HEALTH & HUMAN SERVICES COMMITTEE MEETING MINUTES
December 7, 2021

The Health & Human Services Committee of the Broome County Legislature met on Tuesday, December 7, 2021 via Zoom.

Members Present: J. Shaw (Chair) C. O'Brien, M. Hilderbrant, M. Kaminsky, K. Beebe

Members Absent: None

Others Present: A. Martin, M. Tanzini, R. O'Donnell, J. Scott, C. Hall, K. Wildoner, R. Weslar, S. Ryan, Legislature; M. McFadden, Health Department; R. LaClair, WPRNC; N. Williams, K. White, DSS; B. Ravas, K. Saunders, Mental Health; M. Whitcombe, OFA; J. Garnar, C. Wagner, M. Ponticiello, Executive; J. Knebel, OMB; R. Murphy, OET; D. Camin, IT; E. Gartenman, Assigned Counsel; V. Gialanella, Resident.

The Health & Human Services Committee meeting was called to order by the Chair at 4:30 PM. Ms. O'Brien made a motion to move the agenda, seconded by Ms. Kaminsky.

The Chair requested all renewals, which are Resolutions #6-#22, be grouped together and voted on in a single vote. Ms. O'Brien made a motion to consider the resolutions as one vote, seconded by Ms. Kaminsky. The vote to consider the resolutions as one vote carried, Ayes-5, Nays-0. The resolutions grouped together carried, Ayes- 5, Nays- 0.

The Committee took the following action with regard to the matters before it:

#4 RESOLUTION CONFIRMING APPOINTMENT TO MEMBERSHIP ON THE BROOME COUNTY COMMUNITY SERVICES BOARD
Carried. Ayes-5, Nays-0

#5 RESOLUTION CONFIRMING APPOINTMENTS TO MEMBERSHIP ON THE BROOME COUNTY FAMILY VIOLENCE PREVENTION COUNCIL
Carried. Ayes-5, Nays-0

#6 RESOLUTION AUTHORIZING RENEWAL OF THE AGREEMENT WITH VARIOUS PROVIDER AGENCIES FOR SERVICES FOR THE DEPARTMENT OF SOCIAL SERVICES' PURCHASE OF SERVICE PROGRAMS FOR 2022
Carried. Ayes-5, Nays-0

#7 RESOLUTION AUTHORIZING RENEWAL OF THE SAFE HARBOUR PROGRAM GRANT FOR THE DEPARTMENT OF SOCIAL SERVICES, ADOPTING A PROGRAM BUDGET AND RENEWING THE AGREEMENT WITH CRIME VICTIMS ASSISTANCE CENTER TO ADMINISTER SAID PROGRAM FOR 2022
Carried. Ayes-5, Nays-0

#8 RESOLUTION AUTHORIZING RENEWAL OF THE TITLE III-B SUPPORTIVE SERVICES PROGRAM GRANT FOR THE OFFICE FOR AGING AND ADOPTING A PROGRAM BUDGET FOR 2022
Carried. Ayes-5, Nays-0

#9 RESOLUTION AUTHORIZING RENEWAL OF THE TITLE III-C-1 CONGREGATE MEALS PROGRAM GRANT FOR THE OFFICE FOR AGING AND ADOPTING A PROGRAM BUDGET FOR 2022
Carried. Ayes-5, Nays-0

#10 RESOLUTION AUTHORIZING RENEWAL OF THE TITLE III-C-2 HOME DELIVERED MEALS PROGRAM GRANT FOR THE OFFICE FOR AGING AND ADOPTING A PROGRAM BUDGET FOR 2022
Carried. Ayes-5, Nays-0

#11 RESOLUTION AUTHORIZING RENEWAL OF THE TITLE III-D HEALTH PROMOTION PROGRAM GRANT FOR THE OFFICE FOR AGING AND ADOPTING A PROGRAM BUDGET FOR 2022
Carried. Ayes-5, Nays-0

#12 RESOLUTION AUTHORIZING RENEWAL OF TITLE III-E FAMILY CAREGIVER PROGRAM GRANT FOR THE OFFICE FOR AGING AND ADOPTING A PROGRAM BUDGET FOR 2022
Carried. Ayes-5, Nays-0

#13 RESOLUTION AUTHORIZING RENEWAL OF THE CAREGIVER SUPPORT INITIATIVE PROGRAM GRANT FOR THE OFFICE FOR AGING AND ADOPTING A PROGRAM BUDGET FOR 2022
Carried. Ayes-5, Nays-0

#14 RESOLUTION AUTHORIZING RENEWAL OF THE ELDER ABUSE OUTREACH PROGRAM GRANT FOR THE OFFICE FOR AGING AND ADOPTING A PROGRAM BUDGET FOR 2022
Carried. Ayes-5, Nays-0

#15 RESOLUTION AUTHORIZING RENEWAL OF THE INTEGRATED SOCIAL DAY CARE PROGRAM GRANT FOR THE OFFICE FOR AGING AND ADOPTING A PROGRAM BUDGET FOR 2022
Carried. Ayes-5, Nays-0

#16 RESOLUTION AUTHORIZING RENEWAL OF THE AGREEMENT WITH THE JOHNSON CITY SENIOR CITIZENS CENTER, INC. FOR CONGREGATE NUTRITION PROGRAM SERVICES FOR THE OFFICE FOR AGING FOR 2022
Carried. Ayes-5, Nays-0

#17 RESOLUTION AUTHORIZING RENEWAL OF THE AGREEMENT WITH METRO INTERFAITH HOUSING MANAGEMENT CORPORATION FOR MEAL SERVICES THROUGH THE OFFICE FOR AGING'S TITLE III-C-1 CONGREGATE MEAL PROGRAM FOR 2022
Carried. Ayes-5, Nays-0

#18 RESOLUTION AUTHORIZING RENEWAL OF AN AGREEMENT WITH INDIANA PRINTING AND PUBLISHING COMPANY, INC., FOR PRINTING SERVICES FOR THE OFFICE FOR AGING FOR 2021-2022
Carried. Ayes-5, Nays-0

#19 RESOLUTION AUTHORIZING RENEWAL OF THE AGREEMENT WITH VARIOUS RESPITE SERVICE PROVIDERS FOR SERVICES RELATED TO THE OFFICE FOR AGING'S TITLE III-E FAMILY CAREGIVER PROGRAM AND THE CAREGIVER SUPPORT INITIATIVE FOR 2022
Carried. Ayes-5, Nays-0

#20 RESOLUTION AUTHORIZING THE RENEWAL OF AGREEMENTS WITH VARIOUS VENDORS FOR LEASE OF SPACE FOR THE OFFICE FOR AGING'S MEALS ON WHEELS SITES, SOCIAL ADULT DAY CARE SITES AND SENIOR CENTERS FOR 2022
Carried. Ayes-5, Nays-0

#21 RESOLUTION AUTHORIZING RENEWAL OF THE MEDICARE IMPROVEMENTS FOR PATIENTS AND PROVIDERS ACT (MIPPA)-SHIP & AAA ADRC PROGRAM GRANT FOR THE OFFICE FOR AGING, ADOPTING A PROGRAM BUDGET AND RENEWING AN AGREEMENT WITH ACTION FOR OLDER PERSONS TO ADMINISTER SAID PROGRAM FOR 2021-2022
Carried. Ayes-5, Nays-0

#22 RESOLUTION AUTHORIZING RENEWAL OF THE AGREEMENT WITH BROOME COUNTY COUNCIL OF CHURCHES – FAITH IN ACTION PROGRAM FOR SHOPPER SERVICES FOR THE OFFICE FOR AGING FOR 2022
Carried. Ayes-5, Nays-0

#23 RESOLUTION AUTHORIZING AMENDMENT TO RESOLUTION 139 OF 2021 AUTHORIZING AN AGREEMENT WITH VARIOUS VENDORS FOR TEMPORARY STAFFING SERVICES FOR THE WILLOW POINT REHABILITATION & NURSING CENTER FOR 2021
Carried. Ayes-5, Nays-0

#24 RESOLUTION AUTHORIZING AMENDMENT TO THE AGREEMENT WITH AFFINITY REHABILITATION, LLP FOR REHABILITATION THERAPY SERVICES FOR THE WILLOW POINT REHABILITATION & NURSING CENTER FOR 2021
Carried. Ayes-5, Nays-0

#25 RESOLUTION AUTHORIZING THE WILLOW POINT REHABILITATION AND NURSING CENTER TO WRITE OFF UNCOLLECTIBLE ACCOUNTS
In response to questions from the Committee, Mr. LaClair stated that an uncollectable debt write off will be an annual process moving forward. Mr. LaClair stated that WPRNC personnel would prioritize scheduling a meeting with the County Attorney's Office regarding uncollectible accounts. Mr. LaClair stated that the reasoning behind uncollectible debt can vary. Mr. LaClair stated the current uncollectible debt has accumulated over several years, and the industry standard ranges from 4% to 8% of total facility revenue, and that WPRNC has been around 8%. Mr. LaClair stated that WPRNC revenue totaled around $32,000,000 prior to the pandemic. Mr. LaClair stated that positions within the budget and finance department at WPRNC remain unfilled. Mr. LaClair stated that openings have not been advertised due to the administration of an upcoming civil service test, which candidates must take to qualify for employment. The County Executive stated the positions are budgeted for, and departments are expected to handle the recruitment and the hiring of personnel. Mr. LaClair stated that he would work with the Personnel Department to advertise open positions. Mr. LaClair stated that the deadline to sign up for the civil service test had passed, and the top three candidates must be considered for hire and that would create a difficult recruiting situation if a candidate hadn't taken the civil service test prior to applying.
Not Sponsored. Ayes-1, Nays-4 (O'Brien, Hilderbrant, Kaminsky, Beebe)

#26 RESOLUTION AUTHORIZING A PERSONNEL CHANGE REQUEST FOR THE DEPARTMENT OF SOCIAL SERVICES
Carried. Ayes-5, Nays-0

#47 RESOLUTION AUTHORIZING AMENDMENT TO THE AGREEMENT WITH POINTCLICKCARE TECHNOLOGIES, INC., FOR SOFTWARE AND SERVICES FOR WILLOW POINT REHABILITATION AND NURSING CENTER FOR 2020-2021
Carried. Ayes-5, Nays-0

