STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335164	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. 43802 Based on interview and record review conducted during an Extended survey completed on 5/23/24, the facility did not ensure that each resident had the right to participate in the development and implementation of their person-centered care plan and facilitate the inclusion of the resident for one (Resident #134) of four residents reviewed. Specifically, Resident #134 was not informed, in advance to participate in their scheduled care plan meeting. The finding is: The policy and procedure titled Resident Participation - Assessment/ Care Plans dated February 2021, documented the resident has the right to participate in the development and implementation of their plan of care. The facility staff supports and encourages resident to participate in the care planning process by providing sufficient notice in advance of the meeting; and planning for enough time for exchange of information and decision making. The Social Services Director or designee was responsible for notifying the resident and for maintaining records of such notices. Resident #134 had diagnoses that included benign intracranial hypertension (that causes increased pressure in the skull), chronic pain syndrome and migraine headache. The Minimum Data Set (a resident assessment tool) dated 11/3/2023 documented Resident #134 was cognitively intact, was always understood and understands. Resident #134 comprehensive care plan dated 12/2/23 documented the resident was in the facility for short acute rehabilitation with the goal of returning home. The plan of care documented Resident #134 will be able to communicate required assistance post-discharge and the services required to meet needs before discharge. The facility staff interventions were to encourage resident to discuss feelings and concerns with impending discharge. Review of the Family Planning Meeting dated 11/14/23 revealed the resident would need four weeks of therapy. Family was very supportive and willing to assist as needed. Spoke at length regarding transition to handicap accessible apartment. Patient and family were currently in the process of applying to an apartment complex suitable for patient's needs. No discharge date had been set at this time. Recommendation was to follow up in four weeks to assess patient's progress. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335164	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/15/23 at 9:33 AM, Resident #134 stated that Social Worker #3 did not inform them or invite them to the follow up care plan meeting that was scheduled on 12/15/23. The resident stated their family attended. Resident #134 stated they were upset because they were looking forward to that meeting as they were very excited to be able to show their family the significant progress they had made. During an interview on 5/17/24 PM at 3:40 PM, Social Worker #3 stated the family members of Resident #134 attended the family planning meeting on 12/15/23, and that Resident #134 was not informed of the meeting. Social Worker #3 stated the meeting discussed the residents discharge plans and the resident should have been there. It was their responsibility of informing the residents of time, location, and date of the family planning meetings. Social Worker #3 was unable to provide a template that they utilized for communication to each unit nursing supervisor, or any records they maintained providing the date of contact, the method of contact, input from the resident or resident representatives' attendance, or signature of the individual who contacted attendees. During an interview on 5/17/24 at 3:48 PM, Licensed Practical Nurse Supervisor #1 stated they do recall Resident #134 being very upset they were not informed of the family planning meeting. During an interview on 5/21/24 at 9:31 AM, Nurse Practitioner #1 stated they were aware the 12/15/23 meeting was especially important to Resident #134, and they should have been informed of the meeting. The Resident was upset that Social Worker #3 failed to contact them. NYCCR 10 415.3 (f)(1)(v)

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F 0557

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.

43802

Based on observation, interview, and record review conducted during an Extended Recertification and Compliant (#NY00332285, #NY00329276) survey completed on 5/23/24, the facility did not ensure that each residents had the right to be treated with respect and dignity for three (Resident #1, #101 and #134) of six residents. Specifically, a resident was treated disrespectfully and without dignity when a staff member acted in an unprofessional and undignified manner (#134). In addition, a multi stall bathroom was shared by both male and female residents on the dementia unit without privacy door and/or curtains (#1 and #101).

The findings are:

The policy and procedure titled Dignity dated 2/21 documented each resident shall be cared for in a manner that promotes their sense of well-being, and feelings of self-esteem. The residents are always to be treated with dignity and respect.

1. Resident #134 had diagnoses that included benign intracranial hypertension (increased pressure in the skull), chronic pain syndrome, and migraine headaches. The Minimum Data Set (a resident assessment tool) dated 11/3/2023, documented Resident #134 was cognitively intact, understands and was understood.

The comprehensive care plan dated 10/31/23 documented Resident #134 was to receive care in a calm and reassuring manner related to their impaired coping. Skills. Resident #134 was care planned to be called by their preferred name. Resident #134 had chronic pain related to severe headaches and lower back pain and staff were to respond immediately to any complaints of pain.

Review of an alleged abuse incident report completed by Registered Nurse #3 dated 12/2/23 revealed that Resident #134 was upset they had received their pain medications late. Licensed Practical Nurse #6 allegedly called Resident #134 an inappropriate name that caused Resident #134 to become upset and cry. Education provided to staff on customer service, communication and time management.

During an interview on 5/13/24 at 11:32 AM, Resident #134 stated Licensed Practical Nurse #6 called them an inappropriate name, was rude and disrespectful. Licensed Practical Nurse #6 was late in passing their medications to them; banged on their door, slammed down the medication on the tray table; used profanity they felt was directed at them; slammed the door, and left the room. The resident stated they were upset and had reported it to the nursing supervisor.

During an interview on 5/20/24 at 4:17 PM, Director of Nursing #1 stated Resident #134 had their personal phone number. Resident #134 had called them and had the phone on speaker so they could hear how Licensed Practical Nurse #6 was acting on 12/2/23. Director of Nursing #1 stated that Licensed Practical Nurse #6 was not customer service appropriate with the resident, but they did not hear any swearing.

