STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335142	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Park Rehab & Skilled Nursing	150 Prather Avenue Jamestown, NY 14701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations, interviews, and record review conducted during survey, the facility failed to ensure that the residents' environment remained as free of accidents as possible, and that each resident receives adequate supervision and assistance devices to prevent accidents for one (1) (Resident #21) of four (4) residents reviewed for accidents. Specifically, on 03/11/2026, the facility failed to assist Resident #21 when they were reheating liquid in the microwave oven, resulting in Resident #21 sustaining an 8.5 centimeter by 5-centimeter second degree burn (damage to both the outer (epidermis) and underlying (dermis) layers of skin, causing blisters, pain, and a shiny moist appearance) to their left upper hand. Additionally, the facility failed to develop the care plan to include Resident #21's history of burning self after heating items in the microwave oven. This resulted in actual harm to Resident #21 that was not immediate jeopardy.The findings include: The facility policy titled Food Safety Requirements, with a review date of 04/12/2024 documented education on safe food handling will be provided to all staff, family, residents, resident council, visitors and community groups who may provide foods or fluids to residents of the facility. Leftovers will be reheated to 165 degrees Fahrenheit. The facility was unable to provide a policy or protocol for safe microwave oven operation. The facility policy titled Formation of the Resident Care Plan, with a revised date of 05/23/2018 documented the objective is to maintain an individualized resident-centered plan of care. Resident #21 had diagnoses including Parkinson's disease (tremors and rigidity of movement), hypertension (high blood pressure), and epilepsy (seizure disorder). The Minimum Data Set (a resident assessment tool) dated 02/11/2026 documented the resident was cognitively intact and was independent with activities of daily living (eating dressing, toileting, grooming). The current Comprehensive Care Plan dated 02/11/2026 did not document Resident #21's history of burning self after using the microwave nor inventions related to the use of the microwave oven. During intermittent observations between 04/26/2026 to 04/29/2026, between 7:30 AM and 2:30 PM, there was a microwave oven located on a counter in the First Floor Dining Room. During an observation on 04/26/2026 at 12:49 PM, Resident #21 was observed with a reddened area, approximately 7.0 centimeters by 4.5 centimeters, on their upper left hand. The Resident Incident Form dated 12/02/2025 documented Resident #21 had a fluid filled sac (blister) on the top of the left ring finger from hot water. The resident was heating boil in the bag rice in a bowl in the microwave. The incident form documented Resident #21 had a history of burning self while using the microwave. The resident was educated to ask for staff assistance with kitchen tasks. The Resident Incident Form dated 03/11/2026 documented Resident #21 had an 8.5 centimeter by 5-centimeter blistered area on the top of their left hand. Resident #21 stated they were taking soup out of the microwave when the soup splashed onto their hand. The resident was educated to ask for assistance with hot food from the microwave. The incident report documented that the physician and the family were notified. Review of the Treatment Administration Record dated 03/2026 documented an order dated 03/12/2026 to cleanse the resident's left anterior (top) hand with normal saline, apply Neosporin ointment (over the counter antibiotic) and cover with a nonstick dressing once daily. This treatment was discontinued on 03/14/2026. On 03/14/2026 a new order was obtained to cleanse the resident's left anterior hand (continued on next page)

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

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	with normal saline apply Silvadene (prescription cream used to prevent and treat infections in second- and third-degree burns) topical cream daily for a left-hand burn and cover with a dry dressing. This treatment continued until 04/16/2026. During an interview on 04/29/2026 at 9:15 AM, Resident #21 stated they were taking soup out of the microwave oven when the handle slipped and the hot liquid sloshed on to the top of their left hand. The resident stated the facility had educated them to request for staff assistance when using the microwave oven, but there's only one problem with that, there is no staff to assist so they usually use the microwave by themselves. During an interview on 04/29/2026 at 9:36 AM, Certified Nurse Aide #5 stated Resident #21 used the microwave oven daily, and they have never heard the resident ask for help. During an interview on 04/29/2026 at 9:49 AM, Licensed Practical Nurse #2 stated Resident #21 uses the microwave all the time, and once in a blue moon will ask for staff assistance. During an interview on 04/29/2026 at 9:55 AM, the Director of Nursing stated they would consider the 03/11/2026 incident an avoidable accident that caused Resident #21 harm. During an interview on 04/29/2026, the Acting Administrator stated the facility did not have a policy on safe microwave operation, and apparently Resident #21 had been using the microwave without staff assistance all along and they would consider the burn an avoidable accident that caused Resident #21 harm. During a telephone interview on 04/29/2026 at 2:10 PM, the Medical Director stated Resident #21 had two burns within three months and would want the resident to ask the staff for assistance when using the microwave oven. They stated it was not an appropriate placement to have the microwave oven in the dining room where any resident had access to the microwave oven. Additionally, they stated Resident #21 did not experience permanent harm related to the second degree burn but did experience temporary harm from the blister and associated pain. 10 New York Code Rules Regulations (NYCRR) 415.12(h)(2)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review conducted during survey, the facility failed to ensure sufficient nursing staff to attain and maintain the highest practicable physical, mental, and psychosocial well-being of each resident for three (First floor, Second floor, Third floor) resident care units. Specifically, the facility did not ensure they met their minimum staffing numbers for each shift and there was a lack of sufficient nursing staff to provide timely care to meet the needs of the residents. This involves Resident's #4, #8, #9, #20, #21, #27, #30, #42, #43, #50, #51 #55, #63, #92, #96, #104, #106 and #119. The findings include: Refer to F 677 Activities of Daily Living Care for Dependent Residents, Scope and Severity = D Refer to F 684 Quality of Care, Scope and Severity = D Refer to F 689 Free of Accident Hazards, Scope and Severity = G The facility policy and procedure titled Emergency Staffing with a review date of October 2025 documented when the facility was at a crisis level impeding resident care, the supervisor will notify the Administrator and Director of Nursing regarding emergency needs. All staff on duty would be asked to remain on duty until emergency staffing is resolved. The supervisor or designee would contact off duty nursing personnel to enlist their services. The Administrator or designee would arrange for a loan of nursing personnel from other Heritage facilities, as well as any contracted staffing agency. The Facility assessment dated [DATE] documented the assessment was required to identify and analyze the facility's resident population and identify the personnel, physical plant, environmental and emergency response resources needed to competently care for the residents during the day-to-day operations and emergencies, including nights and weekends. The facility was licensed for 146 beds with an average daily census of 134. The facility will ensure that there was sufficient and competent staff to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility will make decisions on required staffing based on resident census, resident acuity/needs, facility odors, complaints, call lights, and staff's ability to complete assignments. The Facility Assessment documented the following total number or range of nursing staff needed: - Licensed nurses providing direct care 2.5 to 8 - Nurse Aides 4.5 to 17 Review of the Payroll Based Journal Staffing Data Report Fiscal Year Quarter 1 (October 1 -December 31) 2026 revealed the facility had a one-star rating for staffing and triggered for low staffing levels on weekends. The facility resident census at the time of survey entrance on 04/26/2026 was 115. 1.During an interview on 04/29/2026 at 11:03 AM, the Acting Administrator stated the bare minimum staffing needed to provide care to the residents based on the daily average census of 114 was as follows: Licensed Nurses: Day Shift: 7:00 AM - 3:00 PM - one (1) for each unit Evening shift: 3:00 PM -11:00 PM total of three (3) Night shift: 11:00 PM - 7:00 AM total of three (3) Certified Nurse Aides: Day shift: two (2) for each unit Evening shift: total of (eight). Night shift: total of (eight). Further interview on 04/30/2026 at 1:20 PM, the Administrator clarified the minimum number of certified nurse aides on the night shift would be one per unit total of three (3). Review of the facility's nursing daily staffing sheets dated 03/25/2026 - 04/25/2026 revealed the facility did not meet their stated minimum staffing numbers of certified nurse aides on the following dates: -03/25/2026 3:00 PM - 11:00 PM shift - 5 (down 1) -03/27/2026 3:00 PM - 11:00 PM shift - 4 (down 2) -03/28/2026 3:00 PM - 11:00 PM shift - 4 (down 2)-03/29/2026 3:00 PM - 11:00 PM shift - 5 (down 1)-03/30/2026 3:00 PM - 11:00 PM shift - 5 (down 1) -03/31/2026 3:00 PM - 11:00 PM shift - 5 (down 1)-04/02/2026 11:00 PM - 7:00 AM shift - 2 (down 0.5 after 3 AM)-04/06/2026 3:00 PM - 11:00 PM shift - 4.5 (down 1.5)-04/07/2026 3:00 PM - 11:00 PM shift - 5 (down 1)-04/09/2026 11:00 PM - 7:00 AM shift - 2.5 (down 0.5)-04/11/2026 3:00 PM - 11:00 PM shift - 5 (down 1)-04/16/2026 3:00 PM - 11:00 PM shift - 4 (down 2)-04/22/2026 3:00 PM - 11:00PM shift - 4 (down 2)-04/24/2026 3:00 PM - 11:00PM shift - 3.5 (down 2.5) The facility census (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	for these dates was between 113 and 116 residents. Review of the facility's nursing daily staffing sheets dated 03/25/2026 - 04/25/2026 revealed the facility did not meet their stated minimum staffing numbers for the night shift of one nurse per unit on the following dates: -03/26/2026 11:00 PM - 7:00 AM shift - 2 (down 1)-03/31/2026 11:00 PM - 7:00 AM shift - 2.5 (down 0.5 after 3 AM) -04/01/2026 11:00 PM - 7:00 AM shift - 2 (down 1)-04/04/2026 11:00 PM - 7:00 AM shift - 