident had severely impaired cognition. The nursing admission assessment, dated 9/10/20, included no skin issues. The weekly skin check form, dated 9/15/20, documented the resident's skin was intact. The Comprehensive Care Plan, dated 9/15/20, included the resident was at risk for impaired skin integrity. Interventions included to monitor and document skin injuries. A review of the progress notes, from 8/25/20 through 9/20/20, revealed no documented bruises or skin issues. Observations conducted on 9/17/20 at 10:09 a.m., 9/18/20 at 11:10 a.m., and 9/21/20 at 12:34 p.m., revealed the resident had dark purple bruising on the left upper arm, the right upper forearm, and the top of the left hand. When interviewed on 9/21/20 at 9:20 a.m., the Certified Nursing Assistant (CNA) said the resident had no skin issues or bruises. The CNA stated if a bruise was found it would be reported to the nurse immediately. In an interview on 9/21/20 at 12:34 p.m., the Licensed Practical Nurse (LPN) stated weekly skin assessments were completed on the resident's shower day and that he did not note any bruises on the resident. The LPN stated bruises would be reported to the Registered Nurse (RN) Manager and an Incident/Accident Report would be completed. When interviewed on 9/21/20 at 12:47 p.m., the RN Manager stated that he completed the resident's admission assessment and the resident did not have any bruises at that time. The RN Manager stated that he was not aware of the resident having any bruises. At that time the surveyor and RN Manager observed the resident's bruises, and the RN Manager stated that an investigation would be started. In an interview on 9/22/20 at 9:49 a.m., the Director of Nursing (DON) stated weekly skin checks are completed and documented in the computer. The DON stated in between weekly skin checks, the resident's skin was observed during cares and staff should report any bruises to the nurse. She said an Incident/Accident Report should be completed and an investigation started. She said the RN Manager will be starting an Incident/Accident Report for the resident's bruises. (10 NYCRR 415.4(b)(3))
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews conducted during the Recertification Survey, it was determined that for one of two residents the facility did not ensure a comprehensive person-centered care plan was developed that included measurable objectives and timeframes to meet the resident's medical and nursing needs that were identified in the comprehensive assessment. Specifically, Resident #49 did not have a care plan for an actual pressure ulcer and bone infection. This is evidenced by the following: The facility policy, Comprehensive Care Planning, dated April 2020, revealed that actual infections and pressure ulcers would be included in the Comprehensive Care Plan. Resident #49 had [DIAGNOSES REDACTED]. The Minimum Data Set Assessment, dated 8/3/20, revealed the resident had severely impaired cognition, received antibiotics, and had one unstageable pressure ulcer. The care area assessment summary revealed that the care area for pressure ulcers was triggered and addressed in the care plan. The physician history and physical assessment, dated 9/9/20, documented the resident was recently hospitalized with sacral osteo[DIAGNOSES REDACTED] leading [MEDICAL CONDITION] (life threatening response to an infection) and required intravenous antibiotics. The current physician orders [REDACTED]. The current Comprehensive Care Plan included a notation of an unstageable pressure ulcer under the nutritional section. There were no measurable goals or interventions related to pressure ulcers or osteo[DIAGNOSES REDACTED]. The current Kardex instructed to turn and position the resident in bed as necessary. When interviewed on 9/21/20 at 9:20 a.m., the Certified Nursing Assistant (CNA) stated the resident did not have any skin issues. The CNA stated that the use of a special mattress or a cushion in the wheelchair would be found on the resident's Kardex. When interviewed on 9/22/20 at 9:49 a.m., the Director of Nursing reviewed the resident's Comprehensive Care Plan and stated pressure ulcers were noted under the nutrition section but there were no interventions. She said interventions such as weekly wound rounds, measuring of the wound, special mattresses or cushions should be included in the care plan. She said that the Comprehensive Care Plan did not include the use of intravenous medications for osteo[DIAGNOSES REDACTED]. (10 NYCRR 415.11(c)(1))