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 5/20/24 at 4:32 PM, Licensed Practical Nurse #6 stated they did not call Resident #134 any inappropriate names. Licensed Practical Nurse #6 stated they were on their air pods, and they were speaking to someone on the phone. The conversation was not directed at the resident. During an interview on 5/21/24 at 9:54 AM, Registered Nurse #3 they stated they were working the night of the incident on 12/2/23. They stated they heard Licensed Practical Nurse #6 using inappropriate language and behaving unprofessionally. They stated Licensed Practical Nurse #6 stated to the resident, you are going to get your medications when I tell you, then left the room and slammed the door. Resident #134 was upset and Registered Nurse #3 reported what they had witnessed. During an interview on 5/21/24 at 10:06 AM, Certified Nursing Aide #9 stated Licensed Practicable Nurse #6 came to the resident's room, used profanity and slammed the medications on the tray table. 2. During an observation on 5/16/24 at 3:42 PM to 3:50 PM of the fourth-floor corridor shared resident bathroom revealed it was equipped with three toilet stalls. Each toilet was separated by a partition with no stall doors or privacy curtains. During an observation on 5/16/24 at 3:55 PM, Resident #101 was observed to independently walk into the shared resident bathroom of the north hall on the fourth floor. At 4:01 PM Resident #1 was observed to independently walk into the shared bathroom and Resident #101 had not yet exited. Review of the Long-term Care Facility Application for Medicaid Medicare dated 5/14/24 revealed the facility had a designated Alzheimer's special care unit. The census on the unit was 57. During an interview on 5/16/24 at 10:25 AM, Certified Nurse Aide #4 stated the shared resident hallway bathroom that was open on the north hall of the fourth floor and was equipped with three toilets. The stalls had no doors or privacy curtains. Certified Nurse Aide #4 stated some residents would be unable to say that it bothered them, but I guess that would bother them because it would bother me. During an interview on 5/16/24 at 4:01 PM, Certified Nurse Aide #6 stated staff utilized the shared bathroom on the fourth- floor to toilet residents all the time and that some residents utilized it independently. During an interview on 5/20/24 at 8:00 AM, Licensed Practical Nurse #2 stated there was no privacy in the shared residents' bathroom on the fourth floor. They stated both male and female residents use the bathroom. They stated it was a privacy and a dignity problem. During an interview on 5/20/24 at 8:20 AM, Certified Nurse Aide #7, stated that both male and female residents use the shared bathroom on the fourth floor. Certified Nurse Aide #7 stated there should not be a shared bathroom on the dementia unit, it's a privacy concern. During an interview on 5/20/24 at 8:30 AM, Registered Nurse Unit Manager #1 stated there was a shared resident bathroom in the hallway that male and female residents' use. The bathroom had no doors on the stalls, and it was a safety and dignity issue. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/20/24 at 8:50 AM, Director of Nursing #1 stated there should not be shared resident bathrooms on the units. They stated there should be privacy doors/curtains because it was important for the residents' dignity. 10 CYRR 415.3 (a)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43802 Based on observation and interview and record review during a compliant investigation (#NY003266278, #NY00332285) completed during an extended survey ending 5/23/24, the facility did not provide housekeeping and maintenance services necessary to maintain a safe, clean, comfortable, and homelike environment. Specifically, four (1st, 2nd, 3rd, 4th) of four floors had environmental concerns. The issues involved the lacked hot water in resident rooms; lack of adequate resident access to bathrooms, plastic bags over sinks, and call bells that were not functioning in a shared resident bathroom. Additionally, observed were soiled walls, dirty window shades, dirty utility hoppers, mold in shower rooms, foul odors, windows, and ceilings in disrepair/stained. The findings are: The policy statement titled Water Temperatures, Safety of revised 12/09, documented tap water in the facility shall be kept within temperature range to prevent scalding residents. Water heaters should be set no more than 110 degrees. The maintenance staff shall conduct periodic tap water temperature checks and record in maintenance log. The policy and procedure titled Standard Precautions revised 9/22, documented environmental surfaces, beds and other frequently touched surfaces are appropriately cleaned. The policy titled Call System, Residents dated September 2022 documented the residents are provided with the means to call staff for assistance through a communication call system. The call system remains functional at all times. If audible communication is used, the volume is maintained so that can be heard. If visual communication is uses, the lights remain functional. The system is routinely maintained and tested by the maintenance department. 1. Observation on the second floor on 5/14/24 at 9:02 AM revealed the hot water in the sink shared by Resident room [ROOM NUMBER] and #215 fluctuated between 77.0- and 76.0-degrees Fahrenheit, as measured by the Surveyor's Thermocouple thermometer. At the time of the observation, the Interim Maintenance Director stated that was too cool and they needed to make an adjustment in the boiler room. They stated the facility had two separate hot water systems, one for the north wing, and one for the [NAME] and South wings and Maintenance staff took hot water temperatures daily. During an interview on 5/13/24 at 12:55 PM, the Interim Maintenance Director stated the ideal temperature for hot water in resident areas was between 110 and 115 degrees Fahrenheit. Observation on the first floor on 5/14/24 at 9:55 AM revealed the outgoing hot water for the system that served the [NAME] and South wings was 122 degrees Fahrenheit according to the thermometer attached to the mixing valve in the main boiler Room. The Interim Maintenance Director stated they had adjusted the valve to make the water warmer after seeing the water temperature in the bathroom shared by Resident room [ROOM NUMBER] and #215 this morning, and now had to adjust it back down. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on the Fourth Floor on 5/14/24 at 10:05 AM revealed the hot water in the sink shared by Resident room [ROOM NUMBER] and #410 fluctuated between 64 and 62 degrees Fahrenheit, as measured by the Surveyor's Thermocouple thermometer. At the time of the observation, the Interim Maintenance Director stated the hot water was tweaked too low and needed another adjustment. During an interview on 5/14/24 at 10:07 AM, Resident #357 stated they have trouble getting warm/hot water in their bathroom sink. Review of hot water temperature logs from 5/1/24 to 5/15/24 revealed the temperatures ranged from 106.9 to 121.1 degrees Fahrenheit. Observation on the second floor on 5/16/24 at 1:55 PM, revealed the hot water in the sink shared by Resident room [ROOM NUMBER] and #215 was 59.0 degrees Fahrenheit, as measured by the Surveyor's Thermocouple thermometer. During an interview on 5/16/24 at 1:55 PM, Resident #137 stated there was sometimes hot water, but mostly it was cold water, and they didn't know why it was off and on. They stated sometimes they had to wash their hands and face in cold water. Observation on the second floor on 5/16/24 at 2:00 PM revealed the hot water in the sink shared by Resident room [ROOM NUMBER] and #213 was at 63.8 degrees Fahrenheit, as measured by the Surveyor's Thermocouple thermometer. Observation on the third floor on 5/16/24 at 2:05 PM revealed the hot water in the sink shared by Resident room [ROOM NUMBER] and #313 fluctuated between 68.0- and 89.4-degrees Fahrenheit, as measured by the Surveyor's Thermocouple thermometer. Observation on the fourth floor on 5/16/24 at 2:15 PM revealed the hot water in the sink shared by Resident room [ROOM NUMBER] and #410 was fluctuated between 78.0- and 84.0-degrees Fahrenheit, as measured by the Surveyor's Thermocouple thermometer. During an interview on 5/20/24 at 9:10 AM, Resident #358 stated their bathroom sink water was too cold. During an interview and observation on 5/21/24 at 10:38 AM in the shared bathroom for Resident Rooms #214 and #215, the surveyor asked Certified Nurse Aide #8 to check the water temperature after 2 minutes of running. Certified Nurse Aide #8 stated the water was cold and that they would not use water for residents' care. During an interview and observation on 5/21/24 at 10:43 AM in the shared bathroom for Resident room [ROOM NUMBER] and #215, the surveyor asked Licenses Practical Nurse #10 to check the hot water temperature after running it for 2 minutes. Licensed Practical Nurse #10 checked the water with their hand and stated it was too cold to use for resident hygiene. 2. Observation on the Fourth Floor on 5/13/24 at 8:30 AM revealed the door in the corner of the Dining Room in the north hall was screwed shut. At the time of the observation, Certified Nurse Aide #4 stated the room in the corner of the Dining Room was a resident bathroom and it was out of service. They further stated there was only one working hallway bathroom for residents on the Fourth Floor. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on the Fourth Floor on 5/13/24 at 10:45 AM revealed the corridor door near Resident room [ROOM NUMBER], in the west hall, was screwed shut with an L-shaped bracket/corner brace. At the time of the observation, the Interim Maintenance Director stated the room was a resident access toilet and sink room. The fixtures had been removed and the room had been out of service and locked for the entire six months that they had worked at the facility. During an interview on 5/16/24 at 10:03 AM, Licensed Practical Nurse #1 Supervisor stated some resident rooms on the Fourth Floor had no bathrooms in them. The locked resident bathroom in the west hall and resident bathroom in the Dining Room slowed down the efficiency of the staff to care for the residents. During an interview on 5/16/24 at 10:10 AM, Certified Nurse Aide #2 stated some residents on the Fourth Floor did not have a bathroom in their own room, and those residents would have to walk a longer distance to get to the bathroom because two of the resident bathrooms on this floor were closed. Residents could become incontinent while attempting to get to the only available resident bathroom. During an interview on 5/16/24 at 10:20 AM, Certified Nurse Aide #3 stated the residents that did not have a bathroom in their room only had one bathroom in the hallway to use on the entire Fourth Floor. During an interview on 5/16/24 at 10:25 AM, Certified Nurse Aide #4 stated if a resident did not have a bathroom in their own room, they have one bathroom to use on the Fourth Floor, was inconvenient and slowed them down. Observation on the Fourth Floor on 5/16/24 at 3:30 PM revealed the following Resident Rooms were not equipped with a toilet or sink: Resident room [ROOM NUMBER], north hall - quadruple occupancy Resident room [ROOM NUMBER], north hall - quadruple occupancy Resident room [ROOM NUMBER], west hall - double occupancy Resident room [ROOM NUMBER], west hall - double occupancy Resident room [ROOM NUMBER], west hall - double occupancy Resident room [ROOM NUMBER], west hall - quadruple occupancy The distance from the furthest resident room in the west hall (#426) to the resident bathroom in the north hall was approximately 92 feet. Observation and interview on 5/16/24 at 3:30 PM, there was no bathroom in their shared semi-private room. Resident #71 stated that it bothered them not to have a bathroom in their room. Resident #71 stated there was a bathroom down the hall, make a left and it was at the end of the other hallway. Resident #71 stated they had difficulty getting to the bathroom on time and occasionally had incontinent accidents. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 5/16/24 at 3:33 PM, there was no bathroom in a shared semi-private room. Resident #49 stated it was inconvenient to go down the hallway, then go to the end of the other hallway to use a bathroom. Resident #49 stated they had to travel the size of a football field to use a bathroom from their room. During an interview on 5/16/24 at 3:38 PM, Certified Nurse Aide #13 stated they did know there was a hallway bathroom in the west hallway. Certified Nurse Aide #13 stated they took residents down the other hallway to use the bathroom or use another resident's bathroom in the west hallway if it was not occupied. During an interview on 5/16/24 at 3:40 PM, Certified Nurse Aide #1 stated it would be more convenient for residents if they had a bathroom to use in their own hall. There were some residents who lived in the west hall who had to walk to the north hall to use the hallway bathroom, which was a far walk for them, and some had memory issues and could not remember where the bathroom was. During an interview on 5/16/24 at 3:40 PM, Resident #108 stated they had to use a urinal at least twice a day and at night because they did not have a bathroom in their room. They stated when they needed to have a bowel movement either the staff would bring a bedpan, or they would have to use the community bathroom on their unit. Observation on the Fourth Floor on 5/16/24 at 3:42 PM, a community bathroom was about 75 steps away from Resident #108's room. Observation on the Fourth Floor on 5/16/24 at 3:50 PM revealed the corridor resident bathroom near Resident room [ROOM NUMBER] in the north hall was equipped with three sinks and three toilets. During an interview on 5/16/24 at 4:04 PM, Registered Nurse #1, Unit Manager stated the other community bathroom on Unit 4 was closer to Resident #108's room but was locked. During an interview on 5/17/24 at 2:01 PM, the Interim Maintenance Director stated the Fourth-Floor west hall resident bathroom had a drainage problem and the fixtures were removed from that room and the door was locked before they started working at this facility six months ago. The Interim Maintenance Director stated this same drainage problem also affected the Third Floor Lounge resident bathroom, which was also out of service. The Interim Maintenance Director stated when they started working at this facility, they opened the Third Floor Lounge resident bathroom to see if they could get it back in service, but they were unable to. They stated it was a large-scale issue that was too big for their regular plumbing contractor, and they were in the process of obtaining estimates from a couple of different contractors. The Interim Maintenance Director did not have documentation regarding the scope of this project or when repair work would commence. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Observation and interview on the Fourth Floor on 5/16/24 at 3:50 PM revealed the corridor shared resident bathroom near in the north hall was equipped with three sinks and three toilets. Each toilet was separated by a wall with no stall doors. Further observation revealed each of the three stalls contained a nurse call station. To activate the nurse call stations, the button in the center, approximately three-eighths of an inch in diameter, needed to be pushed then twisted. When the nurse call stations were tested at this time, the first stall did not illuminate the light above the corridor door, the second stall did illuminate the light above the corridor door, and the third stall only flickered the light above the corridor door for a brief second. While the nurse call stations from this resident bathroom were being tested , Registered Nurse #1 Unit Manager stated the nurse call system main board at the Fourth Floor Nurses' Station was lighting the room called 01-02. During an interview on 5/16/24 at 3:56 PM, Registered Nurse #1 Unit Manager stated there were no call bells available and there should be. Registered Nurse #1 Unit Manager stated that could be a safety risk for the residents. 4. Observation on the Fourth Floor on 5/13/24 at 8:28 AM revealed one windowpane in the Dining Room was covered entirely with a large piece of wood. During an interview on 5/13/24 at 9:47 AM, the Interim Maintenance Director stated the windowpane had been covered in wood for the six months that they had been working at the facility and they assumed the wood was there to hold a window air conditioning unit in the summer. At this time, the Interim Maintenance Director removed the piece of wood and observed the pane was cracked for its entire length, approximately four feet long. The Interim Maintenance Director stated they were not aware of the crack and the windowpane needed to be replaced right away. During an observation in the dining room on the fourth floor on 5/14/24 at 7:53 AM, a screen was observed coming off a window and another window was observed with a large crack running from bottom to top of window. 5 a. Observation on 5/13/24 at 8:44 AM revealed a brown dripping substance/stain was on the shared bathroom wall next to the sink in between Resident room [ROOM NUMBER] and #412. During an interview on 5/13/24 at 8:45 AM, Resident #104 stated people come in my room and poop on the walls. Resident #104 stated they told someone about it, but nothing was ever done to correct it. Resident #104 stated they try to clean the walls themselves. Resident #104 stated they will use the community bathroom down the hall because theirs is dirty. b. Observation on 5/13/24 at 9:00 AM, revealed a visibly soiled brief and shorts with brown residue were hanging from the T.V mount in Resident room [ROOM NUMBER]. The room had a malodorous odor. During a telephone interview on 5/13/24 at 3:25 PM, a family member stated the smells in the facility were horrendous. The family member stated they always saw diapers and dirty clothes shoved in corners on floors and it was not hygienic. c. Observation on 5/13/2024 at 12:32 PM revealed the shower room on Unit 2 was noted to have mold on the upper right wall of the room. The mold extended down the wall approximately 12 inches from the ceiling. The tub was not clean and long hair strands were noted in the tub and the drain. Several unlabeled toiletry supplies cluttered the tub area. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/13/24 12:28 PM, Resident #10 they stated the tub room was gross and the mold on the wall was just painted over. d. Observation on the fourth floor on 5/14/24 at 7:57 AM, the sink hopper was full of dark brown debris/water and had a malodorous odor. e. Observation on the second floor on 5/13/24 at 10:44 AM, 5/14/24 at 10:14 AM, and 5/15/24 at 10:16 AM, a 3-to-4-centimeter smear of dark brown debris was noted on tile next to toilet in Resident room [ROOM NUMBER] bathroom. During an interview on 5/15/24 at 11:35 AM, a family member stated the night prior another resident came into their family members shared bathroom and defecated all over the toilet and floor. The family member stated it took over an hour for someone to come and clean it up. During an observation and interview on 5/20/24 at 9:01 AM, the smear of dark brown debris remained on tile next to toilet in room [ROOM NUMBER] bathroom. Certified Nurse Assistant #1 stated that it appeared to be feces on the wall tile next to the toilet and needed to be cleaned. Certified Nurse Assistant #1 stated the brown debris should not be there due to infection control and wasn't homelike. Additionally, Certified Nurse Assistant #1 stated it was nursing and housekeeping's responsibility to keep the bathrooms clean. f. Observation and interview on the Third Floor on 5/16/24 at 11:00 AM revealed the ceiling of Resident room [ROOM NUMBER] was bubbled with dried water stains in an area that covered about half of the ceiling. At the time of the observation, the Interim Maintenance Director stated it was water damage from an overflow of the sink in the room above and they were not sure when it happened. They stated the ceiling of Resident room [ROOM NUMBER] needed to be scraped and re-painted. g. Observation on the Third Floor in Resident room [ROOM NUMBER] on 5/16/24 at 11:20 AM revealed the right- side window shade had many splatters, and the windowsill below had an undated cup of orange juice and sticky food spills. Also, the solid ceiling of Resident room [ROOM NUMBER] was bubbled with dried water stains in an area that was three feet in diameter. At the time of the observation, the Interim Maintenance Director stated the window shade splatters were probably food, the shade and sill needed cleaning, and the ceiling damage must have occurred before they started working at the facility. During an interview on 5/16/24 at 1:45 PM, the Housekeeping/ Laundry Director stated the only way to clean the fabric window shades was to wipe them with a damp cloth. They stated this was done with each room's deep clean, which occurred one or two times per month for each resident room. 6. Observation on the First Floor on 5/13/24 at 1:35 PM revealed two of two sinks in the Men's Locker Room were covered with garbage bags. At the time of the observation, the Interim Maintenance Director stated the problem with the sinks was the drainage and it was part of the bigger facility-wide drainage issue, which needed an outside contractor to repair. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335164	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER: Humboldt House Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 64 Hager Street Buffalo, NY 14208	