2 (down 1) -04/05/2026 11:00 PM - 7:00 AM shift - 2.5 (down 0.5 after 3 AM) -04/06/2026 11:00 PM - 7:00 AM shift - 2.5 (down 0.5 after 3 AM)-04/07/2026 11:00 PM - 7:00 AM shift - 2 after 3 AM (down 0.5 after 3 AM) -04/10/2026 11:00 PM - 7:00 AM shift - 2 after 3 AM (down 0.5 after 3 AM)-04/18/2026 11:00 PM - 7:00 AM shift - 2 (down 1)-04/20/2026 11:00 PM - 7:00 AM shift - 2 (down 1) -04/25/2026 11:00 PM - 7:00 AM shift - 2.5 (down 0.5 after 3 AM)The facility census for these dates was between 113 and 116. During an interview on 04/30/2026 at 9:24 AM, the Facility Scheduler stated there was no written policy that documented the minimum amount of staffing needed for each shift. They stated they followed the guidelines provided by administration for minimum staffing which included four (4) licensed nurses on the day and evening shifts, and a total of three (3) licensed nurses on the night shift. The Facility Scheduler stated the certified nurse aide minimum staffing included eight (8) for day and evening shifts and four (4) certified nurse aids for the overnight shift. They stated when staffing fell below the minimum numbers they would notify the Director of Nursing, Administrator, and the Nursing Supervisor. The Facility Scheduler stated in the last 30 days there were a few days when the minimum staffing numbers were not met. They stated the evening shift was the most difficult to staff and the overnight shift fell below minimum at times because some staff only worked until 3:00 AM which created a gap in coverage. They stated the schedule would be staffed adequately but then call offs happened. The Facility Scheuler stated it was important to meet or exceed the minimum staffing to ensure residents received good care. During a Resident Council meeting held on 04/27/2026 at 10:30 AM six (6) residents (Resident #21, #27, #50, #63, #96, #119) participated, residents stated staffing was an issue during the evening and night shifts with only one certified nurse aide for each hallway. They stated their call bell wait times could go longer than an hour before staff responded. At times staff would enter their room, turn off the call light and say they would return but never come back. They stated call lights were not always left within reach, there were not enough staff to properly assist residents with meals specifically, staff would feed the residents too fast, and meal carts would sit on the unit up to 30 minutes before being delivered. 3. Observation and interviews with residents, Ombudsman, and family members and revealed the following: a.During observations and interviews on the third floor on 04/26/2026 at 10:11 AM, Resident #30 was in bed wearing a night gown and they had their call light on; it was sounding an illuminated. Resident #30 at this time stated they needed their brief to be changed. Licensed Practical Nurse #1 was at their medication cart and stated they had about 38 residents on the floor and staffing for the floor consisted of themselves along with two certified nurse aides. Licensed Practical Nurse #1 stated that it was normal staffing for the day shift. Further observation at 10:17 AM, revealed the third floor had two call lights luminated and sounding (Resident #30's bell light along with Resident #92's).The call light system monitor that was placed on top of the nursing station desk displayed two rooms and call light times were: Resident #30's light had been on for 18 minutes and Resident #92 for 34 minutes. A continuous observation was started, and the following was observed: -at 10:25 AM Certified Nurse Aide #1 was overheard to tell the Resident #30 they would be back to take care of them when they completed with a different resident. Resident #30 call light was no longer ringing.-at 10:26 AM the call light monitor displayed that Resident #92 call light was ringing now for 43 minutes. Resident #92 was observed to be sitting on the edge of their bed with their breakfast tray in front of them completed. Resident #92 stated they needed to be rearranged and their legs back in bed. Resident #30's call light was now back on, and the call light monitor displayed three minutes. -at 10:28 AM, Licensed Practical Nurse #1 turned off Resident #92's light and had taken care of their needs. -at 10:30 AM Certified Nurse Aide #1 entered Resident #30's room and closed their door. During an observation on (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	04/26/2026 at 11:20 AM, the third floor had one call light luminated and sounding (Resident #51) The call light monitor displayed Resident #51's light was on for 25 minutes. A continuous observation was started, and the following was observed: -11:23 AM Resident #51 was in their bed in a hospital gown, knitting. During an interview at this time, Resident #51 stated they had their bowel medicine, and they needed the bed pan. Resident #51 stated they usually do not get the bed pan on time and at times, it could take three to four hours before their call light was answered. -11:25 AM Licensed Practical Nurse #1 entered Resident #51's, turned off the call light and was overheard to ask the resident what they needed. Resident #51 replied they had been waiting for the bed pan. The bedroom door was closed.-11:27 AM Licensed Practical Nurse #1 exited Resident #51's room and returned at 11:28 AM with a bed pan in hand and closed the door. b. The Resident Incident Form dated 03/11/2026 documented Resident #21 had an 8.5 centimeter by 5-centimeter blistered area on the top of their left hand. Resident #21 stated they were taking soup out of the microwave when the soup splashed onto their hand. The resident was educated to ask for assistance with hot food from the microwave. During an interview on 04/29/2026 at 9:15 AM, Resident #21 stated they were taking soup out of the microwave oven when the handle slipped and the hot liquid sloshed on to the top of their left hand. The resident stated the facility had educated them to request for staff assistance when using the microwave oven, but there's only one problem with that, there is no staff to assist so they usually use the microwave by themselves. c. During an observation on 04/26/2026 at 10:51 AM Resident #4 was seated in a wheelchair with a dressing (ace wrap) noted on their right shin dated 04/24/2026. During an interview on 04/26/2026 at 10:51 AM at the time of the observation, Resident #4 stated their dressing (treatment) had not been changed yet today and it was not changed the day prior (4/25/2026). They stated one licensed practical nurse consistently completed the dressing changes/treatment but when that nurse was off, the treatment was often not completed. During an interview on 04/29/2026 at 9:26 AM, Licensed Practical Nurse #2 they stated they had noticed Resident #4's daily dressing/treatment was not always completed on their right shin, as ordered. Resident #4 never refused care. They stated they felt the staff were too busy to complete because not all staff were able to complete their work by the end of their shift. During an interview on 04/26/2026 at 12:37 PM, Resident #106 stated staffing on the 3:00 PM - 11:00 PM shift was the worst, meal carts would sit on the unit for 30 minutes before any staff member touched it. They stated dinners were served cold. d. During an interview on 04/26/2026 at 12:50 PM, Resident #42's family member stated the facility was slipping with resident care because they were always short staffed. They stated the nursing staff were wonderful but can only do what they can do, the facility needs more help. During an interview on 04/26/2026 at 12:56 PM, Resident #9 stated staffing was worse on the 3:00 PM - 11:00PM shift, they stated it took forever to get their dinner trays passed and for staff to answer their call light when they needed assistance. During an interview on 04/26/2026 at 1:31 PM, Resident #20's family member stated the facility did not have enough staff, they stated that was why staff would sometimes double brief the resident instead of offering to toilet them. During an interview on 04/27/2026 at 9:46 AM, Resident #30 was in bed dressed in a personal night gown. Resident #30 stated they do not get out of bed because once they get out of bed staff keep them up. Because once you are up you are up. Resident #30 stated there were not enough staff on the overnight shift and on all shifts their call bell goes unanswered for long periods of time. During an interview on 04/27/2026 at 10:19 AM, Resident #8 stated once the day shift staff leaves for the evening, there were not enough staff working the rest of the evening and into the night. They stated they wait a long time for their call bell to be answered and to be toileted. During a telephone interview on 04/27/2026 at 10:37 AM, the Ombudsman stated that one of the facility's biggest challenges was they were consistently short of staff and extremely short staffed on weekends. They stated they would receive complaints from the residents/family members that residents tend to be left in bed for more than 24-hours, catheter bags go unemptied, and colostomy bags explode all due to low staffing. The Ombudsman also stated that residents had complaints about long wait times to answer calls (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	bells, and meeting their toileting needs. During an interview on 04/28/2026 at 8:54 AM, Resident #51 stated when there were only two (2) certified nurse aides on the floor they would have trouble getting staff to assist them on and off the bedpan and to be repositioned in bed for meals. Resident #51 stated they did not get out of bed very often because they required a mechanical lift for transfers and if when there were only two certified nurse aides working staff could not get them out of bed. During an interview on 04/28/2026 at 1:43 PM, Resident #55's family member stated the facility did not have enough staff. They have witnessed residents during activities ask to go to the bathroom and wait for over 30 minutes for a certified nurse aide to take them. During a continuous observation on 04/28/2026 from 8:18 AM until 2:00 PM Resident's #43 and #104 were up dressed and seated in the dining room. The residents were not offered, encouraged, or provided with toileting and/or incontinent care. Both residents were noted to have been incontinent during follow up care observations. During an interview on 04/28/2026 at 1:48 PM, Certified Nurse Aide #1 stated residents who were incontinent should be checked and changed every two hours. They stated they work about twice a week with only a second aide, and it was not possible to toilet every resident every two hours in a shift. They stated both residents should have been provided with care as planned. 