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	04/04/2025

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. 48624 Based on observation, record review and interviews during a complaint investigation (#NY00356620) the facility did not ensure that all residents receive treatment and care in accordance with professional standards of practice for the comprehensive care plans for one (1) (Resident #2) of three (3) residents reviewed. Specifically, treatments to the resident's bilateral lower extremity venous (relating to the vein) ulcers were not being completed as ordered by the physician. The finding is: The policy and procedure titled Pressure Ulcers/ Skin Breakdown- Clinical Protocol with a revision date of March 2014 documented the physician will authorize pertinent orders related to wound treatments, including wound cleansing and debridement approaches, dressings, and application of topical agents if indicated for type of skin alteration. The policy and procedure titled Medication and Treatment Orders with a revision date July 2016 documented orders for medications and treatments will be consistent with principles of safe and effective order writing. Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications. The policy and procedure titled Charting and Documentation with a revision date of July 2017 documented the following information is to be documented in the resident medical record: objective observations, medications administered, treatments or services performed. Documentation of procedures and treatments will include care specific details, including the date and time the treatment was provided, the name and title of the individual who provided the care, the assessment data and or any unusual findings obtained during the treatment, whether the resident refused the procedure/treatment; notification of family, physician or other staff, if indicated and the signature and title of the individual documenting. Resident #2 had diagnoses that included chronic venous hypertension with ulcer (high blood pressure of the leg veins causing poor blood flow and open wounds/ulcers) of bilateral lower extremity, lymphedema (chronic condition where fluid accumulates in the tissues causing swelling), and chronic kidney disease. The Minimum Data Set (a resident assessment tool) dated 3/19/25 documented that Resident #2 was cognitively intact, was understood and understands. Additionally, the Minimum Data Set documented the resident had two venous ulcers and no behavior symptoms or rejection of care. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The comprehensive care plan last revised on 2/17/25 documented Resident #2 had actual vascular wounds to both lower extremities. Interventions included (but not limited to) to administer treatments as ordered and monitor for effectiveness; if resident refuses treatment, confer with the resident, interdisciplinary team, and family to determine why and try alternative methods to gain compliance, document alternative methods; follow facility policies/protocols for the preventions/treatment of skin breakdown. There was no documented evidence within the care plan to show Resident #2 refused care/treatments. The physician's order dated 2/26/25 documented to cleanse opens areas with normal saline, pat dry and apply Medi honey wound/burn dressing external gel to bilateral lower extremity wounds topically every evening shift (3:00 PM - 11:00 PM) for wound healing. During an observation on 4/2/25 at 12:59 PM and 4/3/25 at 8:55 AM, Resident #2 was observed lying in bed with both legs elevated on a pillow. There were no dressings noted to Resident #2's left shin venous ulcer. The ulcer was red and open with no visible drainage noted to the ulcer. However, there was a small amount of dried yellow drainage noted on the pillow under their left leg. Resident #2's right lower extremity was partially covered with a towel, there were no visible dressings or wraps. A small amount of dried yellow drainage was noted on the top of the towel. Additionally, Resident #2 had multiple thick raised scabbed areas present to both lower extremities that appeared dried and intact. During an interview on 4/2/25 at 12:59 PM, Resident #2 stated that they had ulcers on their legs, and they should be wrapped. They stated their treatment was not consistently completed daily and felt their wounds had not improved. Additionally, Resident #2 stated their treatment was not completed yesterday on 4/1/25 and currently had no bandages on their legs. Review of the Treatment Administration Records from 3/1/25 - 4/2/25 revealed there was no evidence the treatments to the resident's bilateral lower extremities were completed as ordered by the physician on 3/2/25, 3/5/25, 3/6/25, 3/8/25, 3/14/25, 3/17/25, 3/18/25, 3/20/25, 3/23/25, and 4/1/25. Review of the weekly Skin and Wound Evaluation assessments completed from 3/5/25 - 3/26/25 documented the