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on the Third Floor on 5/16/24 at 11:10 AM revealed the sink in the bathroom shared by Resident Rooms #327 and #328 was covered with a garbage bag. At the time of the observation, the Interim Maintenance Director stated this bathroom was located directly above the Men's Locker Room and was part of the same plumbing issue, and the toilets functioned in this bathroom and in the Men's Locker Room, but the sinks were backed up. They stated a plumber did visit the facility recently to work on these sinks, but they needed to return to the facility to continue the job. 10 NYCRR 415.29

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43802 Based on interview and record review conducted during an Extended Recertification and Complaint (reference #NY00339732 and #NY00325989) survey from 5/13/2024 to 5/23/2024 the facility failed to protect resident's rights to be free from abuse and failed to protect residents from further abuse for three (Resident #129, #104 and #122) of seven residents reviewed for resident-to-resident abuse. Specifically, Resident #129 was verbally and physically threatened by Resident #74 on 4/16/2024 with a large pair of scissors. The facility failed to provide protection for Resident #129 by allowing Resident #74 ongoing access to Resident #129. This resulted in mental anguish for Resident #129 as they stated on 4/19/2024 to Social Worker #1 that they were fearful for their life as they recounted the events of 4/16/2024. In addition, facility staff failed to provide protection from sexual abuse for Residents #104 and #122. Both residents were severely cognitively impaired and lacked the ability to consent to a sexual relationship. The residents were observed by staff engaged in non-consensual sexual activity on 10/13/2023 and were not immediately separated, which resulted in continued sexual abuse. Neither resident was care planned to prevent sexual abuse. This resulted in, or had the likelihood for, psychosocial harm that is Immediate Jeopardy and Substandard Quality of Care for Resident #s 104,122 and 129 which had the likelihood to affect all 165 residents in the facility. The findings are: The policy and procedure titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised September 2021, documented residents have the right to be free from abuse by anyone which includes but is not limited to verbal, mental, sexual, and physical abuse. Establish and maintain a culture of compassion and caring for all residents and particularly those with behavior, cognitive and emotional problems. Protect residents from any further harm during investigations. 1. Resident #74 had diagnoses which included displaced intertrochanteric fracture (type of hip fracture) of right femur (thigh bone), epileptic seizures (abnormal electrical brain activity), and alcohol dependence with withdrawal. The Minimum Data Set (a resident assessment tool) dated 2/23/2024 documented Resident #74 was cognitively intact. The comprehensive care plan documented Resident #74 was cognitively intact, independent with decision making (2/22/2024) and independent with wheelchair mobility (3/25/2024) on the unit. Resident #129 had diagnoses which included Wernicke's encephalopathy (type of brain injury), alcohol induced persisting dementia and type 2 diabetes mellitus. The Minimum Data Set, dated dated dated [DATE] documented Resident #129 was severely cognitively impaired, was understood and understands others. Resident #129 was independent with chair/bed transfer and required supervision with wheelchair mobility. The comprehensive care plan initiated 8/31/2023 (current) documented Resident #129 was dependent on staff for meeting emotional, intellectual, physical, and social needs related to mild cognitive impairment. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The Investigation Summary/QA (Quality Assurance) Privilege report completed by Director of Nursing #1 documented a resident-to-resident altercation took place on 4/16/2024 and was not reported until 4/19/2024. Allegedly, Resident #74 engaged in a verbal argument with their roommate, Resident #129, that quickly turned violent when Resident #74 threatened Resident #129 with a pair of scissors and stated, I am going to kill you. This resident-to-resident altercation was witnessed by Certified Nurse Aide #1 and was reported to Registered Nurse #1 on 4/16/2024. On 4/19/2024, Resident #129 appeared distraught and tearful when recounting the events that took place on 4/16/2024 to Social Worker #1. Resident #129's verbal statement given to Social Worker #1 on 4/19/2024 documented the resident stated they could not live in violence, and it was not good for their mind and well-being. Review of the case report notes submitted by the facility on 4/22/2024 at 2:20 PM documented Resident #129 was crying and trembling when they gave Social Worker #1 their statement. Resident #129 stated they were fearful for their life and did not want their roommate to come back because they almost got stabbed in the back. Review of facility nurse report sheets, Resident #74 and Resident #129's progress notes dated 4/16/2024 through 4/19/2024 revealed Resident #74 (alleged perpetrator) had ongoing access to Resident #129. The two residents (#74 and #129) remained residing in the same room from 4/16/2024 to 4/19/2024 when Resident #74 was hospitalized for an unrelated illness. Upon Resident #74's return on 4/23/2024 they returned to the same unit as Resident #129. During an interview on 5/20/2024 at 8:41 AM, Certified Nurse Aide #1 stated on 4/16/2024 they heard a loud argument and observed the altercation between Resident #74 and #129. The residents were a little bit farther then an arm's length apart when Resident #74 pulled a pair of scissors out of a black bag and raised them toward Resident #129. Certified Nurse Aide #1 stated had they not intervened Resident #74 would have stabbed Resident #129 in the back. Certified Nurse Aide #1 stated after they intervened Resident #74 placed the scissors back into their bag. Certified Nurse Aide #1 stated they could not locate the nurse on the unit after the altercation and went back to their other work duties. They stated about 30 minutes after the altercation they reported it to Registered Nurse #1. During an interview on 5/20/2024 at 9:16 AM, Registered Nurse #1 stated upon being notified of the altercation they went to Resident #74 and #129's room. Both residents were ok, calm, and sitting in their room in their wheelchairs. Resident #74 was asked to surrender the scissors and they complied. Registered Nurse #1 stated the scissors were huge and that if Resident #74 wanted to use them to cause harm they could. Registered Nurse #1 stated that Resident #74 wanted a room change but didn't want to switch floors. Registered Nurse #1 stated they did not separate the resident's or implement any additional safety measures because they felt the situation was defused. Registered Nurse #1 stated they thought it was more of Certified Nurse Aide #1's viewpoint and didn't consider it to be an allegation of abuse. During a telephone interview on 5/20/2024 at 9:44 AM and 5/22/2024 at 8:20 AM, Social Worker #1 stated on 4/19/2024 Resident #129 told them their roommate (Resident #74) got frustrated, was screaming at them, and tried to stab them with a pair of scissors. Social Worker #1 stated that Resident #129 was crying and shaking when sharing what happened. Resident #129 told them they were afraid for their life. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 5/20/2024 at 11:38 AM, Resident #74 stated they were angry about Resident #129 mixing stuff up in their water pitcher. Resident #74 stated they tried to talk to Resident #129 about it but they're a little off. Resident #74 stated if they caught Resident #129 doing it, they'd stick them, but wouldn't want to hurt them. Resident #74 stated they thought Resident #129 would take the message if they saw the scissors. During an interview on 5/20/2024 at 2:01 PM, Director of Nursing #1 stated the resident-to-resident altercation between Resident #74 and #129 was abuse. Director of Nursing #1 stated the scissors should have been removed immediately from Resident #74. The residents should have been separated for safety and other interventions put into place as deemed appropriate. During an interview on 5/21/2024 at 11:49 AM, current Administrator #1 stated Director of Nursing #1 completed the abuse investigation, and the conclusion was they could not ascertain physical abuse occurred. Administrator #1 stated staff did not follow policy. During a telephone interview on 5/22/2024 at 3:45 PM, the Medical Director stated with resident-to-resident altercations the nursing staff should assess the situation for safety, separate the residents into different rooms, and ensure no additional weapons were present to mitigate any further risk to the resident's safety. 2. Resident #104 had diagnoses including cerebral infarction (stroke), metabolic encephalopathy (a disorder of the brain that can lead to personality changes), and dementia. The Minimum Data Set, dated dated dated [DATE] documented Resident #104 was moderately cognitively impaired, was understood, and understands others. The policy and procedure titled Identifying Sexual Abuse and Capacity to Consent, dated September 2022, documented a resident's consent to sexual activity is not valid if obtained from a resident who lacks capacity to consent, or if consent was obtained through intimidation, fear, or coercion. Sexual abuse is non-consensual sexual contact of any type with a resident, including unwanted intimate touching of any kind especially of breasts or perineal area. Sexual contact is non-consensual if the resident appears to want the contact to occur but lacks the cognitive ability to consent. Any forced, coerced or extorted sexual activity with a resident, regardless of the existence of a pre-existing or current sexual relationship, is sexual abuse. For any allegations or suspicion of sexual abuse, an investigation, protective measures will be implemented to prevent further potential abuse. The comprehensive care plan dated 7/3/2023 documented Resident #104 had impaired cognitive function and was not an independent decision maker. Resident #104 was independent with ambulation and wandered. Intervention included to redirect them as needed. The care plan did not include any evidence of a pre-existing relationship with Resident #122, nor a plan to prevent sexual abuse. A Brief Interview for Mental Status (BIMS) assessment dated [DATE] conducted by Director of Social Work #2 documented Resident #104 scored a 6, indicating they were severely cognitively impaired. Review of the Physician's Statement dated 10/16/2023 revealed Medical Doctor #2 signed that Resident #104 lacked capacity to handle their own affairs. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Resident #122 was admitted with diagnoses including dementia, hypertension (high blood pressure), and benign prostatic hypertrophy (enlarged prostate gland). The Minimum Data Set, dated dated dated [DATE] documented Resident #122 was severely cognitively impaired. The comprehensive care plan dated 12/22/2022 documented Resident #122 had impaired cognitive function; was not an independent decision maker, had impaired thought process and was alert and oriented to self only (initiated on 7/3/2023). Interventions included to communicate with resident/family/caregivers regarding resident's capabilities and needs. The care plan did not include any evidence of a pre-existing relationship with Resident #104, nor a plan to prevent sexual abuse. Review of the Physician's Statement dated 3/23/2023 revealed Medical Doctor #2 signed Resident #122 lacked capacity to handle their own affairs. An Investigation Summary/QA Privilege report signed on 10/20/2023 by Former Director of Nursing #2 documented during the morning shift on 10/13/2023 Certified Nurse Aide #2 observed Resident #104, and Resident #122 engaged in inappropriate sexual touching. Certified Nurse Aide #2's investigation statement dated 10/13/2023, documented Resident #104 and Resident #122 were observed in the dining room hugging. Resident #104 was standing next to Resident #122, who was seated. Resident #122 slid their hand down the front of Resident #104's pants and their other hand up their shirt. According to the witness statement, Certified Nurse Aide #2 asked them to stop. Therapy Aide #1 then walked into dining room and observed the sexual activity. Therapy Aide #1's investigation statement dated 10/13/2023, documented around 11:30 AM on 10/13/23 they were walking a resident into the dining room and observed Resident #104 standing next to Resident #122 who was seated. Resident #122 had their hand down the front of Resident #104's pants. Therapy Aide #1's statement documented they verbally intervened. Resident #122 removed their hand from Resident #104's pants. Resident #104 whispered something to Resident #122, who then proceeded to place their hand back into Resident #104's pants and continued for another minute or so. Therapy Aide #1 documented that there was another aide in the corner that said they had been doing that for about 20 minutes or so and they told them to stop but they did not listen. During a telephone interview on 5/17/2024 at 10:46 AM, Certified Nurse Aide #2 stated on 10/13/2023 they were in the dining room charting on a laptop computer when Resident #104 walked over to Resident #122. The residents conversed a bit and then Resident #122 put their hand down the front of Resident #104's pants. Certified Nurse Aide #2 stated they told them to stop, and they did. Certified Nurse Aide #2 stated they did not separate the residents and went back to their charting. Therapy Aide #1 then walked into the dining room and observed the two residents engaged again in sexual activity and separated them. Certified Nurse Aide #2 stated there had been prior incidents between the two residents of hugging and Resident #122 would slide their hand under Resident #104's shirt. Certified Nurse Aide #2 stated it was kind of like an everyday thing that would happen, if you didn't catch it. They had reported it to other Certified Nurse Aides on the unit and they would just brush it off, just yell and tell them to stop. During an interview on 5/17/2024 at 11:56 AM, Nurse Practitioner #1 stated they felt as though Resident #104 may have known what they were doing but did not think it was a big deal. Nurse Practitioner #1 stated they would consider it to be inappropriate in a public setting. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 5/20/2024 at 9:26 AM, Certified Nurse Aide #3 stated there had been instances prior to 10/13/2023 where Resident #104 and Resident #122 would be seen rubbing each other's backs and with their arms around each other. Certified Nurse Aide #3 stated they would just keep an eye on them and tell them to get away from each other if things got too weird. During a telephone interview on 5/20/2024 at 9:43 AM, Therapy Aide #1 stated they observed Resident #122's hand inside Resident #104's pants and they attempted to intervene by telling the residents to stop. Resident #122 then said to Resident #104, we better stop and removed their hand from Resident #104's pants. Resident #104 whispered something into Resident #122's ear then Resident #122 proceeded to put their hand back in Resident #104's pants. Therapy Aide #1 stated Certified Nurse Aide #2 told them it had been going on for about the past 20 minutes. During a telephone interview on 5/20/2024 at 10:29 AM, former Director of Nursing #2 stated the inappropriate contact happened in the dining room and neither resident had capacity to consent. They did not recall if any prior incidents had been reported to them involving these two residents. During a telephone interview on 5/20/2024 at 10:46 AM, Director of Social Work #2 stated they did not recall either resident having any sort of psychological evaluation completed after the incident. Director of Social Work #2 stated Resident #104 and Resident #122 lacked capacity to make those types of decisions. During an interview on 5/21/2024 at 10:38 AM, current Director of Nursing #1 stated sexual abuse was any unwanted non-consensual situation, could be touching or other forms. Director of Nursing #1 stated Resident #104 and Resident #122 both lacked the capacity to consent according to the Physician Statement documents. They would have expected the residents to be separated by Certified Nurse Aide #2, who witnessed the incident. During an interview on 5/21/2024 at 10:19 AM, Licensed Practical Nurse #8 stated they recalled being made aware of the incident on 10/13/2023 but did not recall any prior instances between Resident #104 and Resident #122. Additionally, they stated they were unsure if staff could properly supervise residents because the staff were always everywhere and the residents are wandering around, so it can be difficult. During an interview on 5/21/2024 at 12:01 PM, Administrator #1 stated sexual abuse was inappropriate touching from someone that was not wanting of that touching and had the capacity to understand what that meant. During an interview on 5/21/2024 at 3:35 PM, the Regional Director of Nursing stated neither resident had a Health Care Proxy on file. During an interview on 5/21/2024 at 3:37 PM, Director of Nursing #1 stated if residents lacked capacity and did not have an activated health care proxy, the residents' responsible parties or next of kin would make decisions for them. They stated a resident who lacks capacity would not be able to consent. (continued on next page)