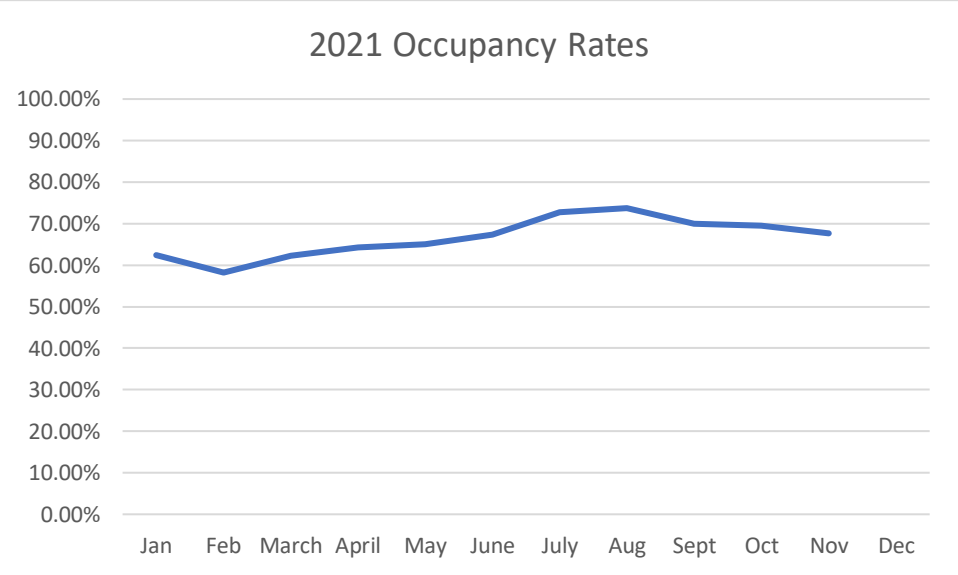
WPRNC Administrator Ryan LaClair provided an update to the Committee on current operations at the Willow Point Rehabilitation and Nursing Center (attached).

There being no further business to come before the Committee at this time, a motion to adjourn was made by Ms. O'Brien seconded by Ms. Kaminsky. The meeting adjourned at 5:11 PM.

Willow Point
Broome County Rehabilitation & Nursing Center

December 7, 2021
Health and Human Services Committee

1. **Census:**
   November census compared to October census shows a drop of 1.89%. Average census dropped 5.65 people per day. Current census is 195. We have 5 units open at this time. We are not taking admissions at this time but plan to do so next week.



2. **Staffing:**

	Budget	Actual	Change Since last report	Vacant	Percent filled
FT CNA	112	42	-	70	37.5%
PT CNA	33	5	-2	28	21.2%
FT Nurse	44	25	-1	19	59.1%
PT Nurse	27	5	-1	22	22.2%

- Current Willow Point staffing allows for us to staff approximately 3 units without the use of agency.
- Willow Point is currently using 24 Agency CNAs, and 5 Agency nurses with varying hours worked.

- An Agency CNA costs an average of $42.46/hour. A Willow Point CNA costs an average of $23.00/hour
- An Agency LPN costs an average of $48.73/hour. A Willow Point LPN costs an average of $31.00/hour

3. National Guard:

On 12/6/2021 Willow Point received 12 individuals from the National Guard. We are currently training these 12 individuals on how to be a CNA so that they will be able to provide care. At this time, they will be working 4 12-hour shifts per week for a total of 48 hours per week. At this time that National Guard will be here until Jan. 15th but they have said that date could be extended. It will be up to the NYSDOH and the Governor.

I personally see the arrival of the National Guard as a gift of assistance to the community, not to Willow Point. 12 full time CNAs is a massive opportunity that needs to be shared. We are moving forward with taking short term admissions starting next week. We want the hospitals to know that we will do all that we can to assist them with the presence of the National Guard.

4. Business Plan:

- Based on average payor sources and average revenue per payor source, we estimate a long term unit to generate approximately 4.0M in revenue.
- Using an estimate, we expect the cost of direct labor to be approximately 2.1M.
- Each unit could expect to see a saving of approximately 1.5M annually when using BC Staff vs. Agency Staff.

5. Quality:

- The results of our Recertification Survey are available, along with the approved plan of correction. It is a 40 page document that is provided separately of this report.
- Food temps continue to be an issue. We are working with Sodexo and WP staff to correct this as much as possible. We will be using steam table service from breakfast/lunch and tray service for dinner. This should help improve meal temps as best as possible.
- Currently we have 1 resident with COVID. It was acquired when a resident went home for Thanksgiving and had close contact with a family member.
- 3 employees are currently out due to COVID. These employees have no contact with the resident and are not considered linked.

Willow Point
Broome County Rehabilitation & Nursing Center

- We continue to track falls and pressure injuries. We still have no in-house acquired pressure injuries.

LEVEL 4	Immediate Jeopardy To Resident Health Or Safety	ISOLATED J	PATTERN K	WIDESPREAD L
LEVEL 3	Actual Harm That Is Not Immediate Jeopardy	ISOLATED G	PATTERN H	WIDESPREAD I
LEVEL 2	No Actual Harm With Potential For More Than Minimal Harm That Is Not Immediate Jeopardy	ISOLATED D	PATTERN E	WIDESPREAD F
LEVEL 1	No Actual Harm With Potential For Minimal Harm	ISOLATED A	PATTERN B	WIDESPREAD C

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335291	A. BUILDING _____ B. WING _____	10/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW POINT REHABILITATION AND NURSING CENTER	3700 OLD VESTAL ROAD VESTAL, NY 13850

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 000	INITIAL COMMENTS Recertification and Complaint Investigation surveys (NY00272363, NY00282322 and NY00283499) were conducted at Willow Point Rehabilitation and Nursing Center from 10/25/21-10/29/21 to determine compliance with 42 CFR Part 483 Requirements for Long Term Care Facilities. Deficiencies were cited as a result of this survey: 42 CFR 483.20 Resident Assessments 42 CFR 483.21 Comprehensive Resident Centered Care Plans 42 CFR 483.24 Quality of Life 42 CFR 483.25 Quality of Care 42 CFR 483.40 Behavioral Health Services 42 CFR 483.45 Pharmacy Services 42 CFR 483.60 Food and Nutrition Services	F 000		
F 645 SS=D	483.20(k)(1)-(3) PASARR Screening for MD & ID §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of	F 645	1. Residents number 187 and 165 had a PASARR completed and are appropriate for skilled nursing placement. 2. All residents have been identified as potentially being affected by the same practice. A full house review of all residents was completed to determine if a Preadmission Screening and Resident Review (PASRR) was conducted prior to admission. All residents have a PASRR in their medical chart. 3. The Administrator, Director of Nursing, Director of Social Services, and Medical Director developed a policy regarding the PRI and Screen. Education was provided to all part and full-time LPNs, RNs, Social Work Assistants, and Admissions Coordinators regarding policies and procedures related to PASRR screening. Educational emphasis was placed on the need to have the PASRR	12/29/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Electronically Signed	11/24/2021

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F 645	Continued From page 1 services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental	F 645	completed and present at time of admission. 4. The facility developed an audit tool to monitor compliance with facility policies and procedures related to PASRR screenings. Facility Social Work Assistants or designees will audit all admissions to the facility to determine if a PASRR is present upon admission. The Director of Social Services or designee will report findings to the Quality Assurance/Process Improvement Committee monthly for three months for evaluation and follow-up, with a compliance goal of 90%. At the end of the three-month period the committee will evaluate the need for additional monitoring or other corrective actions. Ad Hoc meetings will be convened as needed. 5. Responsibility: Director of Social Services	

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F 645	Continued From page 2 disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review and interview during the recertification survey conducted from 10/25/21-10/29/21, the facility failed to ensure that each resident was screened for a mental disorder (MD) or intellectual disability (ID) prior to admission for 2 of 35 residents (Residents # 165 and #187) reviewed. Specifically, there was no documentation that a Preadmission Screening and Resident Review (PASARR, New York State Department of Health form 695) was completed for Residents #165 and #187 by a qualified screener prior to admission to the facility. Findings include: Resident #187 was admitted to the facility with a history of major depressive disorder. The 3/2/21 Minimum Data Set (MDS) admission assessment documented the resident was cognitively intact, felt depressed several days, had not been evaluated by Level II PASARR and required extensive assistance with most activities of daily living (ADL's). Resident # 165 was admitted with diagnoses including depression. The 1/10/2019 comprehensive Minimum Data Set (MDS) assessment documented the resident had moderately impaired cognition, had not been evaluated by Level II PASARR, felt depressed	F 645		

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F 645	Continued From page 3 with most activities of daily living (ADL's). There was no documented evidence Residents #165 and 187 had a PASARR completed prior to admission to the facility as required. During an interview on 10/29/21 at 10:47 AM, the Director of Social Work stated there was not a PASARR for either resident #165 or # 187. The presence of a PASARR was supposed to be monitored by social work, with the help of admissions or the ward clerk, when a resident was admitted. They stated an audit had been performed this week and prior to the pandemic. The facility knew there were missing PASARRs. No change in procedure had been made in response to the missing documents. The purpose of a PASARR was to make sure individuals were appropriate for the level of care and to obtain services as needed. During an interview on 10/29/21 at 10:57 AM, the Admission Coordinator stated their understanding was that unit clerks checked the admission packet from the hospital for PASARRs. They were not aware of a specific checklist or protocol in place regarding PASRRs. If a PASARR was missing, admissions would call case management at the discharging facility and request a screen be sent. They stated appropriate level of care was determined by the screen and services that were needed for the resident. The facility was aware that resident #187's PASRR was missing and had attempted to get one from the previous facility and were told it was not available. 10NYCRR 415.11(3)	F 645		
F 657 SS=D	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision	F 657	1. A case conference was held with resident 191 to review his plan of care and give him opportunity to provide input.	12/29/2021

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F 657	Continued From page 4 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and interview during the recertification survey conducted from 10/25/21-10/29/21, the facility failed to ensure the participation of the resident and the resident's representative(s) in the development of a comprehensive care plan for 1 of 1 resident (Resident #191) reviewed. Specifically, Resident #191 was not invited to attend their comprehensive care plan meeting and the	F 657	2. All residents have been identified as potentially being affected by the same practice. A full house review of all residents was completed to determine who is appropriate to attend their own case conference meeting based on their own wishes and cognitive abilities. 3. The Administrator, Director of Nursing, Director of Social Services, and Medical Director will continue to review and revise, as needed, policies and procedures related to case conference. Education was provided to all Social Work Assistants and Clinical Care Coordinators regarding case conference. Educational emphasis was placed on the rights of the resident to attend their case conference meeting and if unable to participate then the reasoning needs to be documented in the resident's care plan. 4. The facility developed an audit tool to monitor compliance with facility policies and procedures related to case conferences. Director of Social Services or designee will audit 20 case conferences per month for three months for attendance or appropriate documentation if the resident did not attend. The Director of Social Services or designee will report audit findings to the Quality Assurance/Process Improvement Committee monthly for three months for evaluation and follow-up with a compliance goal of 90%. At the end of the three-month period the committee will evaluate the need for additional monitoring or other corrective actions. Ad Hoc meetings will be convened as needed. 5. Responsibility: Director of Social Services	