F 0685 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assist a resident in gaining access to vision and hearing services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews conducted during the Recertification Survey, it was determined that the facility did not provide proper treatment and assistive devices to maintain vision for one of two residents reviewed. Specifically, the facility was unaware that Resident #11 lost their glasses and would like them replaced. This is evidenced by the following: The facility policy, Vision Services and Devices, dated October 2017, directs if a resident loses their devices, the nursing home will assist the resident or designated representative in locating resources including assistance in making appointments and transportation. Resident #11 has [DIAGNOSES REDACTED]. The Minimum Data Set Assessment, dated 6/13/20, revealed the resident had moderately impaired cognition and adequate vision (able to see in adequate light with glasses or another visual appliance). The Visual/Bedside Kardex which directs daily cares, dated 9/22/20, does not include the use of glasses. Review of the Nursing Admission Note, dated 6/3/20, included the resident's vision was adequate with glasses. The resident's picture in the Electronic Medical Record showed the resident wearing glasses. During observations and interviews on 9/16/20 at 1:42 p.m. and 9/18/20 at 12:39 p.m., Resident #11 was not wearing glasses. When interviewed, the resident said that they had glasses when they were admitted to the facility, and they were not sure what happened to them. Resident #11 said they would like new glasses. When interviewed on 9/18/20 at 12:33 p.m., Certified Nursing Assistant (CNA) #1 said the resident had glasses when they were admitted to the facility. In an interview on 9/18/20 at 2:02 p.m., the Registered Nurse (RN) Manager said he admitted Resident #11 and they had glasses with them upon arrival. When interviewed on 9/18/20 at 2:05 p.m., the Social Worker said no one had reported that Resident #11 had missing glasses. In an interview on 9/23/20 at 12:43 p.m., the RN said eye glasses should be included in the resident's care plan. (10 NYCRR 415.12(3)(b))
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews conducted during the Recertification Survey, it was determined that the facility did not provide necessary treatment and services consistent with professional standards of practice to promote healing, prevent infection, and prevent new pressure ulcers from developing for one of three residents reviewed. Specifically, Resident #6 was not wearing blue booties on both feet at all times and was not repositioned every two hours.

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.

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F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) This is evidenced by the following: Resident #6 had [DIAGNOSES REDACTED]. The Minimum Data Set Assessment, dated 6/4/20, revealed the resident had moderately impaired cognition, was dependent on two staff members for bed mobility and transferring, and had a Stage IV pressure ulcer. The initial wound consultant notes, dated 6/4/20, revealed that the resident had a Stage IV pressure ulcer of the sacrum. Interventions in place included a low-air loss support surface, foam seat cushion in the wheelchair, limit sitting time to two hours per episode, and a recommendation for bilateral heel boots. The wound consultant notes, dated 8/6/20, documented that all of the above interventions were in place including the bilateral heel boots. The Comprehensive Care Plan, dated 6/3/20, for sacral pressure ulcer included to turn and reposition the resident at least every two hours and more often as needed or requested. During a continuous observation on 9/21/20, from 9:27 a.m. until 2:00 p.m., the resident was sitting on a foam cushion in their wheelchair and was not repositioned. The resident was not wearing bilateral heel booties until approximately 11:25 a.m. after surveyor intervention. Review of the Documentation Survey report for 9/21/20 documented the times for turning and positioning were scheduled for 8:00 a.m. (signed off as completed at 11:23 a.m.), 10:00 a.m. (signed off as completed at 11:24 a.m.), and 12:00 p.m. (signed off as completed at 11:24 a.m.). Additionally, the bilateral booties were not signed off on 10/61 opportunities and the turning and positing was not signed off for 31/247 opportunities from 9/1/20 through 9/21/20 (day shift). When interviewed on 9/21/20 at 11:15 a.m., the resident said they used to wear heel booties but have not worn them in quite a while. The resident said the booties were right in the drawer in their room and if someone put them on, they would wear them. At that time, Licensed Practical Nurse (LPN) #1 and the surveyor went to the resident's room and found the booties in a drawer. LPN #1 applied the booties and said maybe the booties were not put on because the resident self-propels during the day. In an interview on 9/21/20 at 11:21 a.m. and 9/22/20 at 9:14 a.m., Certified Nursing Assistant (CNA) #1 said the resident had previously worn booties when living on a different unit but has not worn them since moving to that unit. At 2:00 p.m., CNA #1 said she had taken the resident to their room at one point and checked for incontinence but did not know the time. She was unable to say how often the resident should be turned and positioned. CNA #1 said there was no place to document turning and positioning every two hours in the computer. When interviewed on 9/22/20 at 12:33 p.m. and 2:33 p.m., the Director of Nursing (DON) said the resident should be turned and positioned every two hours. She said the resident could be shifted from side-to-side in the wheelchair using a pillow. She said the booties should be worn at all times. The DON said she needed to write an order to limit seating time to two hours. She said after the wound consultant notes are reviewed by the medical provider and the Nurse Manager was responsible for transcribing the orders. She said that was not done, and currently there was no Nurse Manager for the unit. (10 NYCRR 415.12(c)(2))