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During a telephone interview on 5/21/2024 at 3:39 PM, Medical Director #1 stated capacity was a judgement call when it involved determining if a resident lacked capacity to make decisions regarding sexual activity. Medical Director #1 stated it really was a case-by-case basis and depends on who's involved. Sexual touching was probably not something one would usually consent to if they lacked capacity. If there's no health care proxy on file, an interdisciplinary team meeting would be needed to discuss and come up with a plan. 10 NYCRR 415.3 (d) (1) (vii)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43802 Based on interview and record review conducted during an Extended Recertification and Complaint (reference #NY00339732 and #NY00325989) survey from 5/13/2024 to 5/23/2024 the facility failed to ensure that all alleged violations of abuse are reported immediately, but not later than 2-hours after the allegation is made to the administrator of the facility and to appropriate officials (including the State Survey Agency) for three (Resident #104, #122, and #129) of fourteen residents reviewed for abuse reporting. Specifically, Registered Nurse #1 did not report alleged resident-to-resident abuse that occurred between Resident #74 and #129 to the Administrator. The lack of reporting resulted in continued access to each other and mental anguish for Resident #129. Additionally, Residents #122 and Resident #104 who lacked capacity to consent were observed engaged in non-consensual sexual activity. Facility staff failed to report the sexual abuse immediately to the Administrator which resulted in continued sexual abuse between the residents. This resulted in, or had the likelihood for, psychosocial harm that is Immediate Jeopardy and Substandard Quality of Care for Resident #s 104, 122, and 129 which had the likelihood to affect all 165 residents in the facility. The findings are: The policy and procedure titled Abuse, Neglect, Exploitation and Misappropriation-Reporting and Investigating revised September 2022 documented if resident abuse was suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. Immediately is defined as: within two hours of an allegation involving abuse. 1. Resident #74 had diagnoses which included displaced intertrochanteric fracture (type of hip fracture) of right femur (thigh bone), epileptic seizures (abnormal electrical brain activity), and alcohol dependence with withdrawal. The Minimum Data Set (a resident assessment tool) dated 2/23/2024 documented Resident #74 was cognitively intact. The comprehensive care plan documented Resident #74 was cognitively intact, independent with decision making (2/22/2024) and independent with wheelchair mobility (3/25/2024) on the unit. Resident #129 had diagnoses which included Wernicke's encephalopathy (type of brain injury), alcohol induced persisting dementia and type 2 diabetes mellitus. The Minimum Data Set, dated dated dated [DATE] documented Resident #129 was severely cognitively impaired, was understood and understands others. Resident #129 was independent with chair/bed transfer and required supervision with wheelchair mobility. The comprehensive care plan dated 8/31/2023 documented Resident #129 was dependent on staff for meeting emotional, intellectual, physical, and social needs related to mild cognitive impairment. (continued on next page)

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	335164	A. Building B. Wing	05/23/2024