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F 657	Continued From page 5 resident expressed a desire to participate. Findings include: The 2/5/19 "Care Plans" facility policy documented the resident and/or resident's representative will be invited to attend and participate in the Interdisciplinary Team care plan meeting, and if unable or unwilling to attend, the plan of care will be discussed with them by the social worker and noted in the progress notes. Resident #191 was admitted to the facility with diagnoses including chronic kidney disease, hypertensive heart disease with heart failure, and morbid obesity. The 7/31/21 Minimum Data Set (MDS) annual assessment documented the resident was cognitively intact and required extensive assist of two staff for most activities of daily living (ADLs). The 11/23/20 comprehensive care plan (CCP) documented the resident was alert and oriented with some forgetfulness. The goal was for the resident's strengths to be utilized to improve the resident's quality of life. Interventions were to offer choices that emphasized the resident's strengths, design the care plan to incorporate the resident's strengths into the interventions, and communicate the resident's strengths with the interdisciplinary care plan (ICP) team members. The 7/30/21 social services progress notes documented an MDS assessment was completed, the resident was cognitively intact, and the resident's spouse was invited to the resident's annual care plan meeting. There was no documentation the resident had been invited to the care conference.	F 657		

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F 657	Continued From page 6 The undated Care Plan signature sheet documented the annual care plan meeting for Resident #191 occurred on 8/9/21. The resident's spouse signed they were in attendance. During an interview on 10/26/21 at 9:26 AM, Resident #191 stated they had wanted to attend their annual care conference and had not been invited. They had not been aware they had been omitted from the meeting. When interviewed on 10/28/21 at 3:00 PM, social work assistant #17 stated residents were not always included in care plan conferences if they were unable to participate. She stated that Resident #191's family member was present at the care plan meeting, but Resident #191 had not been invited. They stated resident #191 was cognitively intact, and the decision was made by the interdisciplinary team not to invite the resident. They felt that information discussed may have been upsetting to the resident. When interviewed on 10/28/21 at 3:40 PM, the Director of Social Work #2 stated residents should be invited to care plan meetings and assisted to attend. They stated that if a resident was unable to understand or participate, the resident would not be included. Resident #191 was cognitively intact and should have been included in meeting. During an interview on 10/28/21 at 3:53 PM with the resident's family member they stated they participated in the care plan meeting by phone. They stated they did not know why the resident was not included in meeting. 10NYCRR 415.11(c)(2)(ii)	F 657		

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F 677 F 677 SS=D	Continued From page 7 483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview during the recertification survey conducted 10/25/21- 10/29/21, the facility failed to ensure residents who are unable to carry out activities of daily living (ADLs) receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 of 3 residents (Resident #38) reviewed. Specifically, Resident #38 did not receive incontinence care as care planned and was observed inappropriately dressed. Findings include: The 6/2015 facility policy "Toileting" documented residents would be assisted with toileting every 2-4 hours and upon request during the day, when awake and at other times as directed. If a resident is on a toileting assistance schedule that specifies a designated time, they will be assisted with toileting according to the specific schedule. Resident #38 had diagnoses including dementia, anxiety, and depression. The 8/2/21 Minimum Data Set (MDS) assessment documented the resident had moderate cognitive impairment, physical and verbal behavioral symptoms 4 to 6 times, rejected care daily, required extensive assistance of 2 with dressing, and was totally dependent with 2 staff for toileting. The resident	F 677 F 677	1. Resident number 38 was provided incontinence care as described in the statement of deficiencies. Resident's care plan was reviewed by the IDT and reviewed with CNA #36 for re-education regarding following the resident's plan of care. 2. All residents have been identified as potentially being affected by the same practice. All resident care plans were reviewed to ensure accuracy of care required to meet their individual needs. 3. The Administrator, Director of Nursing, and Medical Director will continue to review and revise, as needed, policies and procedures related to ADL Care. Education was provided to all part and full time nursing staff regarding facility policies and procedures related to ADL care. Educational emphasis was placed on timely incontinence care per the resident's care plan and dressing residents appropriately. 4. The facility developed an audit tool to monitor compliance with timely and appropriate ADL care policies and procedures. The Director of Nursing or designee will audit 10 dependent residents weekly to determine if the resident is provided with toileting assistance per their plan of care and if the resident is dressed appropriately. The Director of Nursing or designee will report findings to the Quality Assurance/Process Improvement Committee monthly for three months for evaluation and follow-up, with a compliance goal of 90%. At the end of the three month period the committee will evaluate the need for additional monitoring or other corrective actions. Ad Hoc meetings will be convened as needed.	12/29/2021

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F 677	Continued From page 8 was always incontinent of urine, frequently incontinent of bowel, and was not on a toileting program. The 7/1/21 Comprehensive Care Plan (CCP) documented the resident had an ADL deficit related to limited mobility and dementia. Interventions were for one staff to assist with dressing, shoes and socks, incontinence briefs for dignity, and check and change the resident upon rising, before and after meals, at bedtime and as needed. The undated care instructions (Kardex) documented the resident required assistance of 1 with dressing, socks, and shoes. The resident was incontinent of bladder and bowel and wore incontinence briefs for dignity. The resident was to be checked and changed upon rising, before and after meals, at bedtime, and as needed. The CNA Documentation Report documented that Resident #38 was toileted on 10/27/21 at 2:18 AM on the overnight shift and again at 9:31 AM by CNA #36. The resident was dressed with 1 assist at 9:31 AM by CNA #36. On 10/27/21 at 9:36 AM, Resident #38 was observed sitting in their high back wheelchair at the nursing station with their shoes on the wrong feet. At 12:07 PM, the resident was observed in the dining room and their shoes remained on the wrong feet. When interviewed 10/27/21 at 1:49 PM, CNA #36 stated they were the assigned CNA for resident #38 and the resident was gotten up on the overnight shift. The CNA stated the resident had been up since 6:30 AM and the first time CNA #36 had checked the resident to be changed was at the current time. CNA #36 was	F 677	5. Responsibility: Director of Nursing	

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F 677	Continued From page 9 unsure if anyone else had provided care to the resident during the shift. The resident should be checked and changed every 2-3 hours and should have their shoes on the correct feet. During an observation on 10/27/21 at 2:03 PM, CNA #36 and one other unidentified staff provided incontinence care for Resident #38. The resident's sweatpants were wet in the crotch area and the resident's brief was saturated. The resident had feces on their skin that was pasty and required three soapy washcloths to remove. During a follow up interview at 2:30 PM, CNA #36 stated they documented at 9:31 AM the resident's level of care only and did not document they provided care for the resident at that time. When interviewed on 10/27/21 at 2:32 PM, licensed practical nurse (LPN) #33 stated they had some oversight over the CNAs. It was the CNA's responsibility to review the resident's Kardex on their assignment and provide incontinence and toileting care per the resident's care plan. LPN #33 stated they were unaware Resident #38 had not received any incontinence or toileting care during the day shift and that was a long time for a resident to wait. Staff needed to anticipate Resident #38's needs. LPN #33 expected CNAs to tell them if they were running behind or were unable to provide care. The LPN stated they expected the resident to have their shoes on the correct feet. When interviewed on 10/28/21 at 10:33 AM, LPN Unit Manager #9 stated CNAs were to review the Kardex for each resident on their assignment. CNAs were to let the nurse know if they were running behind or were unable to provide care for a resident. LPN Unit Manager	F 677		

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F 677	Continued From page 10 #9 stated staff should be checking and changing residents at least a couple of times during the day shift and that was a long period for Resident #38 to wait for incontinence care. LPN Unit Manager #9 expected the resident to have their shoes on the correct feet. When interviewed on10/28/21 at 11:21 AM, the Assistant Director of Nursing (ADON) stated CNAs were to check their assigned resident's Kardex. CNAs were to let the nurse know if they were unable to provide care for a resident. The ADON expected the day shift staff to check and change the residents at least a couple of times during the shift and Resident #38 went too long without receiving care. 10NYCRR 415.12 (a)(1)(4)	F 677		
F 689 SS=D	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview during the recertification and abbreviated surveys (NY00283499) conducted from 10/25/2021 through 10/29/2021, the facility failed to ensure the environment remained as free of accident hazards as possible and that each resident received adequate supervision and assistance devices to prevent accidents for	F 689	1. Resident number 37 was treated for her burn due to hot oatmeal. Facility mixing valves were adjusted to bring domestic hot water into acceptable range. 2. All residents have been identified as potentially being affected by the same practice. Thermometers, alcohol pads, and microwave policy were placed at each microwave within the facility. Water temperatures were taken in various locations and all within acceptable range. 3. The Administrator, Director of Nursing, and Food Service Director developed a microwave reheating policy. The Administrator, Director of Nursing, and Facilities Manager developed a mixing valve adjustment policy. Education was provided to all part and full-time employees on microwave reheating policy. Educational emphasis was placed on ensuring acceptable temperatures for	12/29/2021