4. Interviews with Facility Staff: During an interview on 04/28/2026 at 10:05 AM, Certified Nurse Aide #8 stated they worked the 7:00 AM to 3:00 PM shift and at times there would only be two (2) aides working for the whole shift. They stated if there were two certified nurse aides they would each be assigned 18 to 20 residents each. Certified Nurse Aide #8 stated they sometimes stayed over after their shift to complete their assessment, but they were not always able to get resident showers done. During an interview on 04/28/2026 at 10:30 AM, Licensed Practical Nurse #6 stated they worked the 7:00 AM to 3:00 PM shift, they were the only medication nurse for the floor and usually worked with two (2) certified nurse aides. They stated it was a struggle with only two (2) aides on the floor and would assist them the best they could. Licensed Practical Nurse #6 stated at times the certified nurse aides would not be able to make beds, give showers. Toileting and incontinent care would be left for the next shift to be completed because of staffing. During an interview on 04/27/2026 at 4:05 PM, Licensed Practical Nurse #3, stated they worked the 3:00 PM to 11:00 PM shift and were the only nurse for the floor. They stated they were able to pass all medications and complete their treatments but stayed over their shift to finish charting. Licensed Practical Nurse #3 stated they usually worked with two (2) certified nurse aides and at times would only have one certified nurse aide for the entire shift. They stated that when they were short staffed, they prioritized the best they could, but residents often had to wait long periods for care to be provided. At times residents were not toileted or put to bed until the next shift arrived. During an interview on 04/27/2026 at 4:16 PM, Licensed Practical Nurse #7 stated they worked 7:00 AM to 7:00 PM and usual staffing was one (1) to two (2) nurses for their floor and two (2) certified nurse aides. They stated staffing levels were bad, there were not always enough staff to get residents to the dining room timely for meals. They stated they were able to assist those residents that required help with eating but would take a long time to complete. During an interview on 04/28/2026 at 12:42 PM, Certified Nurse Aide #2 stated they currently work the 7:00 AM to 3:00 PM and staffing could be from two (2) to four (4) certified nurse aides. They stated when there were only two (2) aides on the floor they did their best to toilet and provide incontinent care to each resident twice during their shift but were not always able to get to all residents twice. They stated they would give report to the next shift to let them know what residents needed assistance first. During an interview on 04/28/2026 at 4:52 PM, Certified Nurse Aide #12 stated they worked the 3:00P PM to 11:00 PM shift and staffing was usually just two (2) certified nurse aides but stated they have worked as the only aide on the floor before. They stated the nurse sometimes would assist with resident care including transfers and toileting. Certified Nurse Aide #12 stated they did the best they could but were unable to complete showers and some residents would be left up until the 11:00 PM to 7:00 AM shift arrived to assist them to bed. During an interview on 04/29/2026 at 4:34 PM, Certified Nurse Aide #3 stated they work the 3:00 PM to 11:00 PM shift and (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	on average they work with just another aide. They added at times they may work alone with no other aides. They stated when they work alone or with just a second aide do not do resident showers, toilet an incontinent resident every two (2) hours and sometimes they have to leave a resident in their wheelchair until the overnight shift comes in to put them to bed. During an interview on 04/30/2026 at 10:40 AM, Licensed Practical Nurse #8 stated they worked the 3:00 PM to 3:00 AM. They stated staffing on the 3:00 PM to 11:00 PM shift consisted of one (1) nurse and usually two (2) certified nurse aides unless there were call ins and then would only have one (1) certified nurse aide for the evening shift. Licensed Practical Nurse #8 stated it was hard to get resident care done with one (1) to two (2) aides on the floor and would assist with transfers and toileting after they completed their medication pass. They stated there were unit assistants on the floor that helped pass and collect meal trays but could not feed the residents. Licensed Practical Nurse #8 stated there were about five (5) residents on their floor that required total assistance with eating, they would go around the table and assist multiple residents until everyone was fed. Licensed Practical Nurse #8 stated evening shift was not always able to complete timely incontinent care and residents would be left up in the wheelchairs until the night shift arrived. They stated that when their shift ended at 3:00 AM, the nursing supervisor on the night shift (11:00 PM to 7:00 AM) took over for them because they were short staffed. During an interview on 4/30/2026 at 10:48 AM, Registered Nurse Supervisor #3 stated staffing on the 11:00 PM to 7:00 AM shift was not great, and we were lucky to have one certified nurse aide on each floor. They stated some nurses only worked until 3:00 AM and they would have to take over the unit when they left. Registered Nurse Supervisor #3 stated on weekends they often covered two (2) floors and supervised the building; it was just them and one other nurse for the building. They stated not having a nurse on every floor was not safe because there were not enough staff to monitor residents and prevent falls. Registered Nurse Supervisor #3 stated that when there were no aides on the floor the nurse would try to answer the call lights and provide incontinent care to the residents that were heavily soiled but not everyone could get changed. They stated there needed to be more staff for safety reasons. During an interview on 04/30/2026 at 11:02 AM, Certified Nurse Aide #11 stated staffing on the evening shift (3:00 PM to 11:00 PM) was horrible and often worked as the only aide on the floor. They stated they could not get all their work done and only some nurses helped. Certified Nurse Aide #11 stated they tried to get done what they could but were not able to toilet all residents per their care plan. They stated they would check the residents as soon as they could, if a resident was visibly soiled, they would get an aide from a different floor to help provide care If the residents were not visibly soiled, they would have to wait until the next shift to be changed. Certified Nurse Aide #11 stated it was difficult to assist residents with feeding when short staffed, took about an hour to get everyone fed; showers were not completed, and residents that transferred with a mechanical lift were left up in their wheelchair until the next shift came in. Certified Nurse Aide #11 stated the facility staffing was not safe. During an interview on 04/30/2026 at 11:18 AM, Licensed Practical Nurse #9 stated staffing on the 11:00 PM to 7:00 AM shift was one nurse and one aide. They stated at times they have worked with no aide on the floor for four (4) hours because of short staffing. Licensed Practical Nurse #9 stated having only one staff member on the floor was not safe, residents that required two (2) staff members for assistance had to wait longer for care, they could not answer call lights timely and residents could fall. During an interview on 04/30/2026 at 11:31 AM, Certified Nurse Aide #9 stated they worked 11:00 PM to 7:00 AM and often had to float between floors because there were not always enough aides in the building due to call offs. They stated the facility needed more staff to ensure residents were safe and received proper care. During an interview on 04/30/2026 at 1:08 PM, the Director of Nursing stated the minimum staffing numbers were based on the current census of 115 and consisted of one (1) nurse and two (2) certified nurse aides for each floor for both the day shift (7:00 AM - 3:00 PM) and evening shift (3:00 PM - 11:00 PM) and one (1) nurse and one (1) certified nurse aide on every floor for the night shit (11:00 PM - 7:00 AM). The Director of Nursing stated that any time staffing fell below those numbers (continued on next page)

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	335142	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Park Rehab & Skilled Nursing	150 Prather Avenue Jamestown, NY 14701

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	they would not be meeting their minimum staffing. They stated they reviewed the schedule every day to ensure staffing was adequate, however the biggest issue was the call offs which created critical staffing levels. The Director of Nursing stated one aide on a unit for evening shift and one nurse covering multiple floors on night shift was not ideal staffing. Staff would not be able to provide proper and timely care for the residents. During an interview on 04/30/2026 at 1:29 PM, the Acting Administrator stated they were made aware of staffing concerns by the Director of Nursing and the Facility Scheduler. They stated when they were informed of low staffing levels and call-offs, they would offer bonuses to staff, offer schedule changes, or reach out to the other Heritage facility to see if there were staff available to work to cover any open shifts. They stated they made significant strides to staff all shifts but were aware they were not making the minimums every day. The Acting Administrator stated they would expect to have at least one (1) nurse on every floor and two (2) certified nurse aides each floor. They stated nothing less was not feasible and would be below their minimum staffing level. They stated adequate staffing was important to provide the appropriate level of care for the residents. 10 New York Codes Rules Regulations 415.13 (b) (1) (i-ii)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review completed during survey, the facility failed to ensure the comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments for four (4) (Residents #20, 35, 40, and #55) of four (4) residents reviewed. Specifically, comprehensive care plans that did not accurately reflect resident's current Advanced Directives, including their code status (a medical order indicating a patient's preferences for life-saving interventions to guide staff on whether to perform resuscitation- full code (all efforts) or Do Not Resuscitate (DNR)). The findings include: The facility policy and procedure titled Formation of the Resident Care Plan, dated [DATE] documented the comprehensive care plan will be developed within seven (7) days after the comprehensive assessment and will be prepared by an interdisciplinary team that includes, but was not limited to: Attending Physician, a Registered Nurse with responsibility for the resident, and the resident or resident representative, as practicable. Each care plan was reviewed by the committee at least quarterly. The nurse manager was responsible for presenting current information on a resident's condition, noting any changes since last review. The social work policy and procedure manual titled Do Not Resuscitate (DNR), dated [DATE], documented A Do Not Resuscitate (DNR) Order in the resident's medical record instructs the medical staff not to try to revive the resident if breathing or heartbeat has stopped. This means physicians, nurses and others will not initiate such emergency procedures as mouth-to-mouth resuscitation, external chest compression, electric shock, insertion of a tube to open the resident's airway, injection of medication into the heart or open chest heart massage. A do not resuscitate order, written by the attending physician instructs the staff not to perform emergency resuscitation and not to transfer the patient to a hospital only for such procedures. The purpose of the do not resuscitate order was to allow residents or their surrogates to express their wishes regarding the level of therapeutic effort to be expanded in the event of cardiac or respiratory arrest. 