F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews conducted during the Recertification Survey, it was determined that for one (Resident #84) of two residents reviewed, the facility did not ensure that a resident with limited Range of Motion (ROM) received appropriate treatment and services to increase ROM or to prevent further decrease in ROM. Specifically, Resident #84 had contractures of the left upper extremity, and the facility did not implement interventions to prevent complications related to decreased ROM. This is evidenced by the following: Resident #84 had [DIAGNOSES REDACTED]. The Minimum Data Set Assessment, dated 8/24/20, revealed the resident had severely impaired cognition, required extensive assistance of two or more staff for personal hygiene, and had no functional limitations in ROM to the upper extremities. The current Comprehensive Care Plan and Visual/Bedside Kardex (care plan used by Certified Nursing Assistants) revealed the resident had contractures of the left hand and left elbow. Interventions included to provide skin care daily during morning and evening care, to keep skin clean and dry thoroughly to prevent skin breakdown, and required assistance in applying a rolled washcloth in their left hand and left elbow after hygiene in the morning and to remove in the evening. Current physician orders, initiated 2/21/20, included to cleanse the left elbow bend with normal saline, pat dry, apply antifungal powder, and separate the skin with a gauze pad every day and evening shift for fungal rash. An order, dated 8/21/20, included to cleanse the left hand with soap and water, dry thoroughly, and apply a clean, dry washcloth every day shift. Occupational Therapy (OT) Evaluations and Plan of Treatments, dated 5/18/20 and 8/18/20, revealed that the resident had impaired ROM to their left upper extremity and was referred for skilled OT services for a decrease in ROM, reduced sensation, reduced functional activity tolerance, and decreased skin integrity. On 5/18/20, the resident was evaluated to have no pain at rest and reddened areas to the left elbow and web spaces of the fingers. On 8/18/20, the resident had no pain at rest, and there were reddened areas of the skin noted. The September 2020 Treatment Administration Record (TAR) revealed missing documentation on 4 of 21 opportunities for the left hand treatment, and on 6 of 42 opportunities, there was missing documentation for the left elbow treatment. Review of interdisciplinary progress notes, from 6/5/20 to 9/22/20, did not include documented evidence that the resident had refusals of hygiene or the application of the rolled washcloth to the left hand or left elbow. The resident was observed on 9/17/20 at 10:07 a.m., 9/18/20 at 12:16 p.m., 9/21/20 at 9:16 a.m., sitting in a geri-chair outside of the nurses' station, awake and alert, with no obvious signs or symptoms of pain. The resident had a contracture to their left hand and no washcloth in place. The left elbow was not visible. An OT Evaluation and Plan of Treatment, dated 9/22/20 and initiated following surveyor intervention, revealed the resident was referred for an evaluation due to limited care plan carryover by staff and that the resident was demonstrating increased difficulty with tolerating hygiene routines and wearing of washcloth in the left hand. The resident was evaluated to have a pain intensity rated at a 3 out of 10 at rest, 7 out of 10 with movement, and the pain limited their functional activities. Impairment to the skin integrity included reddened areas to the left inner elbow and left hand between the third and fourth digits. Clinical impressions revealed the resident demonstrated increased signs and symptoms of pain during passive ROM and had a decline in the skin integrity of their left hand and elbow. A therapy progress note, dated 9/22/20, revealed the resident presented with a significant decline in skin integrity and tolerance for left upper extremity hygiene and wearing a rolled washcloth in their left hand. In an observation on 9/22/20 at 11:30 a.m., the Registered Nurse (RN) attempted to open the resident's hand at which time the resident yelled, No, and swatted her hand away. Upon opening the resident's hand, the skin was red and white matter was noted between the third and fourth digits. At 11:40 a.m., the RN and a Certified Nursing Assistant (CNA) were observed repositioning the resident in