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The Investigation Summary/QA (Quality Assurance) Privilege report completed by Director of Nursing #1 documented a resident-to-resident altercation took place on 4/16/2024 and wasn't not reported until 4/19/2024. Allegedly, Resident #74 engaged in a verbal argument with their roommate, Resident #129, that quickly turned violent when Resident #74 threatened Resident #129 with a pair of scissors and stated, I am going to kill you. This resident-to-resident altercation was witnessed by Certified Nurse Aide #1 and was reported to Registered Nurse #1 on 4/16/2024. On 4/19/2024, Resident #129 appeared distraught and tearful when recounting the events that took place on 4/16/2024 to Social Worker #1. The report documented the abuse was reported to the New York State Department of Health on 4/19/2024. Review of a witness statement dated 4/20/2024, Certified Nurse Aide #1, documented that on 4/16/2024 they witnessed Resident #74 shouting obscenities, enraged, and raised a large pair of scissors high above their head as they approached Resident #129. Certified Nurse Aide #1 stated at that time there was no nurse available and that after a while they reported what they witnessed to Registered Nurse #1. Review of Registered Nurse #1's employee file revealed a facility Disciplinary Action dated 10/4/2022 revealed a verbal warning for not notifying Administrator/Director of Nursing on 10/2/2022 of a resident-to-resident altercation resulting in a delay in reporting to the Department of Health. During an interview on 5/20/2024 at 8:41 AM, Certified Nurse Aide #1 stated on 4/16/2024 they witnessed a resident-to resident altercation between Resident #74 and #129. Certified Nurse Aide #1 stated about 30 minutes after the altercation they reported the altercation to Registered Nurse #1. During an interview on 5/20/2024 at 9:16 AM, Registered Nurse #1 stated upon being notified of the altercation they went to Resident #74 and #129's room. Both residents were ok, calm, and sitting in their room in their wheelchairs. Resident #74 was asked to surrender the scissors and they complied. Registered Nurse #1 stated the scissors were huge and that if Resident #74 wanted to use them to cause harm they could. Registered Nurse #1 stated Resident #74 wanted a room change but did not want to switch floors. Registered Nurse #1 stated they did not separate the resident's or implement any additional safety measures because they felt the situation was defused. Registered Nurse #1 stated they thought it was more of Certified Nurse Aide #1's viewpoint and didn't consider it to be an allegation of abuse. During a telephone interview on 5/20/2024 at 9:44 AM and 5/22/2024 at 8:20 AM, Social Worker #1 stated on 4/19/2024 Resident #129 told them their roommate (Resident #74) got frustrated, was screaming at them, and tried to stab them with a pair of scissors. Social Worker #1 stated that Resident #129 was crying and shaking when sharing what happened. Resident #129 told them they were afraid for their life. The abusive altercation should have been reported immediately by staff to administration. During an interview on 5/20/2024 at 2:01 PM, Director of Nursing #1 stated the resident-to-resident altercation between Resident #74 and #129 occurred on 4/16/2024 and they weren't notified until 4/19/2024. The Director of Nursing stated all allegations of abuse needed to be immediately brought to their attention so an investigation could be started and reported accordingly. During an interview on 5/21/2024 at 11:49 AM, Administrator stated that staff didn't follow policy. The resident-to-resident altercation should have been reported the moment it occurred so a thorough investigation could be completed and reported accordingly. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335164	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Humboldt House Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 64 Hager Street Buffalo, NY 14208	

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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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	2. Resident #104 had diagnoses including cerebral infarction (stroke), metabolic encephalopathy (a disorder of the brain that can lead to personality changes), and dementia. The Minimum Data Set, dated dated dated [DATE] documented Resident #104 was moderately cognitively impaired was understood and understands others. The comprehensive care plan dated 7/3/2023 documented Resident #104 had impaired cognitive function and was not an independent decision maker. Resident #104 was independent with ambulation and wandered. Intervention included to redirect as needed. The care plan did not include any evidence of a pre-existing relationship with Resident #122, nor a plan to prevent sexual abuse. Review of a brief interview for mental status dated 10/13/2023 was conducted by Director of Social Work #2 Resident #104 scored a 6, indicating they were severely cognitively impaired. Review of the Physician's Statement dated 10/16/2023 revealed Medical Doctor #2 signed that Resident #104 lacked capacity to handle their own affairs. Resident #122 was admitted with diagnoses including dementia, hypertension (high blood pressure), and benign prostatic hypertrophy (enlarged prostate gland). The Minimum Data Set, dated dated dated [DATE] documented Resident #122 was severely cognitively impaired. The comprehensive care plan dated 12/22/2022 documented Resident #122 had impaired cognitive function; was not an independent decision maker, had impaired thought process and was alert and oriented to self only (initiated on 7/3/2023). Interventions included to communicate with resident/family/caregivers regarding resident's capabilities and needs. The care plan did not include any evidence of a pre-existing relationship with Resident #104, nor a plan to prevent sexual abuse. Review of the Physician's Statement dated 3/23/2023 revealed Medical Doctor #2 signed Resident #122 lacked capacity to handle their own affairs. Review of Investigation Summary/QA Privilege report signed on 10/20/2023 by Former Director of Nursing #2 documented during the morning shift on 10/13/23 Certified Nurse Aide #2 observed Resident #104, and Resident #122 engaged in inappropriate sexual touching. Certified Nurse Aide #2 told Resident #122 and Resident #104 to stop. Certified Nurse Aide #2 then returned to doing their charting in the corner. Sometime later, Therapy Aide #1 walked into the dining room and observed Resident #104, and Resident #122 again engaged in sexual activity. During a telephone interview on 5/17/24 at 10:46 AM Certified Nurse Aide #2 stated on 10/13/2023 they observed Resident #104 and Resident #122 engaged in inappropriate sexual touching in the dining room. Certified Nurse Aide #2 stated they told them to stop, and they did. Certified Nurse Aide #2 stated they did not immediately report this incident because this was kind of like an everyday thing that would happen if you didn't catch it. Certified Nurse Aide #2 stated they would report it to other Certified Nurse Aides on the unit and they would just brush it off. They acted like it wasn't a big deal, just yell and tell them to stop and then they would stop. They stated they would consider this sexual abuse because neither resident had capacity to consent. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 5/20/2024 at 9:26 AM, Certified Nurse Aide #3 stated there had been instances prior to 10/13/2023 where Resident #104 and Resident #122 would be seen rubbing each other's backs and with their arms around each other. Certified Nurse Aide #3 stated they would just keep an eye on them and tell them to get away from each other if things got too weird. During a telephone interview on 5/20/2024 at 9:43 AM, Therapy Aide #1 stated they observed Resident #122's hand inside Resident #104's pants and they attempted to intervene by telling the residents to stop. Resident #122 then said to Resident #104, we better stop and removed their hand from Resident #104's pants. Resident #104 whispered something into Resident #122's ear then Resident #122 proceeded to put their hand back in Resident #104's pants. Therapy Aide #1 stated Certified Nurse Aide #2 told them it had been going on for about the past 20 minutes. I told them to stop but they wouldn't. Therapy Aide #2 stated they physically separated them and went to report the incident to the Director of Nursing (Former Director of Nursing #2). During a telephone interview on 5/20/2024 at 10:29 AM, former Director of Nursing #2 stated the inappropriate contact happened in the dining room and neither resident had capacity to consent. They did not recall if any prior incidents had been reported to them involving these two residents prior to 10/13/2023. During an interview on 5/21/2024 at 10:38 AM, Director of Nursing #1 stated they would have expected Certified Nurse Aide #2, who witnessed the incident, to immediately report the sexual activity to the correct entity. During an interview on 5/21/2024 at 12:01 PM, the Administrator stated the basis of any initial report was that it must be reported to administration so that they can go through the process. 10 NYCRR 415.4(b)(2)

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Humboldt House Rehabilitation and Nursing Center	64 Hager Street Buffalo, NY 14208

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F 0610

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Respond appropriately to all alleged violations.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 43802

Based on interview and record review conducted during an Extended Recertification and Complaint (#NY00339732) survey completed 5/23/24 the facility did not ensure that all alleged allegations of abuse, were thoroughly investigated for two (Resident #74 and #129) of fourteen residents reviewed. Specifically, there was a delay in the initiation of an investigation for a reported allegation of resident- to- resident abuse. Additionally, the facility did not complete a thorough investigation to include interviews of residents involved and other potential witnesses.

The finding is:

The policy and procedure titled Abuse, Neglect, Exploitation and Misappropriation-Reporting and Investigating revised September 2022 documented all reports of resident abuse are thoroughly investigated by facility management. The individual conducting the investigation as a minimum: observes the alleged victim, including their interactions with staff and other residents; interviews the resident (as medically appropriate) or the resident's representative; interviews staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; documents the investigation completely and thoroughly.

Resident #74 had diagnoses which included displaced intertrochanteric fracture (type of hip fracture) of right femur (thigh bone), epileptic seizures (abnormal electrical brain activity), and alcohol dependence with withdrawal. The Minimum Data Set (a resident assessment tool) dated 2/23/2024 documented Resident #74 was cognitively intact.

The comprehensive care plan documented Resident #74 was cognitively intact, independent with decision making (2/22/2024).

Resident #129 had diagnoses which included Wernicke's encephalopathy (type of brain injury), alcohol induced persisting dementia and type 2 diabetes mellitus. The Minimum Data Set, dated dated dated [DATE] documented Resident #129 was severely cognitively impaired, was understood and understands.

The comprehensive care plan dated 8/7/23 documented Resident #129 had impaired cognitive function or impaired thought processes related to altered mental status. Interventions included to communicate with resident/family/caregivers regarding residents' capabilities and needs.

The Investigation Summary/QA (Quality Assurance) Privilege report dated 4/19/24 completed by Director of Nursing #1 documented a resident-to-resident altercation took place on 4/16/2024 and wasn't reported until 4/19/2024. Allegedly, Resident #74 got into a verbal argument with their roommate Resident #129, that quickly turned violent when Resident #74 threatened Resident #129 with a pair of scissors and stated, I am going to kill you. Resident-to-resident altercation was witnessed by Certified Nurse Aide #1 and was reported to Registered Nurse #1. On 4/19/2024, Resident #129 appeared distraught and tearful when recounting the events that took place on 4/16/2024 to Social Worker #1. The investigation included a written statement by Certified Nurse Aide #1 dated 4/20/24.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/20/24 at 9:16 AM, Registered Nurse #1 stated that Certified Nurse #1 reported to them the altercation between Resident #74 and Resident #129. Registered Nurse #1 stated they went to the residents' room and both residents were ok, calm, sitting in their room in their wheelchairs. At that time, Resident #74 did not have any scissors in their hand and surrendered them without difficulty. Registered Nurse #1 stated they did not separate the resident's because they felt the situation was diffused and no additional interventions were needed. Registered Nurse #1 stated they did not report the incident to the Director of Nursing or Administrator because they didn't consider it a resident-to-resident altercation, if they did, they would have completed an incident report and notified the Administrator. During an interview on 5/20/24 at 2:01 PM, the Director of Nursing #1 stated they did not obtain a statement from Resident #74 as they were sent to hospital on 4/19/24 and returned on 4/23/24 to a different room. Director of Nursing #1 stated there was no documented evidence that Resident #129's responsible party was notified of the resident-to-resident altercation and should have been. Director of Nursing #1 stated that at the time (4/19/24) they didn't feel it was necessary to interview other residents, as they felt it was an isolated incident. During an interview on 5/21/24 at 11:49 AM, Administrator #1 stated the Director of Nursing was responsible for completing abuse investigations. Administrator #1 stated a completed investigation would be based on statements received from everyone involved. Administrator #1 stated staff should have reported the resident-to-resident allegation the moment it occurred, that day (4/16/24), so that a thorough investigation could have been started. During a telephone interview on 5/21/24 at 3:20 PM, Resident #129's responsible party stated they were never informed of a resident-to-resident altercation involving Resident #129. Resident #129's responsibly party stated they would expect to be informed of anything that happens with Resident #129. 10 NYCRR 415.4(b)(3)

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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

Provide care and assistance to perform activities of daily living for any resident who is unable.