1. Resident #35 had diagnoses that included chronic obstructive pulmonary disease (a progressive lung disease) chronic respiratory failure, and diabetes mellitus. The Minimum Data Set, dated [DATE] documented Resident #35 had moderate cognitive impairment, was usually understood and usually understands. The comprehensive care plan initiated on [DATE], documented interventions that included Resident #35 had a Health Care Proxy; Do Not Resuscitate- see Medical Orders for Life-Sustaining Treatment for details; Full Code- see Medical Orders for Life-Sustaining Treatment for details. Review of Resident #35's Medical Orders for Life-Sustaining Treatment (MOLST) last reviewed and signed by the provider on [DATE] documented Resident #35's had orders for a Do Not Resuscitate status. During an interview on [DATE] at 8:01 AM, Registered Nurse Unit Manager #1 stated they were responsible for updating care plans with any changes. They stated the resident's advanced directives were documented on their Medical Orders for Life-Sustaining Treatment (MOLST) form in the medical record, the care plan, and there would be a blue dot outside the resident's door next to their name that indicated if a resident had a full Code status. Registered Nurse Unit Manager #1 stated if there was a change in residents' code status the care plan would need to be updated to ensure their wishes were followed. Registered Nurse Unit Manager #1 reviewed Resident #35's care plan and stated their advanced directive section indicated both a Do Not Resuscitate and a Full code status. They stated on admission all approaches for advanced directives automatically populated to the care plan and the admitting nurse or nurse manager were to adjust the care plan to match the residents Medical Orders for Life-Sustaining Treatment (MOLST). Registered Nurse Unit Manager #1 stated Resident #35's care plan needed to be updated, and the full code status needed to be removed. 2. Resident #20 had diagnoses including dementia and type II diabetes The Minimum Data Set (a resident assessment tool) dated [DATE], documented that they were severely (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cognitively impaired, usually understood and usually understand others. The comprehensive care plan initiated on [DATE] documented care plan interventions that included Resident #20 had a Health Care Proxy; Do Not Resuscitate- see Medical Orders for Life-Sustaining Treatment for details; Full Code- see Medical Orders for Life-Sustaining Treatment for details. Resident #20's Medical Orders for Life-Sustaining Treatment (MOLST) signed [DATE], documented Resident #20's representative consented to the Advanced Directives, Do Not Resuscitate and Do Not Intubate. 3. Resident #40 had diagnoses including dementia, type II diabetes, and adult failure to thrive (a combination of symptoms that cause a decline in physical, mental, and social functioning). The Minimum Data Set, dated [DATE], documented they were severely cognitively impaired, sometimes understood and sometimes understand others. The comprehensive care plan initiated [DATE] documented interventions that included Resident #40 had a Health Care Proxy; Do Not Resuscitate- see Medical Orders for Life-Sustaining Treatment for details; Full Code- see Medical Orders for Life-Sustaining Treatment for details. Resident #40's Medical Orders for Life-Sustaining Treatment (MOLST) signed [DATE], documented Resident #40's representative consented to the Advanced Directives, Do Not Resuscitate and Do Not Intubate. 4. Resident #55 had diagnoses including dementia, a personal history of breast cancer, and difficulty walking. The Minimum Data Set, dated [DATE], documented they were severely cognitively impaired, sometimes understood and sometimes understand others. The comprehensive care plan initiated [DATE] documented interventions that included Resident #55 had a Health Care Proxy; Do Not Resuscitate- see Medical Orders for Life-Sustaining Treatment for details; Full Code- see Medical Orders for Life-Sustaining Treatment for details. Resident #55's Medical Orders for Life-Sustaining Treatment (MOLST) signed [DATE], documented Resident #55's representative consented to the Advanced Directives, Do Not Resuscitate and Do Not Intubate. During an interview on [DATE] at 8:53 AM, Registered Nurse Unit Manager #2 stated the unit managers were responsible for updating the comprehensive care plans. The residents' care plans should be accurate and show how to care for them. They stated, if the resident's code status was do not resuscitate, the care plan should document that alone. Registered Nurse #2 stated they would review and update the care plans for Residents #20, #40, and #55, and check the accuracy of the rest of the residents on the second floor. Registered Nurse Unit Manager #2 stated further stated the care plan auto populates information and it was the managers responsibility to make sure the care plans were accurate. During an interview on [DATE] at 5:02 PM, Licensed Practical Nurse #3 stated they checked the residents' Medical Orders for Life-Sustaining Treatment (MOLST) to verify if they were a Full Code or Do Not Resuscitate status. Licensed Practical Nurse #3 stated it was the unit managers' responsibility to update care plans and were unsure if the resident's code status was documented on the care plan. During an interview on [DATE] at 1:01 PM, the Director of Nursing stated the nurse managers were responsible for updating resident care plans and expected the care plans to accurately reflect the residents' care needs and preferences including advanced directives. They stated advanced directives were to be documented on the care plan according to the residents' Medical Orders for Life Sustaining Treatment (MOLST) and would expect the care plan to be updated if a change in advanced directives occurred. The Director of Nursing stated they would have expected the care plan to match the Medical Orders for Life Sustaining Treatment (MOLST) to ensure the residents' wishes were followed and the appropriate treatment was provided. 10 New York Codes, Rules, and Regulations 415.11 (c)(2) (ii-iii)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, record reviews, and interviews conducted during the survey, the facility failed to store food in accordance with professional standards for food service safety for one (1) of one (1) kitchen and two (2) (second and third floors) of three (3) resident floors reviewed. Specifically, in the kitchen there were various sticky food spills and sticky residue on the floor, the ceiling tile grid had a visible layer of black dust and there were dirty ceiling tiles, water damaged floor tiles near the ice machine, a broken faucet in the 3-bay sink, flies in the dishwasher and food preparation areas, and a damaged ceiling light cover held together by duct tape. Additionally, the kitchen, unit dining rooms, and activity room coolers/refrigerators/freezers were dirty with liquid spills and contained multiple undated, unlabeled food items. The findings include:The facility policy Food Safety Requirements revision/review date 04/12/2024 documented it is the policy of this facility to provide safe and sanitary storage, handling, and consumption of all food including food and fluids brought to residents by family or other visitors. Additionally, the facility procures food from sources approved or considered satisfactory by federal, state or local authorities. This included storage, preparation, distribution, and serving food in accordance with professional standards for food service safety. Education on safe food handling will be provided to all staff, family, residents, resident council, visitors and community groups who may provide foods or fluids to residents of the facility. The education included: requirements for covered containers or secure wrapping; proper labeling and dating of each item; and leftover foods will be used within 3 days or discarded. Foods requiring refrigeration will be received by the facility designee (activity department, food and nutrition department, charge nurse, etc.) for proper and immediate storage including labeling and dating.1a. Observation in the third floor Dining Room on 04/26/2026 at 9:51 AM revealed the refrigerator contained an unopened 8-ounce container of thickened dairy drink. The manufacturer's stamp on it read Best if Used by 02Apr2026. The refrigerator also contained an opened bag of shredded cheese, about half full, that was not labeled with the date it was opened. The inside of the refrigerator had sticky red and orange beverage spills on the door shelf and one (1) hair in the refrigerator and one (1) hair in the freezer.1b. Observation in the second floor Dining Room on 04/26/2026 at 10:12 AM revealed the refrigerator contained a sandwich on a plate wrapped in clear plastic wrap labeled Turkey and Cheese, with no date. The inside of the freezer had frozen spills and food crumbs throughout the bottom.During an observation in the second floor Dining Room and interview with the Food Service Director on 04/29/2026 at 2:25 PM, a lidded container of mashed potatoes and a lidded container of cooked vegetables were in the refrigerator and were not labeled with a name or date. There was also one 5.3-ounce yogurt container with a manufacturer's stamp that read, Apr24 2026. The Food Service Director stated the mashed potatoes, and cooked vegetables probably came off of a resident's meal tray and should have been labeled by whoever placed them in the refrigerator, using the stickers provided. They stated because the manufacturer's stamp on the yogurt did not specify whether the date was a use by, sell by, or expiration date, it should have been thrown out on the stamped date. Also at this time, the Food Service Director stated the freezer in the second floor Dining Room could use cleaning.1c. Observation in the second floor Activities Room on 04/26/2026 at 10:23 AM revealed the refrigerator contained three (3) 5.3-ounce yogurt cups that were labeled with a resident name and room number. The manufacturer's stamp