their geri-chair. The RN attempted to extend the resident's left arm causing the resident to yell out. The skin was red and there was white matter noted in the bend of the elbow. The RN stated at that time that she would attempt to apply the antifungal powder once the resident was in bed because they seemed uncomfortable and she did not want to hurt them. There was no washcloth observed in place to the left hand or left inner elbow at that time. Interviews conducted on 9/22/20 included the following: a. At 11:17 a.m., the CNA stated that when performing care, she will have the resident open their hand, clean it, and dry it a couple times each day. She does not keep the washcloth in their hand. b. At 11:30 a.m., the RN stated that the resident had a new order to cleanse their hand with soap and water. After reviewing the order, she stated that the task was not delegated to the CNA, so as the nurse she would perform the care. When asked by the Nurse Manager (NM) at 11:43 a.m. if she was able to get the washcloth in the resident's hand, the RN initially stated that the order did not include placing a washcloth in the resident's hand. c. At 11:48 a.m., the NM stated that the resident was supposed to have antifungal powder on and a washcloth placed in the bend. She said the hand is also supposed to be cleaned and dried, then a washcloth placed. She said therapy recommended to place the washcloth to prevent further decline of the contracture. The NM stated that since the treatment was scheduled to be done on the day shift, the nurses have between 6:00 a.m. and 2:00 p.m. to complete it. She said she has told the nurses that they have a better chance of getting the washcloth in earlier because over the course of the day it was more difficult to open the resident's hand and elbow. The NM stated that there had been some trouble getting the treatment done when assigned to the CNAs, so it was added to the TAR for the nurses to complete. She said she expected the nurse to complete the treatment. When the left hand and elbow were observed at that time, the NM stated that they did not appear to have been cleaned. At 2:30 p.m., when asked about missing documentation for treatments on the September 2020 TAR, she stated that she could not say that the treatments were done because there were no signatures. d. At 12:29 p.m., the Occupational Therapist (OT) stated that she had followed the resident a few times for concerns with impaired skin integrity. The OT said she expected that the resident's hand and elbow were cleaned and a washcloth was placed every day to keep the areas dry and to prevent skin breakdown. The OT stated that training with staff had been done a few times, it starts off good then dwindles off. When interviewed on 9/23/20 at 12:06 p.m., the OT stated that she evaluated the resident on 9/22/20 and their hand and

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F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) elbow looked pretty bad. She said the area between the resident's fingers was new. She said it was important that the hygiene gets done daily to keep those areas clean and dry to prevent skin breakdown. She stated that while the resident did not lose much ROM to the left upper extremity, they were having more pain. When asked about missing documentation for treatments on the September 2020 TAR on 9/23/20 at 12:28 p.m., the Director of Nursing (DON) stated that she was unable to determine if the treatments had been completed. She said if it was not documented, then it was not done. The DON said she would expect the nurses to document on the TAR if the treatment was completed or to use an appropriate follow-up code if the treatment was not done or refused. The CCP, Visual/Bedside Kardex, and physician orders [REDACTED]. (10 NYCRR 415.12(e)(2))
F 0698 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Past noncompliance - remedy proposed** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews conducted during the Recertification Survey, it was determined that for one of one resident reviewed, the facility did not ensure that residents received services consistent with professional standards of practice and the comprehensive person-centered care plan. Specifically, Resident #57's fluid restriction was not consistently monitored, assessed, and documented, there was a lack of consistent ongoing communication between the facility and [MEDICAL TREATMENT], and the facility did not consistently document assessments before and after [MEDICAL TREATMENT] treatments. This is evidenced by the following: Resident #57 had [DIAGNOSES REDACTED]. The Minimum Data Set Assessment, dated 8/13/20, revealed the resident had moderately impaired cognition and received [MEDICAL TREATMENT]. The facility's April 2020 [MEDICAL TREATMENT] Policy included the licensed nurse would complete pre and post [MEDICAL TREATMENT] progress notes on [MEDICAL TREATMENT] days including monitoring vital signs, shunt, bleeding, change in condition, and open communication shall be maintained