43802

Based on observation, interview, and record review conducted during the Recertification Survey and Complaint (#NY00326278) survey completed on 5/23/24, the facility did not ensure that each resident who was unable to carry out Activities of Daily Living received the necessary services to maintain grooming and personal hygiene for three (Resident #27,102, 105) of six residents reviewed for Activities of Daily Living. Specifically, Resident #27 was not provided with timely incontinence care that resulted in their brief and bed linens saturated with urine through to the mattress, also the Certified Nurse Aide performed incomplete incontinence care (lack of washing bilateral buttocks and hips and removal of saturated brief) with improper hand hygiene, glove changes, and touched items in the resident's room with soiled gloves. Additionally, Residents #102 and #105 had long jagged fingernails with brown debris.

The findings are:

Review of the policy and procedure titled Perineal (the area between the anus and genitalia) Care revised 2/2018 documented perineal care provided cleanliness and comfort to the resident and prevented infection. The steps of the procedure included to: Wash and dry hands thoroughly: Apply gloves: Wet washcloth and apply soap or skin cleansing agent: Separate labia and wash area downward from front to back: Continue to wash the perineum moving from inside outward towards the thighs. Rinse perineum thoroughly in same direction, using fresh water and a clean washcloth: Gently dry perineum: Ask the resident to turn on their side with the top leg slightly bent: Wash the rectal area thoroughly, wiping from the base of the labia towards and extending over the buttocks: Rinse and dry thoroughly. Place barrier pad under the resident: Provide perineal care: Turn the resident and wash, rinse, and dry buttocks and both hips. Discard gloves and wash hands thoroughly was required for infection control.

Review of the policy and procedure titled Fingernails/Toenails, Care of revised 2/2018 documented nail care included daily cleaning and regular trimming. Proper nail care prevented skin problems around the nailbed. Trimmed and smooth nails prevented the resident from accidentally scratching and injuring their skin.

1. Resident #27 was admitted to the facility with diagnoses which included diabetes mellitus, anxiety, and depression. The Minimum Data Set (a resident assessment tool) dated 12/15/23 documented the resident was cognitively intact, was understood and understands. The Minimum Data Set further documented the resident required partial moderate assistance for toileting hygiene and was always incontinent of urine.

The Visual/Bedside Kardex Report (a tool used by staff to guide care) dated 5/20/24 documented to provide timely incontinent care every two to three hours and as needed.

The Comprehensive Care Plan revised on 1/26/23 documented to check Resident #27 every two hours for incontinence: Wash, rinse, and dry the perineum.

During observation and interview on 5/15/24 at 2:46 PM, Resident #27 was in bed and stated they were not changed today and did not get morning care.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation of incontinent care on 5/15/24 at 3:22 PM, Certified Nurse Aide #15 unfastened the tabs on Resident #27's incontinence brief. The incontinence brief was saturated with yellow, foul-smelling urine. Certified Nurse Aide #15 tucked the brief in between Resident #27's legs while providing care and washed the abdominal fold and perineum from side to side without separating the labia. Certified Nurse Aide #15 rolled Resident #27 onto their left side and tucked the brief, soiled flat sheet, and soiled fitted sheet under Resident #27's left buttock. They did not wash the entire buttocks or the right hip. Certified Nurse Aide #15 applied barrier cream to the right buttock then rolled Resident #27 flat on their back onto the pile of soiled linens and applied additional barrier cream to the perineum. With Resident #27 lying flat on top of with the soiled linens, Certified Nurse Aide #15 placed a clean incontinent brief on top of the soiled brief and secured the clean brief and omitted cleansing the left buttock. Without performing hand hygiene, they touched the resident's clean shirt and pants and put Resident #27's pants on while they laid on the soiled linen. At 3:33 PM, Certified Nurse Aides #14 and #15 removed the soiled incontinent brief and linens from under the resident, placed them on the end of the bed and assisted Resident #27 to a seated position on the edge of the bed. At 3:35 PM, without changing their gloves which were visibly soiled with white barrier cream, Certified Nurse Aide #15 washed Resident #27's face and used a brush and their hand and flattened their hair. Certified Nurse Aide #15 touched the bed remote control, doorknobs, handles on drawers and the sit to stand lift and battery, then transferred Resident #27 using the sit to stand lift with assistance from Certified Nurse Aide #14. Certified nurse aide #15 then wiped the mattress with a towel and stated the mattress was saturated with urine. Certified Nurse Aide #14 gathered the soiled linens and threw them onto the floor. During an interview on 5/15/24 at 3:54 PM, Certified Nurse Aide #14 stated they tossed soiled linens on the floor daily and grabbing a barrier was a time constraint. During an interview on 5/15/24 at 4:18 PM, Certified Nurse Aide # 15 stated they applied barrier cream to the buttocks then the perineum. They should have removed the soiled brief, provided a clean barrier, performed hand hygiene after incontinence care prior to touching items and avoided cross contamination. During an interview on 5/16/24 at 10:23 AM, Licensed Practical Nurse, Unit Manager #3 expected a barrier be placed at the foot of the bed, staff to remove soiled brief and linens, and then perform care. Glove changes and hand hygiene were expected after touching anything dirty and was an infection control issue. The resident's face should have been washed first and would expect both hips and buttocks be washed when doing incontinent care. The same soiled gloves should not be used during the entire process. The Licensed Practical Nurse Unit Manager #3 stated they expected staff to change the resident every 2-3 hours and as needed. During an interview on 5/17/24 at 10:15AM, Registered Nurse, Nurse Educator #6 stated Certified Nurse Aides were taught to fold soiled briefs underneath and wash downwards so bacteria was not introduced causing infection. Wash one side then roll over the resident, pull that brief out completely, and wash the other side including the hips. Soiled items were discarded on a barrier. The barrier was contained and taken to the soiled utility room. Hands should be washed, and gloves should be changed whenever going from dirty to clean processes. During an interview on 5/17/24 at 10:46 AM, Director of Nursing #1 stated Certified Nurse Aides #15 should have provided a clean barrier. Hand hygiene was expected before care, after care, and anytime gloves were visibly soiled and prevented the spread of infection. (continued on next page)

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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	During an interview on 5/20/24 at 9:35 AM, Regional Director of Quality Assurance #1 stated hand hygiene was expected before and after touching anything dirty and prevented the spread of germs. The Registered Nurse Educator needed to be educated. During an interview on 5/21/24 at 2:05 PM, the Administrator stated Certified Nurse Aides #14 and #15 should have followed the process and should have stopped and found out the right way and provided proper care. The incontinent care was inappropriate and they should know better. 2. Resident #102 had diagnoses that included cerebral infarction (stroke), sequelae of cerebral infarction (neurological deficits that persist after a stroke), and legal blindness. The Minimum Data Set (a resident assessment tool) dated 3/13/24 documented Resident #102 understood, understands and was severely cognitively impaired. Resident #102 was dependent on staff for personal hygiene and bathing. The Comprehensive Care Plan dated 2/22/23 documented that Resident #102 was dependent on staff for meeting emotional, intellectual, physical, and social needs. Resident #102 had an activity of daily living deficit related to cerebrovascular accident (stroke) and generalized weakness. An intervention added on 5/13/23 included for personal hygiene/oral care, the resident required extensive assist of one person. Review of Nursing Progress Notes from 10/1/2023 to 5/17/2024 revealed no documented evidence that nail care was provided, or that Resident #102 refused nail care. During an observation and interview on 5/13/24 at 11:14 AM, Resident #102 was lying in bed, the fingernails on both hands were long (beyond the fingertips) and jagged with a thick layer of dark brown debris under the nails. Resident #102 stated they just don't cut them anymore. Additionally, Resident #102 stated they sometimes ate sandwiches with their hands. During an observation and interview on 5/14/24 at 7:45 AM, Resident #102 was lying in bed, nails remained long and jagged with dark brown debris under them. Resident #102 stated they prefer their nails to be short. Resident #102's left hand was contracted (loss of joint mobility) and the 2nd, 3rd, and 4th digit (finger) nails were observed pressing into the palm of the resident's left hand. Resident #102 attempted to open their left hand, was able to open hand approximately 1 inch. The resident's middle fingernail remained pressing against the palm of their left hand. Three red linear indentations were observed on the center of Resident #102's left palm. Resident #102 stated they were extremely itchy and was observed itching their legs and arms with their hands. Fresh blood and scabs were observed to both upper and lower extremities. During an observation on 5/16/24 at 8:01 AM, Certified Nurse Aide #12 and Certified Nurse Aide #3 provided morning care for Resident #102. Certified Nurse Aide #12 cleaned the palm of Resident #102's left hand but did not address the fingernails. After care, Certified Nurse Aide #12 observed Resident #102's nails and stated they were not the resident's normal aide, but they would attempt to cut and file nails. Certified Nursing Aide #12 stated the facility had staff that went around and did nail care specifically. Certified Nursing Aide #12 was unable to answer if someone had provided nail care to Resident #102 recently. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335164	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024

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F 0677

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

During an observation and interview on 5/16/24 at 8:45 AM, Certified Nurse Aide #12 stated they clipped and attempted to file Resident #102's nails, but some were trimmed too short to file. The nails on Resident #102's right hand were short and slightly jagged. Nails on left hand were trimmed slightly, middle fingernail remained thick, long and pressing into the palm of left hand, indentations remained. Nails on both hands were yellow in color. [NAME] debris was no longer present under nails.

During an interview on 5/16/24 at 1:56 PM Certified Nurse Aide #7 stated they are Resident #102's regular aide and that Resident #102 did not refuse care or showers. Certified Nurse Aide #7 stated the resident's spouse would usually do nail care for Resident #102, but the Certified Nurse Aides would do nail care when they noticed Resident #102's nails were getting too long. Certified Nurse Aide #7 stated they approached the nails on the left hand softly due to the contractures (inability to move joint) and it being somewhat painful for the resident. Certified Nurse Aide #7 stated it was important to keep residents' nails short and clean because bacteria can build up underneath and it could be an infection control issue. Certified Nurse Aide #7 stated Resident #102 eats a lot of finger foods so that could be an infection control issue as well.

During an interview on 5/20/24 at 1:56 PM, Licensed Practical Nurse #2 stated they were not aware of Resident #102 refusing any care. Licensed Practical Nurse #2 stated that if a certified nurse aide realized a resident's nails were too long or had dirt under them, they should clip and clean them. Licensed Practical Nurse #2 stated long nails with debris under them was an infection control issue, especially if they ate with their hands.

3. Resident #105 was admitted with diagnoses which included diabetes mellitus, osteomyelitis (infection of bone), and peripheral vascular disease. The Minimum Data Set (a resident assessment tool) dated 4/5/24 documented Resident #105 had moderate cognitive impairment, understood, and understands. Resident #105 required supervision for personal hygiene and bathing.

