STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335164	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Humboldt House Rehabilitation and Nursing Center	64 Hager Street Buffalo, NY 14208

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33313 Based on interview and record review conducted during a Complaint (#NY00363866) investigation, the facility did not ensure that residents receive treatment and care in accordance with professional standards of practice for one (Resident #1) of three residents reviewed for quality of care. Specifically, there was no skin assessment completed for a resident readmitted to the facility with multiple pressure and vascular ulcers (develop due to poor circulation) that included measurements, description of the ulcers, and staging (pressure); this resulted in a delay in obtaining physician orders and treatment initiation. The finding is: The undated policy titled Pressure Ulcers/Skin Breakdown - Clinical Protocol documented the staff will examine the skin of a new admission for ulcerations or alterations in skin. The nurse shall describe and document/report the following: full assessment of pressure sore including location, stage, length, width and depth, presence of exudates (drainage) or necrotic (dead) tissue. The physician will authorize pertinent orders related to wound treatments, including wound cleansing and debridement (removal of dead tissue and/or foreign matter in the wound) approaches, dressings, and application of topical agents if indicated for the type of skin alteration. Resident #1 was readmitted to the facility with diagnoses that included peripheral vascular disease (PVD, poor circulation of the lower extremities), congestive heart failure, and protein calorie malnutrition (overall lack of nutrition). The Minimum Data Set (MDS, resident assessment tool) dated 11/13/24 documented Resident #1 was cognitively intact and had one Stage 3 (full thickness tissue loss) pressure ulcer was present upon admission. Additionally, documented were three unstageable (known but not stageable due to coverage of wound bed by slough and/or eschar - black or brown dead tissue) pressure ulcers and two venous and arterial ulcers. The hospital discharge summary, signed and dated 11/6/24, documented vascular ulcers in lower extremities bilaterally, unstageable heel ulcers, sacral (area above the tail bone on right and left buttocks) ulcer, and ischial (lower part of hip bone) ulcer. The unsigned Clinical Admission assessment dated [DATE] documented a right shin venous ulcer and a right heel pressure ulcer. The assessment did not include measurements, description of the ulcers, staging (pressure) and was not signed as complete. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Order Summary Report Active Orders as of: 11/6/24 did not include any treatments for the pressure or venous ulcers. The electronic medical record documented Registered Nurse Assistant Director of Nursing completed Resident #1's skin assessment which documented measurements, type of wounds, exudate, and staging as necessary for the following wounds on 11/8/24: right heel, left heel, sacrum, left rear thigh, right shin, and left shin. The Treatment Administration Record documented physician orders were obtained on 11/8/24 for treatments to Resident #1's right heel pressure ulcer, left heel pressure ulcer, sacral pressure ulcer, left rear thigh pressure ulcer, right shin venous ulcer, and left shin venous ulcer. The treatments were initiated on 11/9/24. The Comprehensive Care Plan did not address goals and/or interventions related to pressure ulcer and venous ulcer treatment and care. During an interview on 12/16/24 at 11:54 AM, the Registered Nurse Assistant Director of Nursing stated they were responsible to complete skin rounds on all residents that have alterations in their skin integrity weekly. The Assistant Director of Nursing stated the first time they assessed Resident #1's pressure and venous ulcers was 11/8/24. Additionally, they stated alterations in skin integrity should probably be assessed by a Registered Nurse within 24 hours of admission or readmission. The assessment should include type of wound, location, and ideally measurements, but the wounds would eventually get measured. The Assistant Director of Nursing stated treatments should be started immediately after identification of alterations in skin integrity. During an interview on 12/16/24 at 12:14 PM, the Director of Nursing stated skin integrity should be assessed by a Registered Nurse upon admission/readmission to the facility. The Registered Nurse should have completed a head-to-toe assessment of the skin. Ulcer/wound assessments would include measurements, description of wound, surrounding tissues, drainage, and the type of wound. Treatments should be initiated as soon as a wound was identified. During an interview on 12/16/24 at 12:17 PM, the Administrator stated upon admission/readmission a Registered Nurse should assess the residents skin integrity and document size, type of wound, obtain a physician order for treatment, and initiate treatments. During a telephone interview on 12/16/24 at 1:10 PM, the Nurse Practitioner stated treatments should be initiated immediately after the identification of alterations in skin integrity. 10 NYCRR 415.12