with the [MEDICAL TREATMENT] center by utilizing a communication book. The facility's April 2020 Fluid Restriction Policy included the clinical nutrition staff will coordinate with nursing for a 24-hour distribution of the daily allowance for meals, supplements, and med pass. Sample breakdown of orders for each meal from dietary, each med pass for nursing, an order for [REDACTED]. Fluid restrictions will be reviewed for compliance by clinical nutrition staff and interdisciplinary team during morning meetings, with clinical follow-up with physician for exceeding intakes. The current physician orders [REDACTED]. Review of the August 2020 and September 2020 Medication Administration Records (MARs) included entries to document the resident's blood pressure, pulse, and respirations, and temperature on Mondays, Wednesdays, and Fridays before and after [MEDICAL TREATMENT]. The vital signs were not documented 11/21 opportunities from 8/1/20 through 9/20/20. The resident's fluid restriction and breakdown of fluid distribution by nursing and dietary was not documented on the MARs until 9/21/20. Review of the medical record revealed [MEDICAL TREATMENT] report sheets (a communication tool that both the facility and [MEDICAL TREATMENT] center document on each [MEDICAL TREATMENT] session), dated 7/6/20 and 7/17/20, both with concerns that fluids were not being restricted. The facility was unable to provide any additional [MEDICAL TREATMENT] report sheets. The progress notes, from 8/1/20 through 9/20/20, did not include pre and post [MEDICAL TREATMENT] notes. The current Comprehensive Care Plan and Kardex included a recommended fluid intake of 1,632 ml and to monitor and document fluid intake per facility policy. Review of the fluid intake sheets for meals and supplements, from 9/11/20 through 9/20/20, revealed that fluid intakes were 260 ml to 390 ml on four days, 480 ml on two days, 640 ml to740 ml on two days, and over 1,000 ml on two days (1,240 ml and 1,170 ml). During an observation 9/21/20 at 9:00 a.m., the resident's breakfast tray included cottage cheese, scrambled eggs, one slice of toast, one English muffin, two 8-ounce cartons of milk (480 ml) and one small glass of cranberry juice (120 ml). In an interview on 9/21/20 at 9:35 a.m., Certified Nursing Assistant #2 stated she had given the resident the breakfast tray that morning. She observed the resident's tray and stated the resident should only have one milk on the tray. When interviewed on 9/21/20 at 10:12 a.m., the Diet Technician (DT) stated fluid restrictions are ordered by the physician. The DT stated he would inform nursing of the breakdown of fluids available to nursing and amount available to dietary. The DT stated he did not know who monitored the resident's 24-hour fluid totals. He said he reviewed fluid intakes quarterly. In an interview on 9/21/20 at 12:44 p.m. and 9/23/20 at 10:54 a.m., the Registered Nurse (RN) Manager stated the DT managed the resident's fluids. The RN Manager stated the staff would document the fluids the resident consumed. The RN Manager said she was not aware of who was responsible for reviewing, monitoring, or totaling the resident's 24- hour fluid intake to ensure the fluid restriction was maintained. The RN Manager said that there should be a [MEDICAL TREATMENT] report sheet sent every time the resident goes to [MEDICAL TREATMENT]. She said [MEDICAL TREATMENT] staff complete their section and return the form. When interviewed on 9/23/20 at 11:42 a.m., Registered Dietician (RD) #2 stated the DT reviews the 24-hour intakes for residents on fluid restrictions. In an interview on 9/23/20 at 11:43 a.m., the Director of Nursing said that binders (communication books) are sent with the resident to [MEDICAL TREATMENT]. She said the facility staff should complete the [MEDICAL TREATMENT] report sheet and place it in the folder. She said the facility nurses should look for that form upon the resident's return. She said the RN Manager would be responsible for monitoring to ensure that the forms are being completed and sent to [MEDICAL TREATMENT]. (10 NYCRR 415.12)
F 0791 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide or obtain dental services for each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews conducted during the Recertification Survey, it was determined that for one of three residents reviewed, the facility did not ensure a resident was promptly referred to dental services for lost dentures. Specifically, the facility did not identify that Resident #57's dentures were missing or provide dental services to replace them. In addition, the Comprehensive Care Plan (CCP) did not address the resident's dental needs. This is evidenced by the following: Resident #57 had [DIAGNOSES REDACTED]. The Minimum Data Set (MDS) Assessment, dated 8/13/20, revealed the resident had moderately impaired cognition and required the extensive assistance of one staff for personal hygiene (which included oral care). The admission MDS Assessment, dated 12/30/19, did not identify the