During an interview and observation on 5/13/24 at 3:33 PM, Resident #105 was observed have long, yellow/orange-colored fingernails with dark debris under them. Resident #105 stated they were unable to cut their own nails and had previously asked facility staff to please cut them but were told not my department. Resident #105 stated that on shower days, facility staff would clean under resident #105's nails but would never clip the nails. Resident #105 stated it bothered them to have such long fingernails, especially their thumb nails, as I could stab someone with them.

During an observation on 5/15/24 at 10:37 AM, Resident #105's fingernails were noted to continue to be long and jagged.

During an observation on 5/16/24 at 8:59 AM, Resident #105's fingernails continued to be long and jagged. The resident stated they had been given a shower on 5/15/24.

During an interview on 5/16/24 at 9:05 AM, Certified Nurse Aide #8 stated that Certified Nurse Aides would provide nail care when giving showers to residents, but they would only clean under a resident's fingernails and they would not trim nails.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335164	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Humboldt House Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 64 Hager Street Buffalo, NY 14208	

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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	During an interview on 5/16/24 at 9:10 AM, Licensed Practical Nurse #3 (Unit Manager Floor 3) stated they expected Certified Nurse Aides to trim residents' fingernails when giving showers. When asked to comment on Resident #105's nails, Licensed Practical Nurse #3 stated that the resident had recently been moved from a different unit and they would make sure the resident would get their nails cared for. During an interview on 5/21/24 at 3:53 PM, Director of Nursing #1 stated they expected daily care included nail care unless a resident had a bleeding disorder or were a diabetic. If the resident was diabetic or had a bleeding disorder, they would expect staff to consult a provider regarding nail care. Director of Nursing #1 stated long nails could be harmful for reasons such as scratching them self, or potentially introducing bacteria to that area. Director of Nursing #1 stated long nails could be an infection control issue. 10 NYCRR 415.12 (a)(3)

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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** 43802 Based on observation, interview, and record review conducted during an Extended Survey completed on 5/23/24, the facility did not ensure that each resident received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan, for four (Resident #16, #154, #305, #360) of thirty three residents reviewed for quality of care. Specifically, the issues involved inaccurately transcribed physician's orders resulting in delay in treatment and there was no comprehensive care plan developed for indwelling foley catheter use and urinary tract infections (#16). In addition, PICC (peripheral inserted central catheter) line dressing changes (#305, #360), and supplements were not administered in accordance with physician's orders (#154). The findings are but not limited to: The policy and procedure titled Medication and Treatment Orders revised date July 2016 documented that verbal orders must be recorded immediately in the resident's chart by the person receiving the order and must include prescriber's last name, credentials, the date, and the time of the order. The policy and procedure titled Routine Urinalysis Specimen revised date October 2010 documented verify that there is a physician's order for this procedure. The policy and procedure state the following should be recorded: the date and time the specimen was collected; the name and title of the individual who performed the procedure; all assessment data obtained during the procedure. The policy and procedure titled Central Venous Catheter Care and Dressing Changes revised March 2022 documented the procedure was to prevent complications associated with intravenous therapy, including catheter related infections that are associated with contaminated, loosened, soiled, or wet dressings. Perform site care and dressing change as established intervals or immediately if the integrity of the dressing is compromised. 1. Resident #16 had diagnoses including quadriplegia (paralysis of all four limbs), neuromuscular dysfunction of bladder (bladder with diminished sensation) and history of urinary tract infections (infection of the bladder). The Minimum Data Set (a resident assessment tool) dated 3/17/24 documented Resident #16 was cognitively intact, understood and understands. Resident #16 had an indwelling foley catheter and did not document a urinary tract infection within the last thirty days. The Visual Bedside Kardex Report (guide used by staff to provide care) with an as of date of 5/16/24 documented Resident #16 required total assist for foley catheter (tube inserted into bladder to drain urine) care. The comprehensive care plan dated 3/14/24 was not developed to include foley catheter care and urinary tract infection. Review of the physician's readmission history and physical progress note dated 3/16/24 documented Resident #16 recently was treated for urinary tract infection and required an indwelling foley catheter. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the nursing progress notes, Licensed Practical Nurse #4 documented Resident #16 complained of a urinary burning sensation on 5/9/24 at 7:51 PM and contacted Medical Doctor #1. New orders were received for a urine sample and Ciprofloxacin (antibiotic) 500 milligrams by mouth twice a day for seven days for a urinary tract infection. The autogenerated pharmacy order note (an alert) dated 5/9/24 at 8:08 PM documented the physician's order was outside of the recommended dose or frequency. The autogenerated pharmacy order note was acknowledged and signed by Licensed Practical Nurse #4 on 5/9/24. Review of the order recap report dated 5/16/24 revealed there was no documented evidence of a physicians' order for a urine sample. Review of the Medication Administration Record dated 5/10/24 revealed an active physician's order for Ciprofloxacin 500 milligrams one tablet to be given by mouth two times a day every seven days for urinary tract infection. and Resident # 16 was administered the first dose of Ciprofloxacin on 5/10/24 at 7:00 AM. The scheduled dose for 5/10/24 at 7:00 PM was blank. The next dose documented as administered was on May 16th 2024 at 7:00 PM. During an observation on 5/13/24 at 10:36 AM, Resident #16 had an indwelling foley catheter draining clear yellow urine. During an interview on 5/14/24 at 10:22 AM, Resident #16 stated they were on antibiotics for urinary tract infection and still had burning. Review of the third-floor laboratory specimen logbook from 5/1/24 - 5/10/24 revealed there was no evidence that a urine specimen was collected for Resident #16. Review of Resident #16's electronic medical record on 5/15/24 at 9:00 AM revealed a urinalysis was collected on 5/9/24 at 7:30 PM. The urinalysis was positive for nitrates (type of nitrogen chemical which is a sign of possible urinary tract infection) and positive for leukocytes (white blood cells). Review of the drug regimen review report dated 5/15/24 documented Resident #16 was receiving Ciprofloxacin 500 milligrams twice daily every seven days for urinary tract infection. The standard dose was 500 milligrams twice daily for seven days. The Pharmacist Consultant recommended to change the dose to twice daily for seven days. The drug regimen review was addressed and signed by Nurse Practitioner #1 on 5/15/24. During a telephone interview on 5/17/24 at 11:30 AM, Pharmacy Consultant #1 stated the antibiotic was for a urinary tract infection. Ciprofloxacin 500 milligrams every seven days on 5/9/24 was not therapeutic and was a nine-day delay in treatment. During a telephone interview on 5/17/24 at 1:08 PM, Licensed Practical Nurse #4 stated Resident #16 complained of burning with urination on 5/9/24. They notified the Medical Doctor #1), obtained verbal orders for a urinalysis with a culture and sensitivity and Ciprofloxacin 500 milligrams by mouth for seven days was started. They should have entered the physician's order for the urine sample into the electronic medical record but they did not. (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 interview on 5/20/24 at 8:20 AM, Licensed Practical Nurse #4 stated they entered the antibiotic order into the electronic administration record incorrectly. The physician's order should have been entered as Ciprofloxacin 500 milligrams by mouth twice daily for seven days. Verbal orders were written down, repeated back to the provider, and entered in the computer by the nurse who received the order. Urine specimens were entered into specimen laboratory logbook and forgot to log the urine in the book on 5/9/24. During a telephone interview on 5/21/24 at 8:26 AM, Microbiology Supervisor #1 confirmed that the urinalysis and culture and sensitivity were collected for Resident #16 on 5/9/24 and stated the culture and sensitivity results were faxed to the facility on [DATE]. Review of the urine culture and sensitivity report provided by Microbiology Supervisor #1 on 5/21/24 at 8:48 AM, revealed the culture report was sent to the facility on [DATE] at 6:24 PM. The results documented Escherichia (bacteria) greater than 100,000 colony forming unit millimeters and 50,000 - 99,999 colony forming/unit millimeters for Klebsiella pneumonia (bacteria). Ciprofloxacin was resistant to both organisms. During an interview on 5/21/24 at 8:40 AM, Infection Preventionist Nurse/ Registered Nurse #4 stated lab results were sent to the fax box in an email labeled administrative staff. Nurse practitioner #1, Unit Managers, and Nursing Supervisors checked the email daily. Nursing supervisors checked the email on off hours and weekends. Urine culture reports were addressed and signed by the medical providers. Infection Preventionist Nurse/ Registered Nurse #4 stated they were unaware there was a urine culture collected for Resident #16. Licensed Practical Nurse #4 should have entered the physician order correctly into the electronic medical administration record and documented the urine sample in the laboratory specimen logbook. During an interview on 5/21/24 at 9:07 AM, the Director of Nursing #1 stated Unit Managers were responsible for care plan development. Care plan development and revisions were completed quarterly and as needed. Resident #16 had a urinary tract infection with a foley catheter and would have expected both to be on the comprehensive care plan. During an interview on 5/21/24 at 9:53 AM, Licensed Practical Nurse Unit Manager #3 stated when a provider gave verbal orders, nurses were responsible to enter the order into the electronic medical record. Licensed Practical Nurse Unit Manager #3 stated the medication administration record, and the laboratory specimen logbook had no evidence of a urine sample obtained for Resident #16 on 5/9/24. The receiving nurse, Licensed Practical Nurse #4 should have entered the order into the computer and obtained the urine sample. Urine specimens were to be logged into the laboratory specimen book. During an interview on 5/21/24 at 1:04 PM, Nurse Practitioner #1 stated they reviewed the urinalysis results on 5/9/24 and the urine culture and sensitivity report on 5/21/24. They stated they would have expected the results sooner and based on the bacteria, the Ciprofloxacin was inappropriate. During a telephone interview on 5/21/24 at 2:07 PM, Medical Doctor #1 stated they were contacted by Licensed Practical Nurse #4 on 5/9/24 at 7:51 PM. Medical Doctor #1 stated they ordered a urinalysis, a culture and sensitivity and was not notified with results. Medical Providers were available on call and would have expected to be contacted through a phone call, email, or tiger text. Based on the culture and sensitivity report the antibiotic should have been changed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #305 had diagnosis including arthritis due to bacteria of the left ankle and foot, and other synovitis (inflammation and swelling of a layer of connective tissue that lines a joint) and tenosynovitis (inflammation and swelling of a tendon) of the left ankle and foot. The Order Recap Report documented an order with a start date of 4/10/24 documented to change the peripherally inserted central catheter (PICC) site dressing as needed for maintenance and every day shift every Wednesday. The Medication Administration Record dated May 2024 documented to change the peripherally inserted central catheter end cap every week on Friday with dressing change. Medication Administration Record documented with initials the dressing change was completed on 5/3/24 and 5/10/24. Review of the Progress Notes dated 4/10/24 through 5/15/24 revealed there was documented no evidence that central line dressing was changed as ordered. During an observation and interview on 5/13/24 at 8:50 AM and 5/14/24 at 9:10 AM, Resident #305 stated the last time the peripherally inserted central catheter (PICC) line dressing was changed was on 5/2/24 by Unit Manager Registered Nurse #2. Resident #305 stated, waiting for it (dressing) to fall off. The peripherally inserted central catheter line dressing was in the residents right upper arm and was peeling away, edges loose to the transparent dressing and dated and initialed 5/2. During an interview on 5/20/24 at 12:23 PM, Unit Manager Registered Nurse #2 stated they did not have central line dressings available to complete the dressing change for Resident #360 and #305 last week and notified Director of Nursing #1. Additionally, Registered Nurse #2 stated they signed Medication Administration Record for dressing change to the peripherally inserted central catheter line on 5/10/24 in error. During an interview on 5/21/24 at 3:39 PM, the Director of Nursing #1 stated they were aware at one point of being out of central line dressings. Director of Nursing #1 stated they were not aware that the central line dressings changes weren't able to be completed as ordered and would have liked to have known. Director of Nursing #1 stated they expected central line dressings to be changed as ordered to prevent infection. Additionally, the Director of Nursing #1 stated the provider should have been made aware of inability to complete central line dressing change as ordered. During an interview on 5/21/24 at 4:19 PM, Supply Supervisor #1 stated Director of Nursing #1 will usually tell them when anything extra needs to be ordered. Supply Supervisor #1 stated they addressed ordering central line dressings a week or two ago after the Director of Nursing #1 notified them of what to specifically order. 3. Resident #154 had diagnosis that included displaced fracture of base of neck of right femur (thigh bone), acute respiratory failure with hypoxia (absence of oxygen). The Minimum Data Set, dated dated dated [DATE] documented Resident #154 had severe cognitive impairment, was understood, and understands. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of hospital discharge summary dated 4/11/24 at 1:54 PM, documented discharge diagnoses that included hypokalemia (low potassium level), hypomagnesemia (low magnesium level), hypophosphatemia (low phosphate level). Resident #154 required electrolyte repletion during hospital course and recommended repeat serum electrolytes including magnesium and phosphate in 1 week. Discharge medication list included Magnesium Chloride 64-128 milligrams by mouth daily for 7 days, Phosphorus/Sodium/Potassium (Neutra-Phos) 250-250 milligrams by mouth four times a day for 7 days and Potassium Bicarbonate/Citric Acid 40 milliequivalent by mouth daily. Review of Order Summary Report documented Effervescent 20 milliequivalent (Potassium Bicarbonate-Citric Acid) give 2 tablets by mouth one time a day for supplement, Magnesium Chloride-Calcium Tablet Delayed Release 64-106 milligrams give 2 tablets by mouth one time a day for supplement for 7 days, and Phosphorus with Sodium and Potassium oral packet 280-160-250 milligrams give 1 packet by mouth four times a day for supplement for 7 days were ordered on 4/11/24. Review of laboratory, Basic Metabolic Panel, collected on 4/12/24 documented Resident #154's potassium level was low at 3.3 millimoles per liter (unit of measure). Review of the comprehensive care plan dated 4/12/24 documented an alteration in electrolyte balance. Interventions included to administer medications as ordered; Monitor/document for side effects and effectiveness; Monitor for signs of electrolyte imbalance such as weak pulse, faint heart sounds, hypotension, diminished tendon reflexes, and generalized weakness. Review of Medication Administration Record April 2024 for Resident #154 documented: - Phosphorus with Sodium and Potassium oral packet 280-160-250 milligrams give 1 packet by mouth four times a day for supplement for 7 days ordered on 4/11/24 was documented as administered on 4/15/24 and 4/16/24 at 4:00 PM and 8:00 PM; and 4/17/24 at 8:00 AM. All other administration dates and times between 4/11/24 and 4/17/24 were blank, or coded 9. Resident #154 received 5 out of 22 scheduled doses between 4/11/24 and 4/17/24. - Effervescent 20 milliequivalent (Potassium Bicarbonate-Citric Acid) give 2 tablets by mouth one time a day for supplement ordered to start 4/12/24 was signed as given on 4/17/24 at 7:00 AM. Administration dates 4/12/24 through 4/16/24 were coded 9 or left blank. Resident #154 received 1 out of 6 scheduled doses between 4/11/24 and 4/17/24. - Magnesium Chloride-Calcium Tablet Delayed Release 64-106 milligrams give 2 tablets by mouth one time a day for supplement for 7 days ordered to start 4/12/24 was signed as given on 4/17/24 at 7:00 AM. Administration dates 4/12/24 through 4/16/24 were coded 9 or left blank. Resident #154 received 1 out of 6 scheduled doses between 4/11/24 and 4/17/24. Review of Progress Notes dated 4/11/24 through 4/17/24 revealed on 4/12/24 at 12:25 PM Licensed Practical Nurse #1 documented a Medication Administration Note-awaiting pharmacy arrival. There was no documented evidence that Resident #154 received supplements as ordered, refused medications/supplements and the medical providers were notified. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 5/16/24 at 12:18 PM, Pharmacist #2 stated the pharmacy did not dispensed Magnesium Chloride-Calcium Tablet, Phosphorus with Sodium and Potassium oral packet. Pharmacist #2 stated that most over the counter (OTC) supplements were not provided for this facility, and they had these supplements listed as a stock medication at the facility according to their records. Pharmacist #2 stated the pharmacy did not receive any over the counter (OTC) authorization forms requesting these supplements. During an interview on 5/16/24 at 12:55 PM, Licensed Practical Nurse #11 stated they usually don't get medications right away from the pharmacy for new admissions, they usually come the next day depending on what time a resident was admitted to the facility. Licensed Practical Nurse #11 stated that a provider should be updated if a medication/supplement wasn't available and it should be documented in a progress note so it can be communicated with other staff. During an interview on 5/16/24 at 1:20 PM, Unit Manager Registered Nurse #2 stated if a medication/supplement wasn't available nursing staff should have obtained a hold order or an alternate order from a medical provider. Registered Nurse #2 stated if a medication/supplement was held or changed it should have been documented on the medication administration record or in the nurses note. During an interview on 5/16/24 at 1:28 PM, Medical Doctor #2 stated if a medication/supplement wasn't available they would have expected the nursing staff to talk to the pharmacy and notify a medical provider. Medical Doctor #2 stated that not receiving ordered medication/supplements could cause adverse effects on a resident. During an interview on 5/16/24 at 1:33 PM and at 2:25 PM, Nurse Practitioner #1 stated they would have expected nursing to administer medication/supplement as ordered, if they were not available to call pharmacy first to find out when medication/supplement would be available and give them a heads up to find out what they should do. Additionally, Nurse Practitioner #1 stated they were not notified and would have expected nursing to notify them, and document refusals of medication/supplements. During an interview on 5/16/24 at 1:49 PM Licensed Practical Nurse #1 stated Licensed Practical Nurse #1 stated that the number 5 code, on the Medication Administration Record means a medication was held and number 9 code means other, nurse can free write reason, usually means awaiting arrival of medication. During a telephone interview on 5/16/24 at 2:02 PM, Licensed Practical Nurse #12 stated they recalled Resident #154 and used code 9 on the Medication Administration Record to indicate that a medication was not available. Licensed Practical Nurse #12 stated they couldn't recall if they notified a medical provider about Resident #154's medication/supplements not being available. During an interview on 5/16/24 at 2:37 PM, Director of Nursing #1 stated they expected nurses call the medical provider to get an alternative order if the medication/supplement were not available to be given as ordered. The Director of Nursing #1 stated if a resident is refusing medications/supplements a nursing progress note should be written. Director of Nursing #1 stated a blank on the Medication Administration Record means it didn't happen, the medication wasn't given. Additionally, Director of Nursing #1 stated they would expect nursing to document a note to alert the provider. 10 NYCRR 415.12