on each read, Feb22 2026. The refrigerator also contained one (1) 6-ounce yogurt cup with a manufacturer's stamp that read, Sell by 3/29/26. There was also a pitcher of thickened beverage, approximately 2 cups, that was not dated. In the freezer, there was a small plastic leftover container with ice cream and toppings. There was a layer of thick frost over the ice cream, and it was not labeled with a resident's name or date. Additionally, there were at least six (6) hairs inside the refrigerator.Further observation on 4/29/26 at 2:58 PM, revealed signs were posted on the third floor Dining Room refrigerator, second floor Dining (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Room refrigerator, and the Activities Room refrigerator. One (1) sign read, Attention: Family members may bring in items for their loved ones. However please make sure these items are labeled! The label must include the resident it is for, the date it was opened/ placed in the refrigerator, and the expiration date (4 days including date it was opened/ placed in the refrigerator). Anything without a label will be disposed of. Another sign read, All food for residents must be labeled with resident name and dated per Department of Health regulations. Protein based food can be kept for 3 days. All other food can be kept for 5 days then it will be disposed of.During an interview on 04/26/2026 at 10:23 AM, Activities Aide #1 stated Activities staff checked the refrigerator in the Activities Room occasionally, but it was not documented. They stated the yogurts belonged to a specific resident, so they would not throw them out. They stated if they noticed an item in the refrigerator for a long time, they would usually say something about it to their supervisor, but they did not personally see that the dates on the yogurts had passed. They were not sure who placed the pitcher of thickened beverage in the Activities Room refrigerator, but it should have a date written on it. Activities Aide #1 stated they were not told that Activities staff were supposed to clean the refrigerator in the Activities Room, it was probably assigned to Dietary staff, and the hairs inside the refrigerator needed to be removed.During an observation in the second floor Activities Room and interview with the Food Service Director on 04/29/2026 at 2:30 PM, a pitcher of less than 1 cup of thickened beverage that was undated was in the refrigerator. The small plastic leftover container with ice cream and toppings remained in the freezer. The Food Service Director stated they did not know when the thickened beverage was made, therefore it should be discarded. Dietary staff should place a date on the pitcher when it was made, and thickened beverages could be kept in the refrigerator for three (3) days after opening. They also stated the leftover container of ice cream did not come from the Main Kitchen and needed to be labeled with the resident's name and date. Staff must keep their own personal food and drinks in the basement Cafe refrigerator.During an interview on 04/29/2026 at 2:15 PM, the Food Service Director stated the refrigerator in the Activities Room was maintained by Activities staff only. They stated the refrigerators in the resident unit Dining Rooms were maintained by Nursing and Dietary staff and Housekeeping staff cleaned the insides of those refrigerators. They stated most dairy products could be served three (3) to four (4) days beyond the manufacturer's best by date and could be served four (4) to five (5) days beyond the manufacturer's sell by date. The Food Service Director stated the sandwich in the second floor Dining Room refrigerator was probably taken off of a resident's tray to save for later. Stickers were provided at the refrigerators and were to be used to label and date foods at the time they were being placed in the refrigerator.2a. Observation in the Main Kitchen on 04/26/2026 at 9:46 AM included the following: - various sticky food spills on the floor- a 32-ounce plastic container of cornstarch with the lid not screwed on and a whitepowder-like substance on the tops of the canned goods on the shelf below in the dry storage room- multiple unlabeled, undated food items in stainless steel containers in the walk-in cooler- 22 unlabeled, undated gelatin cups in the walk-in cooler- uncovered, unlabeled and undated cheese block in the walk-in cooler- thick layer of frost in the upright freezer with multiple undated, unlabeled food itemsDuring an interview on 04/26/2026 at 10:00 AM, the Dietary Supervisor stated all food items should be labeled and dated.During an interview on 04/30/2026 at 9:49 AM, the Acting Administrator stated all food items need to be labeled and dated, and there should not be a thick layer of frost in the freezer.2b. Observation in the Main Kitchen on 04/26/2026 at 2:10 PM revealed the walk-in freezer was not operating, and it was being used to store dry goods. Further observation revealed an upright freezer in the Main Kitchen was empty, had its door propped open, and was defrosting.At the time of the observation, the Food Service Director stated on 06/27/2025, the walk-in freezer went down. They stated they brought in a smaller freezer to help the situation, and it was currently being defrosted. The smaller freezer was used for odds and ends frozen storage. They stated ice cream was delivered to the facility on Fridays, and it went straight to the freezers on the resident units for frozen storage. They also stated food delivery occurred each Tuesday and Friday and they planned (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	their menu around the delivery dates, as frozen storage was very limited.During an interview on 04/26/2026 at 2:45 PM, the Corporate Director of Environmental Services stated they were aware that the walk-in freezer was out of service. They stated they tried to get a vendor to come out to provide an estimate for repair, but they had not come out yet. They stated the first step was to obtain estimates for repair and then decide if it would be a better decision to repair the walk-in freezer or replace it. They stated there was no proposed timeline for repair or replacement at this time.3. Observation in the Main Kitchen on 04/26/2026 at 2:15 PM revealed water to the three (3)-bay sink in the dishwash area could not be shut off at the faucet but had to be shut off at the valve under the sink. Also, the floor at the perimeter of the room and around stationary equipment, such as refrigerators, sinks, tables, the mixer, and the ice machine had a sticky, blackish residue. The floor tiles under the ice machine were curled from water damage. Further observation revealed a 5-gallon bucket of soy sauce was uncovered and three (3) live flies were flying around the opening. There were also about eight (8) live flies in the vicinity of the soy sauce, at the far corner of the Ansul suppression hood. There were at least four (4) live flies observed in the dishwash area, and an insect light trap was present, but not plugged in. The shelf that the soy sauce was stored on near the far corner of the Ansul suppression hood had various sticky food spills. Additional observation revealed the four (4) ceiling vents closest to the Ansul suppression hood that were white had a black discoloration, and the ceiling tiles that surrounded each had a black discoloration. One (1) ceiling light in the Main Kitchen had its cover held up with duct tape and approximately 30 percent of the ceiling tile grid in the Main Kitchen appeared dusty with a visible layer of black dust.During an interview on 04/26/2026 at 2:15 PM, the Food Service Director stated they were not aware that the water at the three (3)-bay sink needed to be shut off at the valve, and it was not like that on Friday, 04/24/2026. The Food Service Director stated the Main Kitchen floor had not been stripped and waxed in about two (2) and a half years, and Dietary staff swept and mopped the floor twice per day and tried to scrape under the equipment as much as they could. They stated it was possible that some tiles were just stained. The Food Service Director also stated they started to notice the flies recently, and it was possible that they came in with the last fruit delivery. The insect light trap worked but needed new glue paper. They stated they had already informed the Acting Administrator and requested new glue paper. The Food Service Director also stated that the shelf the soy sauce was stored on needed to be cleaned.During an interview on 04/26/2026 at 2:30 PM, the Environmental Supervisor stated the discoloration around the ceiling vents in the Main Kitchen was likely due to air discharge and could be cleaned off of the metal vents, but the surrounding ceiling tiles could not be cleaned and needed to be replaced. The Environmental Supervisor stated the Main Kitchen floor was stripped and waxed about every two (2) years and it was probably due for another strip and wax again. They stated one (1) ceiling light fixture cover in the Main Kitchen had a strip of duct tape on it, which needed a more permanent solution. The Environmental Supervisor stated they were not aware of any flies in the Main Kitchen, and the facility had a licensed exterminator who did not have regularly scheduled treatments but would come for service when needed. The licensed exterminator had not done any recent treatments in the Main Kitchen.During an interview on 04/26/2026 at 2:44 PM, the Corporate Director of Environmental Services stated the licensed exterminator provided the insect light trap in the dishwash room and the facility refilled the glue paper as needed.10 New York Code Rules Regulations (NYCRR) 415.14(h)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview and record review conducted during an Onsite Post Survey Revisit #1 completed on 06/25/2026, the facility did not ensure that the Quality Assurance Performance Improvement Program (QAPI) Committee developed and implemented appropriate plans of action to correct identified quality deficiencies and regularly reviewed, analyzed, and acted on available data to make improvements. Specifically, the facility did not maintain effective systems to maintain compliance, and there were repeated deficiencies observed from the Standard survey completed on 04/30/2026, in the areas of Right to be Free from Physical Restraints, Care Plan Timing and Revision, Food Procurement, Store/Prepare/Serve-Sanitary, Emergency Lighting, and Fire Alarm System - Testing and Maintenance. In addition, the facility did not follow their plan of correction from their Standard survey 04/03/2026 to provide education to staff in the areas of Activities of Daily Living Care Provided for Dependent Residents (F677); and Infection Control (I210). The findings include: Refer to: F 604- Right to be Free from Physical Restraints - Scope and Severity D F 657- Care Plan Timing and Revision - Scope and Severity D F 677- ADL Care Provided for Dependent Residents F 812- Food