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F 689	Continued From page 11 1 of 4 residents (Residents #37), 2 resident bathrooms and 1 shower room reviewed. Specifically, Resident #37 sustained a burn to their left ankle after a staff member spilled a reheated bowl of oatmeal on the resident and the facility did not develop a plan to prevent reoccurrences. Additionally, the hot water from bathroom sinks in South Unit resident room 103 and South Unit resident room 203 was over 120 degrees Fahrenheit (F), and the South Unit 2 shower room had a water temperature over 120 F. Findings include: REHEATING FOOD The undated facility policy "Storage of Resident Food Brought in from Outside of the Facility" documented the facility would provide safe and sanitary storage, handling, and consumption of all food including those brought in for the residents by family and visitors. There was no documentation what the appropriate temperatures were for reheating foods or fluids using the microwave. Resident #37 had diagnoses including fractured right femur and acute kidney failure. The 8/3/21 admission Minimum Data Set (MDS) assessment documented the resident was cognitively intact and required set-up assistance with meals. The 7/27/21 Comprehensive Care Plan (CCP) documented the resident had an activity of daily living (ADL) deficit and required set-up help with meals. The care instructions (Kardex) documented the resident received a regular diet, required set-up assistance at meals, and preferred to have their	F 689	food after reheating and how to properly test the temperature of reheated food items. Education was provided to all part and full-time maintenance staff on domestic water temperature policy. Educational emphasis was placed on ensuring domestic hot water is between 90 and 120 degrees. 4. The facility developed an audit tool to monitor compliance with microwave reheating policy. The Food Service Director or designee will audit 5 meals per week to determine if staff are reheating food per policy. Should a microwave not be used then the Food Service Director will interview an employee on knowledge of the proper procedure to reheat food in a microwave. The Food Service Director or designee will report findings to the Quality Assurance/Process Improvement Committee monthly for three months for evaluation and follow-up, with a compliance goal of 90%. Another audit tool was developed to monitor domestic hot water temperatures. The Facilities Manager or designee will audit 10 locations weekly to monitor domestic hot water temperatures. The Facilities Manager will report findings to the Quality Assurance/Process Improvement Committee monthly for three months for evaluation and follow-up, with a compliance goal of 90%. At the end of the three-month period the committee will evaluate the need for additional monitoring or other corrective actions. Ad Hoc meetings will be convened as needed. 5. Responsibility: Administrator	

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F 689	Continued From page 12 food items kept on the tray. Nursing progress notes on 9/19/21 documented: -at 9:11 AM, a nurse on the unit brought oatmeal they had reheated in the microwave to the resident at 8:45 AM and the nurse accidentally dropped the bowl. Hot oatmeal landed on the resident's foot causing a painful reddened area. Ice was immediately applied, and a registered nurse (RN) assessed the resident and observed no other injuries or blistering. The resident's medical provider and family would be notified. -at 9:12 AM, the RN documented at 8:45 AM, they assessed the resident's skin after a staff member lost their balance and spilled 2 tablespoons of oatmeal on the resident's left foot area. On assessment the resident was awake and oriented, sitting in their wheelchair, and eating breakfast. The left ankle/foot area was intact and had a reddened area approximately 5 centimeters (cm) by 6 cm. No blisters were noted. The resident complained of burning sensation to the area. Staff removed the resident's socks and shoes, wiped the oatmeal off the resident and applied an ice pack to the area. The medical provider and family were notified. -at 9:49 AM, the facility Administrator was notified of the incident. -at 9:59 AM, LPN #14 documented Resident #37 and Resident #37's roommate complained the oatmeal and coffee were cold and requested the items to be heated up. After reheating the items, LPN #14 set down the roommate's coffee and the oatmeal fell out of the LPN's hand spilling on the tray table, the floor, and Resident #37's inner left ankle. Resident #37 reported "it is burning, and some fell on my leg". The oatmeal was wiped away, ice was applied per the resident's request and the nursing supervisor was notified. The RN assessed the resident, the resident has	F 689		

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F 689	Continued From page 13 a round reddened area to left inner ankle the size of a silver dollar with no blistering noted. Medical and family were notified. On 9/19/21 at 10:07 AM, a physician order documented to apply ice as needed, on for 20 minutes and off for 20 minutes for 3 days, apply Bacitracin (antibiotic) ointment as needed up to 3 times a day for 7 days. Nursing progress notes on 9/19/21 documented: -at 4:58 PM by LPN #14 the resident's family member noted blistering to the resident's left inner ankle. Upon inspection there were 2 fluid filled blisters in the middle of a reddened area, both approximately a 1/2 inch in length. The on-call provider was notified of the resident's change. -at 5:07 PM by LPN #14 ice was applied to the left inner ankle for 20 minutes and removed. Bacitracin ointment was applied. -at 11:52 PM, Bacitracin ointment was applied, and the resident offered no further complaints of pain. The CCP was updated on 9/19/19 and documented the resident had a red area on the left ankle foot area from hot oatmeal. Interventions included to apply ice to the left inner ankle for 3 days, on for 20 minutes and off for 20 minutes and apply silver sulfadiazine (SSD) cream to the left ankle and cover with gauze twice daily. There was no documented evidence the CCP was updated to include interventions to prevent further burns. The 9/19/21 facility Investigation Statement documented LPN #14 brought Resident #37 and Resident #37's roommate reheated oatmeal and coffee at 8:30 AM. The resident was sitting in their manual wheelchair with the wheels locked	F 689		

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F 689	Continued From page 14 at bedside with their tray table in front of them. LPN #14 heated the oatmeal for 45 seconds in the microwave, which was the time the LPN stated they would heat the item for their child at home. The LPN accidentally dropped the bowl of oatmeal and approximately 2 tablespoons of oatmeal landed on the resident's left foot and inner ankle. The oatmeal was wiped away and ice was applied. LPN #14 notified the nursing supervisor of the incident. The 9/22/21 Individual Education Record documented LPN Unit Manager #9 provided LPN #14 with informal education or instruction on warming food in the microwave for residents. Microwaved food was to be heated in 15 seconds intervals so the temperature of the item could be monitored. There was no documentation how the staff would monitor the temperature of the food item. On 10/25/21 at 12:03 PM, Resident #37 was observed in their room seated in their wheelchair wearing shoes and socks. There was a dried scab on their left ankle. Resident #37 reported a nurse spilled oatmeal on them, staff tended to the area, and their family was notified right away. The resident stated their oatmeal was cold and they were unsure if staff had to reheat food often. On 10/25/21 at 1:44 PM, the kitchen area of 2 South was observed. There was a microwave in the kitchen and no food thermometers were observed in the kitchen. There was no guidance observed on how long to reheat food or to what temperature. During an interview with CNA #30 on 10/28/21 at 8:44 AM, they reported staff reheated food items in the microwave. They tested the	F 689		

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F 689	Continued From page 15 temperature of the food by feeling it and stirring it up. They reported there were no thermometers available to take food temperatures and they were unsure how to test the food temperatures. During an interview with CNA #31 on 10/28/21 at 8:49 AM, they stated staff sometimes heated food in the microwave. The CNA stated they did not check the temperature of the food prior to serving the residents. There were no thermometers on the unit, and they had never received any education regarding microwave usage at the facility. During an interview with CNA #32 on 10/28/21 at 8:54 AM, they reported when they used the microwave, they heated the food in 30 second intervals. The CNA stated there was a thermometer in the 2 South kitchen and they made sure the food items were 145 degrees Fahrenheit (F) after stirring the food. The CNA opened a drawer in the kitchen area and showed the surveyor a food thermometer and alcohol wipes. During an interview with LPN #33 on 10/28/21 at 9:01 AM, they reported staff were not to heat food items in the microwave as they were unable to control the temperature of the food. The LPN stated they were educated at a previous employer and were unsure if they received any training on microwave usage at this facility. They thought there was a thermometer in the kitchen and stated the kitchen staff knew the proper temperatures food items were to be heated to. During an interview with the LPN #9 on 10/28/21 at 9:06 AM, they stated staff could heat up food in the microwave. They had not received any education on microwave usage at this facility.	F 689		

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F 689	Continued From page 16 There was a thermometer in the kitchen and on the West Wing the microwave had instructions for heating food, but the 2 South Unit did not have instructions. Staff should not heat up food for longer than a minute and the LPN stated they expected staff to take the temperature of the food when it came out of the microwave prior to serving the residents. On 10/28 the following observations were made in the unit kitchen areas; -at 9:14 AM, on 1 South there was a microwave and no food thermometers or guidance on how long to reheat food or proper food temperatures. -at 9:18 AM, on 3 South there was a microwave and no food thermometers or guidance on how long to reheat food or proper food temperatures. -at 9:30 AM, on 2 North there was a microwave and no food thermometers or guidance on how long to reheat food or proper food temperatures. -at 10:04 AM, on the West wing there was a microwave with a document titled "Microwave Settings for Call Down Items for Each Portion" which included the time each item should be heated for. There were no recommendations for temperatures and no food thermometer was observed. During an interview with LPN Unit Manager #9 on 10/28/21 at 10:33 AM, they reported the microwave was not regularly used. Staff had not received training on how to use the microwave. Staff were to reheat food items in small increments to control the temperature of the food items. The LPN Unit Manager stated they were unsure if there was a thermometer available on the unit for taking food temperatures. The LPN Unit Manager stated they tested reheated food temperatures by stirring the food, putting on a glove, and checking the middle of the item with their finger.	F 689		

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F 689	Continued From page 17 During an interview with the Assistant Director of Nursing (ADON) on 10/28/21 at 11:22 AM, they reported they did not recall if nursing staff received education on microwave usage. If staff needed to reheat an item, they were to use clinical judgment. They should look for steam, touch the bowl or plate, and wait for it to cool down. The ADON stated there were some thermometers on the units, but nursing staff did not take food temperatures. During an interview with the Director of Nursing (DON) on 10/28/21 at 1:34 PM, they stated nursing staff was able to heat food items in the microwave, they did not take any food temperatures and was unsure if there were food thermometers in the unit kitchens. They said taking the temperature of food items would help prevent food borne illness and accidents. During an interview with the Food Service Director on 10/29/21 at 10:16 AM, they stated there were thermometers in the unit kitchens. The Food Service Department had not provided any education to nursing staff regarding microwave usage. The Director stated staff should be taking the actual temperature of the food item versus heating it up for a certain timeframe. They were unaware there was a document on the West Wing microwave that indicated reheating times, and this was not to be used and should be discarded, as every microwave was different. WATER TEMPERATURES The undated blank "Water Temperature Readings" documented the following data was to be completed during water temperature	F 689		

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WILLOW POINT REHABILITATION AND NURSING CENTER	3700 OLD VESTAL ROAD VESTAL, NY 13850

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F 689	Continued From page 18 readings: the staff member name completing inspection, the date, location, the temperature reading, the time, and staff initials. During an observation on 10/25/21 at 12:07 PM, the bathroom sink water temperature on the 2nd floor South Unit was measured in room 203. The temperature of the water was 122 degrees F. The resident who resided in the room reported sometimes the water was too hot. During an observation on 10/25/21 at 2:21 PM, the bathroom sink water temperature on the 1st floor South Unit was measured in room 103. The temperature of the water was 121.7 degrees F. On 10/25/21 at 3:05 PM, on the 2nd floor South Unit, the bathroom sink water temperature was remeasured in room 203. The temperature of the water was 122 F. On 10/25/21 during an interview at 3:30 PM, the Maintenance Director stated the South Unit boiler water was maintained at 118 degrees F and the facility did weekly water temperature checks. On 10/25/21 during an observation in the boiler room at 3:43 PM, the South Unit boiler water temperature gauge was reading 122 degrees F. During an interview on 10/25/21 at 3:43 PM, maintenance mechanic #29 stated that the boiler that supplied the water to the South Unit resident's bathroom sinks and shower areas could go up or down 2 degrees F depending on water usage. During an observation on 10/25/21 at 3:45 PM, the West Wing Unit boiler water temperature gauge was reading 122 degrees F.	F 689		