resident as edentulous (no natural teeth). A dental evaluation, dated 12/17/19, revealed the resident had full upper dentures and was edentulous. The full upper denture fits well and no treatment was needed at that time. Current physician orders [REDACTED]. The current CCP and Certified Nursing Assistant (CNA) Kardex did not include that the resident had dentures. The Kardex included the resident required the assistance of staff for oral care. During an observation on 9/17/20 at 9:58 a.m., the resident was edentulous and eating breakfast without difficulty. When interviewed at that time, the resident stated their dentures were lost. The resident stated they would like new ones so they could eat better. During an interview on 9/22/20 at 8:39 a.m. and again at 1:19 p.m., CNA #1 stated the resident had dentures and she had put them in that morning. CNA #1 later stated that she had misspoken earlier and the resident had not worn dentures in a long time. When interviewed on 9/22/20 at 12:14 p.m., the Registered Nurse Manager stated the resident does not like to wear dentures. He said he was not aware that the dentures were missing. In an interview on 9/22/20 at 1:09 p.m., the Social Worker (SW) stated the facility did not locate the resident's missing dentures. She said she would send a referral to the dentist. The SW stated dentures should be included on the Kardex. (10 NYCRR 415.17(a-d))
F 0801 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.** Based on interviews and record review conducted during the Recertification Survey, it was determined that the facility did not ensure that a qualified dietician carried out the functions of the food and nutrition services. Specifically, the Registered Dietician had not been onsite since March 2020 and had not completed physical nutritional assessments or participated in interdisciplinary care plan meetings. This is evidenced by the following: When interviewed on 9/22/20 at 2:49 p.m., the Director of Nursing said visitors to the building were limited due to the COVID-19 pandemic. She said she considered the Registered Dieticians (RD) contractors and told them not to come onsite. She said that she did not realize that the RDs performed physical nutritional assessments. In an interview on 9/23/20 at 9:45 a.m. and 10:01 a.m., RD #1 said the last time an RD was in the building was in March 2020. She said the RDs have been working remotely with access to the medical record. She said the RDs did not have access to electronic devices to be able to physically see or interact with residents. She said the RD did not complete any physical assessment and did not attend care plan meetings. She said she considered RDs essential personnel. During an interview on 9/23/20 at 11:14 a.m., the Dietary Technician (DT) said that the Registered Dieticians have not been onsite at the facility since March 2020. When interviewed on 9/22/20 at 2:06 p.m., the Administrator said he did not know why the RDs were not providing onsite visits. He said that he understood the difference

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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 0801 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) in education and scope of practice between an RD and DT and understands why RDs are required by regulation. (10 NYCRR 415.14(a)(1)(2))
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Provide and implement an infection prevention and control program.** Based on observation, interviews, and record reviews conducted during the Recertification Survey, it was determined that for three of three residential units, the facility did not establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. Specifically, the facility was unable to provide evidence of a complete infection control program that consistently identified, tracked, investigated, monitored, and analyzed surveillance data to prevent infections in the facility. This is evidenced by the following : A review of the infection control program was conducted on 9/23/20 at 2:00 p.m. with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON). When asked for the facility infection control line listing, the DON provided an Antibiotic Tracking Form. The ADON said that the Antibiotic Tracking Form was used to track and trend all infections and antibiotic usage. Review of the form, from 1/1/20 to present, revealed inconsistent data regarding culture results or organisms, location of the infection, control measures, and the infection resolution date. When interviewed at that time, the ADON said the date of the infection was actually the date the antibiotic was started, and the date of resolution was the date the antibiotic was completed. When asked for the trending information or if comparisons were done month to month, or if an analysis of the information was completed the DON said no it was not done. On 9/23/20 at 1:35 p.m., the Administrator with the DON present said he was not aware the Infection Control Program was not complete. (10 NYCRR 415.19(a)(1-3))