Procurement, Store/Prepare/Serve - Sanitary - Scope and Severity E K 291- Emergency Lighting - Scope and Severity E K 345- Fire Alarm System - Testing and Maintenance - Scope and Severity E I 210- Infection Control The policy and procedure tilted Quality Assurance Performance Improvement (QAPI) Program and Committee revised 2018-11-2 documented it shall be the policy of the facility to conduct an ongoing evaluation of all services provided to Residents utilizing tools and methods throughout our organization to determine root causes of problems and to establish improvements to be implemented and measured to determine progress towards excellence. The committee shall monitor items such as, but not limited to: Quality Measures, Plan of Correction Updates, Standard Measures of Professional Practice, Department of Health Reportable Events. The committee shall ensure outcomes of reviews are shared with appropriate staff to be used for the revision or development of policies and practices. Review of Summary Report of Meeting dated 06/12/2026 at 9:30 AM, documented type of meeting: Quality Assurance, presented by the Administrator. Subject covered: Plan of Correction, Audits and Scheduled Education. Review of Quality Assurance Meeting Agenda dated 06/12/2026, documented Statement of Deficiencies - Reviewed. Education provided for F604, F657, F677, F689. Education reviewed for F812. There was no documentation that the I210 was reviewed during the meeting. Review of Standard Survey Statement of Deficiencies (form 2567) issued by the New York State Department of Health with an exit date of 04/30/2026 revealed the facility was cited as follows: F 604- facility failed to ensure residents were free from physical restraints imposed for purposes of discipline or convenience that were not required to treat the resident's medical symptoms. The facilities Plan of Correction documented the deficiency would be corrected by 06/22/2026 and was not.F 657- the facility failed to ensure the comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. The facilities Plan of Correction documented the deficiency would be corrected by 06/22/202 and was not.F 812- the facility failed to store food in accordance with professional standards for food service safety. The facilities Plan of Correction documented the deficiency would be corrected by 06/22/2026 and was not.K 291- the facility failed to test battery-powered emergency lighting at least monthly for 30 seconds and annually for 90 minutes. The facilities Plan of Correction documented the deficiency would be corrected by 06/22/2026 and was not.K 345- the facility failed to maintain the fire alarm system. The facilities Plan of Correction documented the deficiency would be corrected by 06/22/2026 and was not. F 677- the facility failed to ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good grooming and personal hygiene. Form 2567 documented the facilities approved Plan of Correction would include that Licensed nursing staff and Certified Nurse Aides (continued on next page)

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	335142	A. Building B. Wing	04/30/2026

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Heritage Park Rehab & Skilled Nursing	150 Prather Avenue Jamestown, NY 14701

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	would be re-educated on: following individualized care plans; timely provision of incontinent care, feeding assistance, and hygiene support; documentation requirements; Resident dignity and quality of life expectations; and Escalation processes when resident care concerns arise or assistance is needed to meet resident needs. The facilities Plan of Correction documented the deficiency would be corrected by 06/22/2026 and staff education was not completed.I 210- the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Form 2567 documented the facilities approved Plan of Correction would include that the Environmental Supervisor, Maintenance Department, and Administrator received education regarding regulatory requirements, vendor oversight expectations, scheduling accountability, and documentation processes. The facilities Plan of Correction documented the deficiency would be corrected by 06/22/2026 and staff education was not completed. During an interview on 06/25/2026 at 1:51 PM, the [NAME] President of Skilled Nursing Operations stated the in-service and education for Legionella was completed but they were not able to locate that information. During an interview on 06/23/2026 at 1:27 PM and 1:49 PM, the Director of Nursing stated they were looking for additional signatures for education completed per the Plan of Correction. They stated education started approximately two weeks ago and was being completed by themselves, the Administrator and Day Supervisor. When interviewed on 06/24/2026 at 1:09 PM, the Director of Nursing stated the Administrative Assistant was responsible for staff education related to fire alarm pull stations. The Director of Nursing further stated the in-service education was a read and sign maintained at the Administrative Assistant's desk. The Administrative Assistant stated they did not reach out to per diem staff, and staff that were already in the building or staff that came in for in-service education signed off on the policy review. The Administrative Assistant further stated they were not present for overnight staff education, and they would return the sign off sheet to the Administrator at the end of their shift.During an interview on 06/24/2026 at 2:48 PM, the Director of Nursing stated responsibility to ensure the Plan of Correction was completed on or by 06/22/2026 rested on both the Administrator and the Director of Nursing. The Director of Nursing stated they were off last week but could not honestly say why staff education related to restraints and care plans was not fully completed. They stated the Plan of Correction should have been completed by 06/22/2026 because that was their deadline. During an interview on 06/25/2026 at 12:49 PM, the Director of Nursing stated they did not know why education was not completed for Activities of Daily Living Care for Dependent Residents per the Plan of Correction to Licensed Nurses and Certified Nursing Aides . They stated it should have been completed last week while they were out. They stated the education should have been completed on or prior to 06/22/2026 because it was their timeline. Additionally, the Director of Nursing stated the Administrator was not available to be interviewed. During an interview on 06/25/2026 at 1:51 PM, the [NAME] President of Skilled Nursing Operations stated the in-service education sign off sheets contained per diem and terminated staff, and those inaccuracies could have added to part of the problem. They stated the education sign off sheets needed to accurately reflect current staff so they could see who had been educated. The [NAME] President of Skilled Nursing Operations further stated staff that worked on the third shift should have been educated either by supervisory staff coming in early or supervisory staff on the night shift. The [NAME] President of Skilled Nursing Operations stated they did not know who educated third shift staff, but it would most likely not be assigned to an hourly employee who does not work that shift, like the Administrative Assistant, it would have been supervisory staff. Additionally, the [NAME] President of Skilled Nursing Operations stated the person assigned as responsible for completion of the corrective action should have reviewed the in-service education sign off sheets and verified accuracy. The [NAME] President of Skilled Nursing Operations stated they did not know why the Plan of Correction was not completed and stated it should have been on or prior to 06/22/2026 because that was the facility's completion date. They stated they needed to complete what they said they were going to do in the Plan of Correction. 10NYCRR 415.27(c)(3)(iv)(v)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on observations, interviews, and record reviews conducted during the survey, the facility failed to ensure residents were free from physical restraints imposed for purposes of discipline or convenience that were not required to treat the resident's medical symptoms, used for the least amount of time and document ongoing re-evaluation of the need for restraints for one (1) (Resident #104) of one (1) resident reviewed for physical restraints. Specifically, there were no evaluations completed to determine if Resident #104's lap tray and seat belt devices were restraints or re-evaluations to assess their continued need, staff did not release the seat belt or lap tray devices for over five (5) hours, and there were no provider orders to release the devices. The findings include: The facility policy and procedure titled Restraints and Safety Devices dated 10/07/2014 documented the objective of the policy was to maintain dignity of the resident at all times and promote greater functional independence. The policy documented that residents shall not be restrained unnecessarily or for convenience of staff. When a safety device is necessary, the least possible restrictive device shall be used. The nurse's responsibility was to consult with the physical therapist and the resident's physician prior to application of the safety device and choose the least restrictive device possible. The policy documented the physician must order the least restrictive safety device, document the specific reason for use of the device and designate the length of time the device was to be used. A treatment plan needed to be immediately developed and include removal of device to ensure exercise, ambulation and/or range of motion and change of position every two hours. Resident #104 had diagnoses that included seizures, intellectual disabilities and legal blindness. The Minimum Data Set (a resident assessment tool) dated 02/11/2026 documented Resident #104 had severe cognitive impairment, sometimes understood and rarely/never understands. The assessment tool documented Resident #104 was dependent on all activities of daily living. The comprehensive care plan dated 04/22/2026 documented Resident #104 had impaired functional status and was a dependent two assist with a full lift and full body sling to transfer to/from the bed. They used a custom tilt wheelchair that had a seat belt and padded lap tray to facilitate neutral alignment of their pelvis, trunk and head. Staff were to assist the resident back to bed if they showed signs and symptoms of discomfort. The Resident ADL/Daily Care List (a guide used by staff on how to provide care) dated 09/02/2025 documented Resident #104 was a dependent two assist with a full lift and full body sling to transfer to/from the bed; they used a custom tilt wheelchair that had a seat belt and padded lap tray to facilitate neutral alignment of their pelvis, trunk and head. Staff were to assist back to bed if showing