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F 689	Continued From page 19 During an interview at 3:45 PM on 10/25/21, the Maintenance Director stated the West Wing Unit boiler supplied water to the West Wing resident bathroom sinks and shower areas. The water temperatures could be adjusted using a valve and they had tried to keep the water under 120 degrees F. During an observation on 10/25/21 at 3:50 PM, the North Unit boiler temperature gauge read 122 degrees F. The Maintenance Director stated this boiler supplied water to resident bathroom sinks and shower areas. During an observation on 10/25/21 at 3:59 PM, the 2nd floor South Unit shower area/tub water temperature measured at 120.9 degrees F, and then held the temperature at 120.8 degrees F. The temperature of the water was hot to touch, and the surveyor's pointer finger turned dark pink when held under the water. During an interview on 10/25/21 at 4:00 PM, licensed practical nurse (LPN) #22 stated that the residents received baths once or twice a week and basic hygiene was provided to all residents using tap water. If they noticed or were told the water temperature was too hot, they would adjust the water temperature at the tap by adding more cold water. If the temperature could not be adjusted, they would notify the nursing supervisor and maintenance would be called. During an interview on 10/25/21 at 4:03 PM, with certified nursing assistant (CNA) #23 they stated residents received weekly showers and basic hygiene daily. The CNA stated sometimes on the "B" side of the unit a resident would report the water was too hot. If they were unable to adjust the water temperature at the tap, they	F 689		

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F 689	Continued From page 20 would bring the resident to the "A" side of the unit. They would alert the unit's nurse manager or charge nurse and tell maintenance. During an interview on 10/25/21 at 4:11 PM, 1st floor South Unit LPN #24 stated that residents received baths once a week and basic head to toe hygiene daily. They had heard from both staff and residents the water temperatures had fluctuated and would not stay a steady temperature. They thought the water temperature was better during the evening time. The LPN stated they would notify the maintenance department via email if there were water issues. During an interview on 10/25/21 at 4:20 PM, CNA #25 stated they would check bath and shower water temperature and if able have the resident check the water temperature for comfort before giving a bath or shower. They stated they checked the temperature with their hand and the water temperature did not remain steady and would alternate between hot and cold at all times of the day. If the water was too hot, they would remove the resident from the water and wait for the water to cool down before resuming the bath or shower. The CNA stated they thought this was how the water was at the facility and they had never reported the issue. The CNA stated most residents on the unit had complained about the water temperature being too hot. During an observation on 10/25/21 at 4:40 PM, the "Water Temperature Log" binder documented there had been water temperatures over 120 degrees F in March and April 2021. There was no documentation to indicate what the facility had done to adjust the water temperatures. The log did not include the	F 689		

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F 689	Continued From page 21 previous week's temperature log and the facility was unable to locate the missing temperature log. During an interview on 10/25/21 at 4:45 PM, the Maintenance Director stated that the allowable water temperature range in the resident areas was 95-120 degrees F. The "Water Temperature Log" was created with the assistance of the Administrator and was meant to keep track of the water temperature. The facility previously used a spreadsheet with temperature guidelines that would prompt the user to recheck the water temperature after there was a reading greater than 120 degrees F. They were unsure why the facility had stopped using this form. The Director stated water temperatures would fluctuate throughout the day and they were unsure if the facility had a hot water policy. The Director stated staff should notify maintenance via a work order if water was too hot and maintenance would adjust the boiler mixer valve. The Maintenance Director verified there was no documentation that the boiler mixer value had been adjusted after the hot water temperatures were identified in March and April 2021. The Director stated maintenance thermometers used to check the water temperatures on the units had not been calibrated since they were purchased. The Director stated if the mixing valve was adjusted or there were any water temperature readings over 120 degrees F the water temperature should have been retested. They were not aware of any hot water issues at the facility and the facility's resident council had only identified that the water temperature would fluctuate from hot to cold. During an interview on 10/25/21 at 5:21 PM, the Director of Nursing (DON) stated they were had not heard of any recent hot water issues at the	F 689		

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F 689	Continued From page 22 facility. In the past there had some instances of hot water and the maintenance department had to replace some mixing valves to address the issues of fluctuating water temperatures. If the water was too hot in a resident's bathroom sink or in a shower room the resident should be removed from the hot water immediately and maintenance staff and the Maintenance Director would be notified. There were on-call maintenance staff available on evenings, nights, and weekends. During an interview on 10/25/21 at 5:24 PM, CNA #27 stated if the water was too hot, they would adjust the water at the tap using more cold water. The CNA stated the water temperature was hard to adjust because the shower handles had a lot "play" in them. The CNA stated some resident's bathroom sinks (216) would feel too hot. The water temperature would flare up and take 10 minutes before going down to acceptable temperature. The CNA stated if they were unable to adjust the water temperature, they would use a washcloth to finish bathing the resident with water from another source. During an interview on 10/26/21 at 10:15 AM, the Maintenance Director verified the facility had 3 or 4 thermometers and that the thermometers had never been calibrated. The Director stated they could not find last week's completed "Water Temperature Log". During an interview on 10/26/21 at 10:15 AM, maintenance mechanic #29 stated that the usual maintenance worker who was responsible to test water temperatures at the facility was not available. They stated the number of testing locations varied weekly. The maintenance worker stated the maximum temperature the	F 689		

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F 689	Continued From page 23 water could be in resident areas was 120 degrees F. The temperature coming out of bathroom sink or shower should not be above the boiler missing valve temperature. They checked the water temperature usually during peak water usage, 9 AM - 11 AM and sometimes in the afternoon. The thermometers used to test the water temperature on the resident units had a + / - 4 degree F range. They would run the water for 2-3 minutes or until the thermometer temperature stabilized or started going down. 10 NYCRR 415.12(h)(1)(2)	F 689		
F 740 SS=D	483.40 Behavioral Health Services §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview during the recertification survey conducted 10/25/21-10/29/21, the facility failed to provide necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care for	F 740	1. Resident number 202 no longer resides at the facility. 2. All residents have been identified as potentially being affected by the same practice. A full house review of all resident PHQ-9 interviews was conducted. All residents with a PHQ-9 score of 8 or higher were offered behavioral health services if they were able to participate. 3. The Administrator, Director of Nursing, Medical Director, and Director of Social Services will continue to review and revise, as needed, policies and procedures related to behavioral health services. Education was provided to all part and full time staff regarding the need to provide behavioral health services to help residents maintain their highest level of function. Educational emphasis was placed on the need to initiate a referral for behavioral health services when residents are exhibiting signs and symptoms of depression. 4. The facility developed an audit tool to monitor compliance with making referrals for behavioral health services	12/29/2021

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F 740	Continued From page 24 1 of 6 residents (Resident #202) reviewed. Specifically, Resident #202 was withdrawn and seclusive in their room and was refusing food and medications and a referral for behavioral health services was not completed as ordered. Findings include: The undated facility policy "Behavioral Health Services" documented all residents receive the necessary behavioral health care and services to assist him or her to reach and maintain the highest level of mental and psychosocial functioning. Behavioral health care plans shall be reviewed and revised quarterly, annually, and as needed such as when interventions are not effective or when the resident experiences a change in condition. Resident #202 had diagnoses including dementia, anxiety, and depression. The 10/13/21 Minimum Data Set (MDS) assessment documented the resident had severe cognitive impairment and required extensive assistance of one for most activities of daily living (ADLs). The resident scored 8 on the Resident Mood Interview (PHQ-9, an interview that screens for symptoms of depression, 8 is mild depression). The 10/13/21 comprehensive care plan (CCP) documented the following care areas: - Activities, the resident was shy in groups and needed gentle encouragement to participate; interventions were to encourage them to participate in programs for social stimulation, 1:1 visits within room activities such as magazines and coloring, praise when attending activities, inform on benefits of remaining active. - Mood and behavior disorder related to altered mental status and hallucinations (stated they ate glass, nurses made them blind, poor appetite); interventions were to administer medications as	F 740	when necessary. The Director of Social Services or designee will audit 10 residents per month with a PHQ-9 score of 8 or higher. Any resident will a score of 8 or higher will be offered behavioral health services. The Director of Social Services will report audit findings to the Quality Assurance/Process Improvement Committee monthly for three months for evaluation and follow-up with a compliance goal of 90%. At the end of the three-month period the committee will evaluate the need for additional monitoring or other corrective actions. Ad Hoc meetings will be convened as needed. 5. Responsibility: Director of Social Services	

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F 740	Continued From page 25 ordered, behavioral health consult and treat, give the resident as many choices as possible, monitor behaviors every shift, observe need for food, drink, pain medication, provide baby doll or stuffed animal for comfort, psych consult as indicated. The physician orders documented the following: 3/15/18 Behavioral Health consult; 10/12/21 Downgrade Diet to Regular pureed texture, regular consistency; 10/25/21 Physical Therapy evaluation secondary to decline in ability to stand and transfer, 5 times a week for 4 weeks. The 2/3/20 Psychologist #11 progress note documented the resident had low mood, poor sleep, poor concentration, and lack of enjoyment in activities. The resident had sufficient cognitive capacity to benefit from psychotherapy. Services were recommended 1- 4 times per month; the resident had a biologically based mental illness requiring ongoing treatment and continued to experience symptoms of depression which negatively impacted functioning. There were no other documented Behavioral Health progress notes. The 10/1/21-10/11/21 Nursing progress notes documented Resident #202 was weepy, anxious, and not easily redirected. The resident had a poor appetite, refused to eat and consumed drinks with much encouragement. On 10/11/21, Nurse Practitioner (NP) #12 was updated of the resident's decline, difficulty feeding self and transferring. The 10/13/21 social worker assistant #13 progress note documented the resident was seen to complete an MDS assessment. The resident was alert with confusion and stated they	F 740		