progress of Resident #2's right medial (toward the middle or center) shin venous ulcer had showed deterioration of the wound on 3/5/25, 3/12/25, and 3/26/25. Review of the weekly Skin and Wound Evaluation assessments completed from 3/5/25 - 3/26/25 documented the progress of Resident #2's left medial shin venous ulcer had showed deterioration of the wound on 3/12/25 and 3/26/25. Review of the Nursing Progress and Medication Administration Notes from 3/1/25 - 4/1/25 revealed there was no evidence that ulcer care had been provided or refused by Resident #2 on 3/2/25, 3/5/25, 3/6/25, 3/8/25, 3/14/25, 3/17/25, 3/18/25, 3/20/25, 3/23/25, and 4/1/25. Review of the 24-hour nursing reports revealed there was no evidence Resident #2 refused their treatments or the treatments were completed as ordered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation of wound care on 4/4/25 at 10:30 AM, Resident #2's left lower extremity was noted to have an adhesive 4x4 foam dressing dated 4/3/25 on the top of their left shin and above their left ankle. Resident #2's right lower extremity was noted to have an adhesive 4x4 foam dressing dated 4/3/25 to their right shin and an undated gauze dressing was present to their right foot. Licensed Practical Nurse #2 and the Assistant Director of Nursing removed the old dressings revealing there were two open wounds on each extremity with a moderate amount of purulent (containing pus) drainage noted from all sites. During the observation, the Assistant Director of Nursing stated that Resident #2's wounds were chronic and would frequently open and close, they stated their wounds appeared to be stable. During an interview on 4/4/25 at 10:45 AM, Licensed Practical Nurse #2 stated they had removed the foam dressings to Resident #2's lower extremities, cleansed the open wounds with normal saline, applied Medi honey, dry clean dressing and had wrapped both legs with kerlix. They stated the physician ordered treatment did not include the use of foam dressing. Licensed Practical Nurse #2 stated Resident #2's wounds had small to moderate amount of purulent drainage present and should be wrapped daily to prevent infection. Licensed Practical Nurse #2 stated they would sign that the treatment was completed on the treatment administration record. They stated Resident #2 did not refuse to have their wound care treatments completed and that any refusals should be documented on the treatment administration record and a progress note written in the medical record. During an interview on 4/4/25 at 12:30 PM, Registered Nurse Unit Manager #1 stated they expected nurses to complete and document treatments were done on the Treatment Administration Record. They stated if a physician ordered a treatment and was not completed, or the resident refused their treatment it should be documented in the medical record with a reason provided. Registered Nurse Unit Manager #1 pulled up and reviewed Resident #2's Treatment Administration Record for March 2025 and April 2025, stating the blanks on the treatment administration record would indicate their treatment had not been completed. Registered Nurse Unit Manager #1 stated they were unaware Resident #2's treatments were not being completed as ordered. They stated Resident #2 was alert and oriented and was able to communicate whether their treatment had been completed or not. During an interview on 4/4/25 at 12:55 PM, the Assistant Director of Nursing stated during wound care today Resident #2 was found to have adhesive foam dressings on their wounds. They stated they would not consider this to be wrong but was not the preferred treatment because the adhesive dressing may cause skin irritation. The Assistant Director of Nursing stated they expected nurses to follow the physician orders and complete treatments as ordered. They stated if there was an improvement or decline in the wound it should be documented in the medical record and the nurses should update them or their Unit Manager so the wound can be reassessed. Additionally, they stated nurses should document on the Treatment Administration Record whether the treatments were administered or refused, and a blank box on the Treatment Administration Record indicated the treatment was not signed off or was not completed. During an interview on 4/4/25 at 2:04 PM, the Acting Director of Nursing stated they expected physician orders to be followed, and treatments were to be administered as ordered. They stated nurses were responsible to complete and sign off their treatments on the Treatment Administration Record and would expect them to document resident refusals in the medical record. The Acting Director of Nursing stated the expectation was no omissions on medication or treatment administration records, they stated omissions indicated the treatment was not completed as ordered. (continued on next page)

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