signs and symptoms of discomfort. The care guide did not instruct to remove or release the seat belt and lap tray every two hours. The Physician's Orders dated 04/30/2026 documented an order dated 02/05/2026 for Resident #104 to use a wheelchair with chest support, a seat belt and a lap tray to facilitate neutral alignment of their pelvis, trunk (torso), and head. Staff assistance was required for the medical equipment and there was no order to release the seat belt and lap tray. The Medication Administration Records and Treatment Administration Records dated 04/2026 lacked documented evidence that the seatbelt and lap tray were released. Review of the interdisciplinary notes dated 09/02/2025 through 04/30/2026 lacked documented evidence that the restraint was released every two hours. The following was documented:- On 09/03/2025, an occupational therapy evaluation documented Resident #104's durable medical equipment/positioning was a custom tilt-in-space wheelchair from the group home. Wheelchair had a chest support, seat belt and padded lap tray to facilitate neutral alignment of pelvis, trunk and head. If patient shows signs of discomfort, please assist back to bed. -On 11/13/2025, an occupational therapy screen was completed and documented Resident #104's durable medical equipment/positioning was a custom tilt-in-space wheelchair from the group home. Wheelchair had a chest support, seat belt and padded lap tray to facilitate neutral alignment of pelvis, trunk and head. If patient shows signs of discomfort, please (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assist back to bed. There was no determination if the seat belt or padded lap tray were restraints. Review of the Occupational Therapy Evaluations and treatment notes dated 09/03/2025 through 10/02/2025 lacked documented evidence of an assessment for the use of a restraint. Review of the Physical Therapy Evaluations and treatment notes dated 09/03/2025 through 10/02/2025 lacked documented evidence of an assessment for the use of a restraint. During an observation on 04/26/2026 at 12:11 PM, Resident #104 was observed in the dining room in a tilt in space wheelchair (a wheelchair that can be reclined backward in a sitting position) with a padded lap tray in front of them. The lap tray attached to both arms of the wheelchair crossing in front of the resident's upper abdomen/lower chest area. During an observation on 04/27/2026 at 9:22 AM, Resident #104 was observed to be in the dining room, in their wheelchair with the padded lap tray attached to the arm rests. Resident #104 was observed to rest their head on the lap tray. During a continuous observation of Resident #104 on 04/28/2026 from 8:18 AM-2:00 PM the following was observed:-at 8:18 AM, Resident #104 was observed in their wheelchair next to a table in the dining room. Resident #104 was sitting upright and was wearing clean clothing. A padded lap tray was observed to be attached to both arms of the wheelchair and crossing in front of the resident's upper abdomen/lower chest area. There was also a seat belt buckled across the resident's thighs.-at 8:34 AM, Certified Nurse Aide #2 sat next to Resident #104 and started assisting them with their breakfast tray until 8:49 AM with the lap tray and seat belt remaining in place.-at 11:04 AM, Registered Nurse #1 wheeled Resident #104 out of the dining room to the scale and returned the resident back next to the table in the dining room within a few minutes. The lap tray and the seatbelt remained in place.-at 12:25 PM, Licensed Practical Nurse #1 sat next to Resident #104 and began assisting the resident with their lunch meal with the lap tray and seat belt remaining in place.-at 2:00 PM, the continuous observation was completed. Resident #104 was observed not to have the lap tray or seat belt released. Resident #104 was observed to move their upper body forward and backward throughout the observation; would place their head on the lap tray at times; and lean forward hugging a stuffed avocado on top of the lap tray. During an interview on 04/28/2026 at 3:02 PM, Certified Nurse Aide #1 stated they were responsible for Resident's #104 care for the day. They stated they got Resident #104 washed, dressed and into their wheelchair at 8:06 AM and had not provided any further care for the resident since then. Certified Nurse Aide #1 stated Resident #104 utilized a seat belt and lap tray when they were in their wheelchair and the resident came into the facility with those devices. Certified Nurse Aide #1 stated Resident #104 did not walk but they have seen the resident try to stand from their bed. During an interview on 04/28/2026 at 3:11 PM, Licensed Practical Nurse #1 stated Resident #104 wore a seat belt and utilized a padded lap tray while they were up in their wheelchair. They stated they did not know why Resident #104 utilized the seat belt and lap tray, but they used both since admission to the facility. Licensed Practical Nurse #1 stated Resident #104 previously lived in resource style housing and they utilized the devices there. They stated the resource style housing regulations were different and they asked the Director of Nursing about them when Resident #104 was admitted . Licensed Practical Nurse #1 stated they were not releasing the devices every two hours nor were they ever instructed to do so. During an observation and interview on 04/29/2026 at 2:52 PM, the Assistant Director of Therapy was brought to the dining room where Resident #104 was sitting in their wheelchair. Resident #104 had a seat belt that was attached to their wheelchair that was buckled closed, and the strap was across their thighs. The padded lap tray was attached to both arm rests. The Assistant Director of Therapy stated that Resident #104 could not remove those devices on command because they were deaf and blind. The Assistant Director of Therapy stated the purpose of Resident's #104 seat belt was to keep the buttocks to the back of the chair and prevent the resident from sliding out of the chair and it might be considered a restraint. The stated the purpose of Resident's #104's padded lap tray was to keep the resident in an upright position as the resident tended to roll into a hunched position and could tumble out of the chair if it was not in place. The Assistant Director of Therapy stated they had never done a restraint assessment and there was (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nothing put into place to ensure the devices were removed every two hours. They stated staff would only remove the devices prior to transfers. The Assistant Director of Therapy stated they attempt to do a skin check weekly on Resident #104 when time allows to make sure there was no rubbing with the lap tray or seatbelt. They stated all their documentation would be in the electronic medical record. During an interview on 04/29/2026 at 4:34 PM, Certified Nurse Aide #3 stated Resident #104 utilized a lap tray and a seat belt while in the wheelchair. They stated they are not sure why Resident #104 used the devices they are assuming the resident came to the facility with the devices. Certified Nurse Aide #3 stated Resident #104 did not walk or did not stand but they had seen the resident scoot across their bedroom floor into the hallway. Certified Nurse Aide #3 stated they believed Resident #104 would fall from their wheelchair if their lap tray was not in place and that Resident #104 was smart and could find a way to get out of their wheelchair. During a telephone interview on 04/30/2026 at 9:35 AM, Registered Nurse #1 Unit Manager stated that Resident #104 was a mechanical lift, if the resident was to stand it would be spontaneous self-positioning and the resident tended to do fast forward movements while they were in their wheelchair. Registered Nurse #1 stated they were aware Resident #104 utilized a padded lap tray and just found out they utilized a seat belt also. They stated the seat belt was utilized in the group home Resident #104 previously resided in as a safety measure to hold the resident in their chair from their spontaneous movements and from standing. Registered Nurse #1 stated that the lap tray was utilized as a sense of comfort for Resident #104 as they had sensory issues. They stated Resident #104 cannot self-release the seat belt or the lap tray and they did not think staff knew they had to release those devices every two hours. Registered Nurse #1 stated they did not feel Resident #104 needed both devices. During an interview on 04/30/2026 at 11:17 AM, the Director of Rehabilitation stated when Resident #104 was admitted to the facility, therapy would attempt to stand the resident. Resident #104 could bear some weight but needed a maximal assist of two for standing and could not follow any commands. The Director of Rehabilitation stated Resident #104 came from their group home with the tilt in space wheelchair, lap tray and seat belt. They stated that in a way those items were restricting Resident #104's movements. The Director of Rehabilitation stated Resident #104's lap tray was to help the residents positioning and the seat belt was to keep the resident in their chair. The Director of Rehabilitation stated Resident #104 did not have any restraint screens completed and that therapy did not do any restraint screening. During a telephone interview on 04/30/2026 at 1:19 PM, the Medical Director stated they were familiar with Resident #104, and they see the resident at least once a month. They stated that they were not sure if Resident #104 utilized a lap tray and seat belt, but if those items were utilized all the time, then it would be considered a restraint. The Medical Director stated Resident #104 should have had a restraint assessment completed. They stated they would expect the facility to follow the facility's policy for restraints. During an interview on 04/30/2026 at 1:51 PM, the Director of Nursing stated they could not locate any restraint evaluations for Resident #104 in the electronic medical record. They stated all they could locate was the occupational evaluation dated 09/30/2025. The Director of Nursing stated they were aware Resident #104 utilized a lap tray but was unaware they also utilized a seat belt until this week. They stated they believed the seat belt was used for positioning and they could not say if the seat belt was restricting the resident's movement because they just found out about it. The Director of Nursing stated they did not feel the lap tray was restricting the resident's movement because it was utilized for comfort and positioning due to the resident's contractures. The Director of Nursing stated that any restraints needed a medical provider order but was not sure if the facility's policy was that any restraints needed to be released in a specific time frame. 