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F 740	Continued From page 26 felt bad about themself. When asked how, the resident responded, "I don't know, I just do." They reported having trouble falling asleep which made them tired during the day. The plan was to follow the care plan through next review. There was no documented evidence the resident was referred for behavioral health. The 10/13/21 NP #12 progress note documented they saw Resident #202 for overall decline. The resident was no longer feeding themself, and on exam appeared more withdrawn and flatter than normal. The resident reported feeling sad and depressed every day. After discussion with the Medical Director, the plan was to start mirtazapine (an anti-depressant, also used to stimulate the appetite) 15 mg (milligrams) daily and increase to 30 mg in 2 weeks. The 10/14/21 dietary progress note documented the resident's diet was recently downgraded to pureed, intakes averaged 45%. The resident started on Remeron (mirtazapine) for depression which could also help with appetite stimulation. The resident had unfavorable weight loss related to decreased intakes of pureed diet. The intervention was to add Ensure Plus to meals. The following weights were recorded for the resident: 10/7/21-143.8 pounds (lbs) 10/26/21-136.2 lbs (a 5.2% weight loss). The 10/14/21-10/22/21 nursing progress notes documented the resident continued to remain weepy, anxious, and needed much encouragement to go to the dining room for meals. The resident refused meals and alternatives offered and refused medications. The resident was withdrawn and seemed	F 740		

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F 740	Continued From page 27 depressed. On 10/21/21 NP #12 was updated on the resident's refusals of meals and walking. The mirtazapine was increased to 30 mg and labs were ordered. The 10/22/21 licensed practical nurse (LPN) Unit Manager #3 documented NP #12 reviewed the resident's lab results and an order was made for the resident to receive 2 liters of fluids via clysis (injection) for dehydration. NP #12 reviewed resident status with the Medical Director; felt Resident #202 was having a cycle of psychosis and ordered 1 mg Haldol (an antipsychotic). The 10/23/21-10/27/21 nursing progress notes documented the resident continued to have a poor appetite, wanted to stay in their room, and was afraid. Medications and nutritional intakes were refused. Emotional support was offered with little effect. The resident was not bearing weight with transfers and a referral was sent to physical therapy (PT). The 10/26/21 social work assistant #13 progress note documented the inter-disciplinary team care plan meeting was held. The team discussed how Resident #202 had been struggling to be themself, the care plan was reviewed, and no changes were made. The was no documented evidence the resident had been referred to the psychologist for follow-up of recommended services since 2/3/20. On 10/27/21 at 9:54 AM, Resident #202 was observed in their room and had just returned from the dining room after breakfast. The resident was in a wheelchair wrapped in a blanket. The resident spoke in whispers and did not make eye contact.	F 740		

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F 740	Continued From page 28 On 10/28/21 at 10:15 AM, the resident was in their room seated in their wheelchair. The television was on, the resident was looking down. At 1:22 PM, the resident was in the dining room and was assisted with their meal. The resident did not feed themself and took only small sips of their drink. When interviewed on 10/28/21 at 1:49 PM, certified nurse aide (CNA) #15 stated they were familiar with Resident #202 and noticed a difference in the resident. The resident was normally happy and interacted with the staff but lately was not upbeat. The CNA stated the resident used to like to eat but no longer wanted to. The resident used to sit in the common area after meals or enjoyed coloring but had not been receptive and said no to pretty much everything. CNA #15 stated they had talked about the resident's decline with the previous unit care coordinator. When interviewed on 10/28/21 at 2:15 PM, LPN #16 stated the resident took their medications on this day without a problem but had been refusing them lately. The resident had also been refusing to eat even when offered alternatives and no longer walked to the dining room LPN #16 was unsure if the resident had lost weight and the decline was new for the resident. LPN #16 was aware the resident had a history of mental health concerns such as hallucinations and delusions but was uncertain if the resident had seen a counselor in the past. LPN #16 had discussed the resident with LPN Unit Manger #3 and thought there had been a care conference for the resident that week. When interviewed on 10/28/21 at 2:43 PM, LPN Unit Manager #3 stated they had spoken with NP #12 on 10/27/21 and the plan was to give	F 740		

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F 740	Continued From page 29 the mirtazapine time to become effective and then increase it, and to change the resident to weekly weights. Physical therapy had also started to work with the resident due to trouble ambulating. The LPN was not aware if the resident had seen a counselor in the past. When interviewed on 10/28/21 at 5:15 PM, the Director of Social Work #2 stated the facility had used an agency for behavioral health services. During the pandemic, the agency completed resident sessions by telephone. The behavioral health agency determined if a resident needed to continue participation in their services and if the resident was cognitively able to benefit. The Director of Social Work stated the last behavioral health entry from 2/2020 documented to continue services. The Director had contacted the behavioral health agency and stated they were told the resident had been discontinued from services. The Director stated for the resident to be seen again a referral would be made and the behavioral health service would screen the resident to determine if they would benefit from services again. The resident's history and statements made to social work assistant #13 on 10/13/21 should have triggered a referral. When interviewed on 10/29/21 at 8:33 AM, social work assistant #13 stated they saw the resident on 10/13/21 for a MDS assessment and again at lunch the past week and the resident was not doing well. Social work assistant #13 stated on 10/13/21 they documented in a progress note the resident had stated they felt bad about themself and did not know why. The social work assistant stated when a resident with a history of behavioral health concerns made such statements, they would try to learn the resident's baseline or would discuss the resident	F 740		

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F 740	Continued From page 30 with their supervisor. The social work assistant stated they had not sent a referral for the resident. The social work assistant stated there was a care plan meeting on 10/26/21 and the resident was discussed from more of a nursing and medical focus. Social work assistant #13 stated when they had discussed the resident with NP #12 it was about advanced directives. When interviewed on 10/29/21 at 9:31 AM, NP #12 stated the resident had a significant mental health history. NP #12 had discussed the resident's care with the Medical Director. The resident's medications had been reviewed; the resident had been stable on their current medication regimen. Mirtazapine was added but took time to become effective. Dietary had added supplements for the resident, labs had been drawn and clysis had been administered when the resident started to look dry. The NP stated the resident also received a little dose of Haldol to possibly break the psychosis. NP #12 was not aware the resident had seen behavioral health services in the past but stated it would be worth a screen. NP #12 stated the last time they saw the resident, the resident was withdrawn and had stated their food was poisoned. Based on that, NP #12 determined the resident's food issues and dehydration were a result of depression. NP #12 stated it could not be known but it was possible if Resident #202 had been seen earlier by behavioral health the depression may not have progressed as far. 10 NYCRR 415.12(f)(1)	F 740		
F 761 SS=D	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently	F 761	1. Identified expired medications were discarded. 2. All residents have been identified as potentially being affected by the same practice. A full house review of all medications was conducted and all expired	12/29/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335291	A. BUILDING _____ B. WING _____	10/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW POINT REHABILITATION AND NURSING CENTER	3700 OLD VESTAL ROAD VESTAL, NY 13850

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F 761	Continued From page 31 accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview during the recertification survey conducted 10/25/21-10/29/21, the facility failed to label drugs and biologicals in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable for 1 of 4 nursing unit medication rooms and 1 of 5 medication carts (South 2B unit medication room and medication cart) reviewed. Specifically, the facility did not dispose of expired medications and biologicals in the medication room and medication cart on South 2B unit.	F 761	medications were discarded. 3. The Administrator, Director of Nursing, and Medical Director reviewed and revised the Medication Storage policy to include procedures for checking for expired medications. Education was provided to all part and full-time nursing staff regarding the Medication Storage policy. Educational emphasis was placed on the frequency to check medications for expiration and to discard if expired. 4. The facility developed an audit tool to monitor compliance with facility Medication Storage policy. The Director of Nursing or designee will audit each medication room and medication cart monthly for expired medications. The Director of Nursing or designee will report audit findings to the Quality Assurance/Process Improvement Committee monthly for three months for evaluation and follow-up with a compliance goal of 90%. At the end of the three-month period the committee will evaluate the need for additional monitoring or other corrective actions. Ad Hoc meetings will be convened as needed. 5. Responsibility: Director of Nursing	

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F 761	Continued From page 32 The facility policy "Medication Storage" revised 2/6/19 documented all medications were to be stored according to pharmacy instructions and manufacturer recommendations. The policy did not document protocol for monitoring for expired medications or biologicals. On 10/27/21 at 9:26 AM during a medication cart storage observation on South 2B unit with licensed practical nurse (LPN) #8, there was a stock bottle of Calcium 600 milligrams (mg) with Vitamin D3 400 units that had a manufacturer expiration date of 3/21 and an opened bottle of docusate sodium (Colace- stool softener) 100 mg with a manufacturer's expiration date of 9/21. On 10/27/21 at 9:26 AM during a medication room storage observation on South 2B unit with LPN #8, the following was observed: - 1 open bottle of Thera Vitamins with a manufacturer expiration date of 9/21; - 1 unopened bottle of Colace 100 mg with a manufacturer expiration date of 9/21: - 1 unopened bottle of Gerimucil (stool softener) with a manufacturer expiration date of 8/21; and - 1 opened vial of Afluria (flu vaccine) in the medication refrigerator with no documented opened date on the vial or box. When interviewed on 10/27/21 at 9:26 AM, LPN #8 stated they were unaware of any resident that received the expired medications. The LPN stated the 11-7 shift was expected to check for expired medications in the medication carts, rooms, and refrigerators. The LPN was not sure of the frequency of the checks. The expired medications should have been discarded. The vial of flu vaccine was considered expired as there was no way to determine how long the vial had been opened and it was only good for 30	F 761		

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F 761	Continued From page 33 days once opened. When interviewed on 10/27/21 at 9:50 AM, LPN Manager #9 stated the 11-7 nurse was responsible for checking stock medication expiration dates. The unit currently did not have a full-time night nurse and was using agency. The LPN stated the day shift was responsible for checking for expired medications at that time and the checks were to be done monthly. The LPN stated the medication cart, room and refrigerator checks were audited randomly last on 10/22/21 by the unit manager. The LPN stated the nurse opening any vial or medication was expected to hand write the opened date on the bottle or vial. Any expired medications should have been discarded and each nurse should check expiration dates prior to administering medications to a resident. 10NYCRR 415.18(d)(e)(2-4)	F 761		
F 812 SS=D	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812	1. Kitchen ice machine was repaired and all standing water was cleaned up along with any debris. Ceiling tiles were wiped clean/replaced as needed, and all undated/unlabeled food items were discarded. 2. All residents have been identified as potentially being affected by the same practice. The main kitchen was inspected for any other standing water, stained ceiling tiles, and unlabeled food items. 3. The Administrator and Food Service Director will continue to review and revise, as needed, policies and procedures related to kitchen food labeling, cleaning policy for floors and ceilings, and kitchen ice machine was placed on a preventative maintenance schedule. Education was provided to all part and full time dietary staff regarding kitchen	12/29/2021

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F 812	Continued From page 34 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review during the recertification survey conducted from 10/25/21-10/28/21, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 main kitchen reviewed. Specifically, the main kitchen had an unclean/unsanitary empty storage room floor, multiple dirty/stained ceiling tiles and multiple unlabeled and outdated food items. Findings included: The facility policy "Food Safety Product Labeling and Dating Guideline" revised 1/29/21, documented ready to eat food, time/ temperature control (TCS) food prepared and held longer than the subsequent meal period must be marked to indicate the date or day which food should be consumed or discarded by. The facility Food Service Worker job description dated 3/2016, documented the general responsibilities included assisting with the preparation of hot and or cold foods, properly storing food, utilizing knowledge of temperature requirements and spoilage, and complying with all Hazard Analysis Critical Control Point (HACCP) policies and procedures. UNCLEAN/UNSANITARY KITCHEN ENVIRONMENT During an observation with the Food Service	F 812	sanitation and proper labeling of food items. Educational emphasis was placed on ensuring there is no standing water present in the kitchen, that ceiling tiles remain in a sanitary condition, and food is properly labeled and stored. 4. The facility developed an audit tool to monitor compliance with food procurement, storage, preparation, and kitchen sanitation. The Food Service Director or designee will audit the kitchen 5 times per month to monitor compliance for proper food sanitation/storage. The Food Service Director or designee will report audit findings to the Quality Assurance/Process Improvement Committee monthly for three months for evaluation and follow-up with a compliance goal of 90%. At the end of the three-month period the committee will evaluate the need for additional monitoring or other corrective actions. Ad Hoc Meetings will be convened as needed. 5. Responsibility: Food Service Director	

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F 812	Continued From page 35 Director on 10/26/21 at 12:35 PM, an empty storage room floor had 2-3 inches of standing brown/unclean water. Worms were observed crawling on the floor. There was a dirt buildup with more worms behind the bottom wall cove base of one of the empty storage room walls. Unclean light brown water was flowing into the room from behind the ice machine. The natural flow of water on the floor inside the main kitchen flowed along the wall of the three-bay sink, then behind the ice machine, and then directly into the empty storage room. During an interview on 10/26/21 at 12:42 PM, the Food Service Director stated the empty storage room had not been used since they had been hired 3 years ago. The Food Service Director was not aware of the current condition of this room. They stated it had been at least 6 months since they had been in the room since it had not been in use for a long period of time. The Food Service Director stated that this room was part of the kitchen and it was negligent on part of kitchen staff not to clean the room. The Food Service Director stated that when the ice machine leaked, water would flow along wall into the unused storage room. They could not recall the last time the ice machine had leaked or been repaired and could not provide any work orders. During an observation on 10/27/21 at 12:45 PM, there were multiple soiled/stained ceiling tiles throughout the main kitchen. During an interview on 10/27/21 at 12:45 PM, the Food Service Director stated that there were stained ceiling tiles in the main kitchen, and they were aware of some of the stained ceiling tiles. They stated that the kitchen did have cleanable ceiling tiles. The Food Service Director could not provide documentation on the last time the	F 812		

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F 812	Continued From page 36 ceiling tiles were cleaned. The Food Service Director stated that it was the responsibility of the housekeepers to clean the ceiling tiles in the main kitchen, after hours. During an interview on 10/27/21 at 12:55 PM, the Food Service Director stated that the unused storage room in the kitchen had approximately 2 inches of water on the floor that morning when the morning kitchen staff came it. They stated all the water in the unused storage room had been vacuumed out the night before. During an interview on 10/27/21 at 4:47 PM, the Food Service Director stated cleaning behind ice machines should be done twice a day and had not been completed recently. The Food Service Director stated that there was no facility policy for cleaning the floors/ceilings in the main kitchen. OUTDATED/UNDATED FOOD During an observation on 10/25/21 at 10:40 AM, with the Food Service Director present, the cook's cooler contained 3 dishes of uncovered oatmeal, 5 uncovered pans of chicken ala king, unlabeled mixed vegetables, and unlabeled broccoli. During an interview on 10/25/21 at 10:40 AM, the Food Service Director stated that the chicken ala king was placed in the cook's cooler less than ten minutes ago to cool. On 10/25/21 at 10:51 AM, with the Food Service Director and food service worker #18 present, the following was observed in the dinner cooler: - 1 can of pumpkin with a metal lid and an opened date of 10/13; - 14 undated servings of puree coconut cream	F 812		

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F 812	Continued From page 37 pies; - 1 cup of undated salad with egg and cheese; - 2 cups of undated mixed fruit; - 1 cup of undated puree cottage cheese; and - 2 cups of undated puree fruit. On 10/25/21 at 10:51 AM, with the Food Service Director and food service worker #18 present, the following was observed in the breakfast cooler: - 21 cups of undated stewed prunes; - 7 cups of undated diet banana pudding; - a 5 pound bag of brown shredded lettuce; and - 1 cup of undated diced peaches. During an interview on 10/25/21 at 10:51 AM, food service worker #18 stated that the 1 cup of puree cottage cheese was placed in the dinner cooler on 10/19/21, the 2 cups of puree fruit were placed in the dinner cooler on 10/21/21, the 21 cups of stewed prunes were placed in the breakfast cooler on 10/19/21, the 7 cups of diet banana pudding were placed in the breakfast cooler on 10/21/21, and the 1 cup of diced peaches was placed in the breakfast cooler on 10/19/21. On 10/25/21 at 11:01 AM, with the Food Service Director and food service worker #18 present, the following was observed in the special cooler: - 9 cups of undated diced peaches; - 5 cups of undated cut watermelon; -17 cups of undated banana pudding; and - 2 cups of undated chef salad with egg and cheese. During an interview on 10/25/21 at 11:01 AM, food service worker #18 stated that the 9 cups of diced peaches were placed in the special cooler on 10/21/21, the 5 cups of cut watermelon were placed in the special cooler on 10/21/21, the 17	F 812		

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F 812	Continued From page 38 cups of banana pudding were placed in the special cooler on 10/21/21, and the 2 cups of chef salads with egg and cheese were placed in the special cooler on 10/22/21. During an interview on 10/27/21 at 12:55 PM, the Food Service Director stated after the breakfast service the warm oatmeal that was not used was placed into the walk-in cooler. It was placed in the cooler uncovered to assist with the cooling process. The oatmeal would be covered once it was fully cooled. It was policy to keep warm objects in coolers uncovered to speed up the cooling period. These food items would be covered after 3 or 4 hours. The Food Service Director stated everything that goes into the cooler should be properly labeled. During an interview on 10/27/21 at 4:47 PM, the Food Service Director stated the cooks, cold prep staff, and production manager would check to ensure food was labeled. The Food Service Director stated the facility had a policy to discard food 3 days after the prepared by date. They stated that all staff entering the walk-in coolers, walk-in freezers, and refrigerators should have been checking the labeled dates. The Food Service Director stated that due to the fact they did not have any blast chillers, prepared hot foods were currently kept uncovered in the walk-in coolers to ensure that warm foods are cooled within the 2 hour and 4 hour windows for proper cooling temperatures. During an interview on 10/27/21 at 4:52 PM, cook #19 stated that every time they made food it would be labeled before being placed in the walk-in cooler. The cook stated that food was discarded after 3 days of the preparation date, and that all staff entering the walk-in coolers, freezers, and refrigerators should be checking	F 812		

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F 812	Continued From page 39 the labeled dates. During an interview on 10/29/21 at 8:21 AM, food service worker #18 stated that food was supposed to be dated either on the tray or on the item before being placed in the cooler and could be kept for 3 days. Food service worker #18 stated they looked at the posted menu for a date if they did not know when the food was made. They stated the kitchen staff would try to make food items a day ahead and would discard food if older than 3 days. Food service worker #18 stated that they had not received any food service training at this facility. They stated that the staff person whose role they took over had discussed the policies regarding food storage and labeling. During an interview on 10/29/21 at 8:27 AM, Food Service Operations Manager stated that they oversaw all operations of kitchen. They stated It was their expectation that kitchen staff ensured that food was dated and on a 3 day rotation. If a food was not labeled or dated, it should be immediately discarded. 10NYCRR 415.14(h)	F 812		

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	335291	A. BUILDING 01 - WILLOW POINT B. WING _____	10/28/2021

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K 291 SS=E	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This STANDARD is not met as evidenced by: Based on observation and interview during the Life Safety Code recertification survey conducted 10/25/21-10/28/21, the facility failed to ensure that emergency lighting was not tested and maintained for three of three battery operated lights (north unit generator room, west unit generator room and south unit generator room) as required by code. Specifically, the annual 90 minute run test was not completed for the battery-operated emergency lights in the north unit generator room, the west unit generator room and the south unit generator room. Findings include: During review of the facility's Emergency Light Check Sheets for 2020 there was no documentation of an annual 90 minute run test being completed for 2020. During a tour of the facility on 10/28/11 at 10:45 AM, the following was observed: - there were no battery back-up lighting in the north unit generator room; - there were no battery back-up lighting in the west unit generation room; and - there were no battery back-up lighting in the south unit generator room. During an interview on 10/28/21 at 10:45 AM, the Maintenance Director stated that an annual	K 291	1. A 90-minute run test was completed for the three identified battery-operated emergency lights. 2. All residents have been identified as potentially being affected by the same practice. A full house review was conducted to identify all battery-operated emergency lights and were tested. 3. The Administrator and Facilities Manager developed a policy regarding emergency lights. Education was provided to all part and full-time maintenance employees on new policy and procedure for emergency lights. Educational emphasis was placed on the need to conduct a 90-minute run test annually. 4. The facility added a 90-minute run test for all battery-operated emergency lights into the preventative maintenance system to ensure compliance. The Facilities Manager or designee will ensure a 90-minute run test is completed for all battery-operated emergency lights and the area of concern was added to the facilities Quality Assurance/Process Improvement Committee annual agenda with a compliance goal of 90%. Ad Hoc Meetings will be convened as needed. 5. Responsibility: Facilities Manager	12/27/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Electronically Signed	11/30/2021