10 New York Codes, Rules, and Regulations (NYCRR) 415.4(a)(2)(iii)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews conducted during survey, the facility failed to ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good grooming and personal hygiene for two (2) (Resident #43 and #104) of eight (8) residents reviewed for activities of daily living (ADLs). Specifically, Residents #43 and #104 were not provided with timely incontinence care. The findings include: The facility policy and procedure titled Care of Incontinent Resident dated 10/07/2014 documented that providing incontinent care was to keep a resident with problems of involuntary elimination, clean and dry to promote cleanliness, comfort and to prevent skin issues. An incontinent resident in bed should be checked and change incontinence product as per care plan The facility policy and procedure titled Activities of Daily Living dated 01/14/2015 documented the nursing staff will assist the resident with any of the activities that they were unable to perform. 1. Resident #43 had diagnoses including dementia, hypertension (high blood pressure), and chronic kidney disease. The Minimum Data Set (a resident assessment tool) dated 02/11/2026 documented Resident #43 had severe cognitive impairment, understands and usually was usually understood by others. The resident assessment also documented Resident #43 was always incontinent of bladder/bowel and was dependent for toileting transfers and toileting hygiene. The comprehensive care plan dated 03/23/2026 documented Resident #43 had an impaired functional status, was dependent on two staff members assist with a full lift and full body sling to transfer to/from the bed; dependent on one staff member assist for toileting tasks completed via check and change; and to encourage toileting /incontinent care every two (2) to four (4) hours and as needed. The care plan documented Resident #43 had urinary incontinence. The Resident ADL/Daily Care List (guide used by staff to provide care) dated 07/21/2025 documented Resident #43 was a dependent two assist with a full lift and full body sling to transfer to/from the bed; a dependent one assist for toileting tasks completed via check and change; and to encourage toileting /incontinent care every two (2) to four (4) hours and as needed. The care plan documented Resident #43 had urinary incontinence. A continuous observation of Resident #43 on 04/28/2026 from 8:18 AM to 2:00 PM revealed the following: -at 8:18 AM, Resident #43 was seated in a Geri chair (a chair that reclines into a laying position and has wheels) next to a table in the dining room. Resident #43 was wearing clean day clothing, slippers and had blanket covering them.-at 8:24 AM Resident #43 had their breakfast tray on the table in front of them-at 8:47 AM Registered Nurse #1 sat next to Resident #43 and started assisting Resident #43 with their breakfast meal. At 8:49 AM Certified Nurse Aide #2 replaced Registered Nurse #1 to finish assisting Resident #43 with their breakfast. -at 12:02 PM Resident #43's family member was in the facility and was visiting with the resident who had remained in the dining rom. -at 12:20 PM Resident #43 was served their lunch tray. Certified Nurse #1 and Registered Nurse #1 boosted Resident #43 in the Geri chair and placed the resident in an upright position. Resident #43's family member assisted the resident with their lunch meal. -at 12:55 PM Resident #43 completed their lunch meal and the resident's family member then pushed the resident into their room.-at 2:00 PM the continuous observation was completed. Resident #43 was not removed from the dining room and/or provided with any additional care during this time, including toileting or checking for incontinence. During an interview on 04/28/2026 at 1:48 PM, Certified Nurse Aide #1 stated they started their shift at 7:00 AM and they finish work at 3:00 PM. They stated they got Resident #43 washed, dressed and out of bed at 7:40 AM. They stated Resident #43 was incontinent and they resident should be checked and changed every two (2) hours. Certified Nurse Aide #1 stated they had not provided any incontinent care for Resident #43 since they were gotten out of bed because there were other residents they had to get up and did not check on. Certified Nurse Aide #1 stated they were working with only one other aide, and it was not possible to provided incontinent care to all their assigned residents every two (2) hours. They stated they usually can only provide (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	incontinent care once a shift, sometimes twice, when there were only two aides on the unit. During a care observation on 04/28/2026 at 2:35 PM, Resident #43 was placed into bed via a mechanical lift by Registered Nurse #1 and Certified Nurse Aide #1. When Resident #43's brief was unfasted the brief was visibly wet with urine and soiled with feces (bowel). 2. Resident #104 had diagnoses that included seizures, intellectual disabilities and legal blindness. The Minimum Data Set, dated [DATE] documented Resident #104 had severe cognitive impairment, sometimes understood and rarely/never understands. The resident assessment tool documented Resident #104 was always incontinent with bladder and bowel and was dependent on all activities of daily living. The comprehensive care plan dated 04/22/2026 documented Resident #104 had impaired functional status and was dependent on two staff members assist with a full transfer lift for to/from bed for check and change; dependent for peri-care and clothing management; and to encourage toileting/incontinent care every two (2) to four (4) hours and as needed. The care plan documented Resident #104 had urinary incontinence. The Resident ADL/Daily Care List dated 09/02/2025 documented Resident #104 was dependent on two staff members assist with a full transfer lift for to/from bed for check and change; dependent for peri-care and clothing management; and to encourage toileting /incontinent care every two (2) to four (4) hours and as needed. The care plan documented Resident #104 had urinary incontinence. A continuous observation of Resident #104 on 04/28/2026 from 8:18 AM to 2:00 PM revealed the following: -at 8:18 AM, Resident #104 was seated in a tilt in space wheelchair (a wheelchair that can be reclined backward in a sitting position) next to a table in the dining room. Resident #104 was sitting upright and was wearing clean day clothing.-at 8:24 AM Resident #104 had their breakfast tray on the table in front of them-at 8:34 AM Certified Nurse Aide #2 sat next to Resident #104 and started assisting them with their breakfast tray until 8:49 AM.-at 11:04 AM Registered Nurse Unit Manager #1 wheeled Resident #104 out of the dining room to the scale and returned the resident back next to the table in the dining room within a few minutes. -at 12:20 PM Resident #104's lunch tray was placed in front of them on the table. -at 12:25 PM Licensed Practical Nurse #1 sat next to Resident #104 and began assisting the resident with their lunch meal. -at 2:00 PM the continuous observation was completed. Resident #104 was not provided with any additional care during the observation including toileting and/or checking for incontinence. During a further interview on 04/28/2026 at 3:02 PM, Certified Nurse Aide #1 stated they were also responsible for Resident's #104 care for the day. They stated they got Resident #104 washed, dressed and into their wheelchair at 8:06 AM. Certified Nurse Aide #1 stated they had not provided any further incontinent care for Resident #104 after getting them out of bed. They stated Resident #104 was an incontinent resident and should have been toileted every two (2) hours. They stated they could not provide the care due to staffing. Certified Nurse Aide #1 stated that if they could not get to a resident prior to the end of their shift they would notify the oncoming shift to make sure the oncoming shift made that resident a priority. Certified Nurse Aide #1 stated the importance of timely incontinent care, so the residents did not get any sores or skin breakdown. Additionally, it was a resident right to use the bathroom in a timely manner. During a care observation on 04/28/2026 at 3:37 PM, Resident #104 was placed into bed via a mechanical lift and incontinent care was provided by Certified Nurse Aide #3 and Certified Nurse Aide #4. As Resident #104 was being lifted out of their wheelchair a strong odor of urine was noted and when Resident 104's brief was unfasted the brief was visibly wet. During an interview on 04/28/2026 at 3:11 PM, Licensed Practical Nurse #1 stated an incontinent residents should be toileted every two (2) to four (4) hours. They stated that Resident #43 and Resident #104 were both incontinent and Resident #43's family preferred the resident to be back into bed after lunch daily. Licensed Practical Nurse #1 stated Resident #43 not having incontinent care provided until from 7:40 AM - 2:30 PM and Resident #104 not having incontinent care provided to them from 8:05 AM to the end of the day shift was not appropriate and it was due to staffing. During an interview on 04/28/2026 at 3:17 PM, Registered Nurse Unit Manager #1 reviewed Resident #43's care plan and stated the resident was incontinent and they were to be toileted every two (2) to four (4) hours and as needed. They stated it was also the same for (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335142	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Park Rehab & Skilled Nursing	150 Prather Avenue Jamestown, NY 14701

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #104. Registered Nurse #1 stated Certified Nurse Aide #1 did tell them they could not provide incontinent care to Resident #43 until 2:30 PM but they were not told that Resident #104 was not provide care since that morning. Registered Nurse #1 stated the outgoing shift were to do a unit walk through with the oncoming shift so it was communicated which residents the outgoing staff could not provide care to timely. Registered Nurse #1 stated the care was not completed timely due to staffing concerns on the unit and both residents should have been checked and changed sooner as standards of care were to provide toileting to a resident every two (2) to four (4) hours. During an interview on 04/30/2026 at 1:51 PM, the Director of Nursing stated their expectation for toileting an incontinent resident would be every two (2) to three (3) hours. They stated they were familiar with Resident #43 and Resident #104 and both residents were incontinent. The Director of Nursing stated they were unsure why Resident #43 and Resident #104 went so many hours without incontinent care on 4/28/2026 but five (5) to seven (7) hours was untimely and not appropriate. The Director of Nursing stated the floor was staffed at bare minimum on 04/28/2026 and that could have contributed to the untimely care. The Director of Nursing stated that timely incontinent care was important for a resident's dignity, skin integrity and the residents plan of care was not followed. 10 New York Codes, Rules, and Regulations (NYCRR) 415.12(a)(3)