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K 291	Continued From page 1 90 minute run test was not completed for 2020 and was not aware of this requirement. They stated that the monthly 30 second run test had been completed for 2020 and 2021. 2012 NFPA 101: 19.2.9.1, 7.9 10NYCRR 415.29(a)(1&2), 711.2(a)(1)	K 291		
K 321 SS=D	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)	K 321	1. Third floor south unit dining room storage room door was replaced with a ¾ hour fire resistant door and a self-closing device. All items located in the north lower-level dining room were removed. 2. All residents have been identified as potentially being affected by the same practice. A full house review was conducted of the facility. Hazardous rooms over 100 square feet were identified and checked to ensure a ¾ hour fire resistant door was present with a self-closing device. 3. The Administrator and Facilities Manager developed a policy and procedure regarding hazardous rooms. Education was provided to all part and full-time maintenance employs on new policy and procedure for hazardous rooms. Educational emphasis was placed on the need for rooms to have a ¾ hour resistant fire door and self-closing device. 4. The facility developed an audit tool to monitor compliance with facility policies and procedures related to hazardous rooms. The Facilities Manager or designee will audit 10 rooms per month to ensure room over 100 square feet are not storing combustible items and if they are that a ¾ hour resistant fire door with a self-closing device is present. The Facilities Manager will report finding to the Quality Assurance/Process Improvement Committee monthly for three months for	12/27/2021

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K 321	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation and interview during the Life Safety Code recertification survey conducted 10/25/21-10/28/21, the facility failed to ensure the 3/4 hour fire resistance rating of 2 isolated hazardous area doors were maintained (third floor south unit dining room storage room, lower level north unit storage room). Specifically, the fire-rated doors for the third floor, south unit dining room storage room and the lower level, north unit storage room were not 3/4 hour fire rated, or self closing. Findings include: During an observation on 10/25/21 at 11:45 AM, the door for the third floor south unit dining room storage room was not 3/4 hour fire rated and it lacked a self closure device. This room was approximately 140 square feet. There were 3 fake christmas trees, a wooden bowling alley, and boxes of miscellaneous boxes stored in this room. During an observation on 10/26/21 at 11:45 AM, the double doors for the lower level north unit storage room were not not 3/4 hour fire rated and both lacked self closure devices. Also, the kitchenette has an opening into this room and the door to that room was not fire rated and it lacked a self closure device. This room was originally a dining room and was approximately 2200 square feet. There were 12 pallets of PPE supplies, 15 wheel chairs, and 15 broda chairs being stored in this room. During an interview on 10/28/21 at 10:52 AM, the Maintenance Director stated that hazardous rooms over 100 square feet were required to have fire rated doors and the doors were required to be self-closing. They stated were	K 321	evaluation and follow-up, with a compliance goal of 90%. At the end of the three-month period the committee will evaluate the need for additional monitoring or other corrective actions. 5. Responsibility: Facilities Manager	

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K 321	Continued From page 3 they not aware of the amount of storage found in the third floor south unit dining room storage room. The Maintenance Director stated that the pallets of PPE supplies had been temporarily stored in the lower level north unit storage room for a couple of months, and had not thought about the storage requirements when the pallets were placed in this room. 2012 NFPA 101 19.3.2.1 10NYCRR 415.29(a)(2), 711.2(a)(1)	K 321		
K 918 SS=E	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and	K 918	1. The three identified emergency generators had a remote manual stop station installed outside of the generator housing. 2. All residents have been identified as potentially being affected by the same practice. A full house review was conducted of the facility and no other generators were identified. 3. Education was provided to all part and full-time maintenance employees on the location and purpose of the remote manual stop station outside each generator room. 4. The facility added a new ticket in the preventative maintenance system to inspect the remote manual stop stations for damage. The Facilities Manager or designee will report completed preventative maintenance outcomes to the Quality Assurance/Process Improvement Committee monthly for three-months for evaluation and follow-up. At the end of the three-month period the committee will evaluate the need for additional monitoring or other corrective actions. Ad Hoc meetings will be convened as needed. 5. Responsibility: Facilities Manager.	12/27/2021

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K 918	Continued From page 4 circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is not met as evidenced by: Based on observation and interview during the Life Safety Code recertification survey conducted 10/25/21-10/28/21, the facility failed to ensure that 3 of 3 emergency generators (north unit generator, west unit generator, and south unit generator) were properly maintained. Specifically, there were no remote manual stop station installed outside of the weatherproof housing of the outside generator. Findings include: During an interview on 10/28/21 at 11:30 AM, the Maintenance Director stated that they were not aware of the code requirement to have a remote manual stop station for each facility generator. They stated that the only stop buttons for the generators were located on the generators themselves. During a tour of the facility on 10/28/21 at 5:05 PM, the following was observed: - the north unit generator room did not have a remote manual stop station installed outside of that room; - the west unit generation room did not have a remote manual stop station installed outside of that room; and - the south unit generator room did not have a remote manual stop station installed outside of that room.	K 918		

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K 918	Continued From page 5 2010 NFPA 110: 5.6.5.6 10NYCRR 415.29(a)(2), 711.2(a)(1)	K 918		
K 921 SS=D	NFPA 101 Electrical Equipment - Testing and Maintenanc Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This STANDARD is not met as evidenced by: Based on observation, record review, and	K 921	1. The seven identified items were either discarded or inspected by maintenance and documented. 2. All residents have been identified as potentially being affected by the same practice. A full house review was conducted to identify all PCREE and non-PCREE items for inspection per NFPA 99. 3. The Administrator and Facilities Manager will continue to review and revise, as needed, policies and procedures related to PCREE and non-PCREE. Education was provided to all part and full time employees regarding the facility Preventative Maintenance policy. Educational emphasis was placed on ensuring all electrical equipment is inspected by the maintenance department and tagged for documentation. 4. The facility developed an audit tool to monitor compliance with facility policies and procedures related to PCREE and non-PCREE. The Facilities Manager or designee will audit 5 resident rooms per week for three months for electrical items with appropriate documentation for inspection and preventative maintenance. The Facilities Manager or designee will report findings to the Quality Assurance/Process Improvement Committee monthly for three months for evaluation and follow-up, with a compliance goal of 90%. At the end of the three-month period the committee will evaluate the need for additional monitoring or other corrective actions. Ad Hoc meetings will be convened as needed. 5. Responsibility: Facilities Manager	12/27/2021

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K 921	Continued From page 6 interview during the Life Safety Code recertification survey conducted 10/25/21-10/28/21, the facility failed to ensure patient care related electrical equipment (PCREE) was maintained in accordance with National Fire Protection Agency (NFPA) 99 for 7 PCREE items observed (electric recliner, music player, 3 blow dryers, 1 hair straightener, and 1 hair curler); and for 2 resident owned equipment (non-PCREE) items observed (electric piano, and electric recliner). Specifically, there was no documented maintenance found for the above mentioned PCREE and non-PCREE items, and staff were not following the facility policy pertaining to electrical equipment. Finding include: 1. Patient Care Related Electrical Equipment (PCREE) A. Electric Recliner, Music Player, Blow Dryers, Hair Straightener, Hair Curler During an observation on 10/25/21 at 11:110 AM, with the Maintenance Director present, there was an untagged electric recliner in the third floor south unit sun room. During an observation on 10/25/21 at 11:33 AM, there was an untagged music player in the third floor south unit dining room. During an observation on 10/25/21 at 12:00 PM, there were two untagged blow dryers in the third floor south unit B-side clean utility room. During an observation on 10/25/21 at 12:15 PM, there was an untagged blow dryer and an untagged hair straightener in the second floor south unit B-side clean utility room.	K 921		

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K 921	Continued From page 7 During an observation on 10/25/21 at 12:45 PM, there was an untagged hair curler in the first floor south unit A-side clean utility room. The facility's undated Preventative Maintenance policy stated "Preventative maintenance schedules are established and assigned per the needs of the equipment including daily, weekly, quarterly or semi-annually. The Plant Services Director is responsible to enter any new equipment into the software". The untagged items found during survey were not in the facility's maintenance system and were not assigned an electrical inspection frequency. During an interview on 10/28/21 at 3:15 PM, the Maintenance Director stated that all items purchased for the facility were electrically inspected prior to being used within the facility. They stated they were not sure if the untagged electrical recliner, the music player, the untagged blow dryers, the untagged hair straightener, and the untagged hair curler were originally resident owned equipment and had become facility owned equipment when a resident had left the facility. The Maintenance Director could not verify if any of the listed equipment was facility owned, and stated that regardless if this was PCREE or non-PCREE equipment they should have had inspection tags on them. The Maintenance Director could not provide any electrical inspection documentation for the above mentioned equipment. 2. Non-Patient Care Related Electrical Equipment (non-PCREE) During an observation on 10/25/21 at 11:20 AM, there was an untagged small electric piano in resident room 301. During an observation on 10/25/21 at 12:25 PM,	K 921		

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K 921	Continued From page 8 there was an untagged electric recliner in resident room 219. The facility's undated Resident Equipment Inspection Policy stated "It is the responsibility of all staff to ensure that equipment has been checked by maintenance staff before it is put into service. Also to notify staff or department head of any un-inspected equipment that was put into service without proper permission". This policy did not include a minimum frequency for the electrical inspections of non-PCREE equipment. The untagged resident owned items found during survey were not identified within the resident records as being owned by the resident. During an interview on 10/28/21 at 3:16 PM, the Maintenance Director verified that the Resident Equipment Inspection Policy did not include the electrical inspection frequency for non-PCREE equipment, and stated that the facility admissions staff and social workers were responsible for documenting the inventory of equipment for each resident. The Maintenance Director stated the maintenance staff would initially check the electrical safety of resident owned equipment (non-PCREE), but they did not think that maintenance staff were electrically inspecting non-PCREE equipment after the initial check was made. The Maintenance Director could not find any documentation for the electrical inspections of the small electric piano in resident room 301, or the electric recliner in resident room 219. The Maintenance Director could not determine how long the identified resident owned equipment had been in the resident rooms. During an interview on 10/28/21 at 3:25 PM, Social Work Director stated that the electric	K 921		

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K 921	Continued From page 9 recliner was delivered to the facility by the husband of the resident in room 219 in 2020, and they found this information by checking the progress notes of the resident. A progress note dated 5/13/2020, for the resident in room 219, stated that the resident's husband was updating the facility on the delivery of a chair. This note does not include that this chair was an electric recliner. 2012 NFPA 99: 10.5.3 10NYCRR 415.29(a)(1&2), 711.2(a)(1)	K 921		