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 43802 Based on observation, interview, and record review conducted during the Extended Recertification and Complaint (#NY00333644) survey completed on 5/23/24, the facility did not provide food and drink that was at a safe and appetizing temperature for three (Second floor Unit, Third floor Unit, and Fourth floor Unit) of three test trays. Specifically, food and beverages during meals were served at suboptimal temperatures and were not palatable. Residents #21, #27, #41, #82, #125, #134, #359, and #506, were involved. The findings are: The policy and procedure titled Food Temperature Monitoring dated 3/23/23, documented that potentially hazardous foods shall be kept at 41 degrees Fahrenheit or below when cold or 135 degrees Fahrenheit or above when hot, and temperatures shall be maintained during storage, preparation, transport, and service. During an interview 5/13/24 11:54 AM, Resident #134 stated the food that was provided to the residents was horrible, portion sizes were very small, the biscuits were hard, the bread was soggy, and they had found hair in their food once. They stated sometimes the food was unidentifiable and it was always cold, they stated they will either not eat at all or order out. During an interview on 5/17/24 at 1:21 PM, Resident #82 stated they did not like the food, and it was slop. They stated they received care packages with snack foods from family members. During an interview on 5/13/24 at 12:51 PM, Resident #359 stated the food had no flavor and that the food and coffee were cold when served. During an interview and an observation on 5/17/24 at 4:14 PM, Resident #41 the food was cold and the biscuits were hard, and the facility put gravy over the hard biscuits to soften them up. During a family interview on 5/15/24 at 11:35 AM, Resident #506's family representative stated the food at the facility was impossible, and they brought dinner to the resident daily because they were either unable to eat it or did not like what the facility was serving. During an interview on 5/13/24 at 12:06PM, Resident #21 stated meals were tepid and not served warm. During an interview on 5/13/24 at 11:34 AM, Resident #125 stated the food was often cold. On 5/14/24 at 8:21 AM, the resident stated the food was cold again yesterday for all meals. During an interview on 5/14/24 at 9:50 AM, Resident #27 stated meals were cold. The Certified Nurse Aides let them sit in the cart. (continued on next page)

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	335164	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a lunch meal tray line observation on 5/16/24, the Unit carts left the kitchen at the following times: Second floor Unit cart at 12:14 PM, Third floor Unit cart at 12:55 PM and Fourth floor Unit cart at 2:10 PM. The lunch meals were plated, covered, and for some trays there were no insulated bases. The tray carts for all test trays were open and had no insulating doors. Temperatures were taken throughout the tray line service and all hot food items were held at above 140 degrees Fahrenheit. Cold food and drink items were held pre-portioned and pre-poured on metal trays at the tray line. Plates were pre-warmed in the oven, as the plate warmer was out for repairs. 1.During a test tray observation on 5/16/24 at 11:55 AM, on the Second floor Unit, tray cart one was brought onto the floor at 11:55 AM on an open tray cart, the second tray cart was brought out at 12:18 PM, and all residents were served their lunch by 12:26 PM. A test tray was completed with Dietary Director #1 at 12:26 PM for temperatures and palpability. The temperatures were taken by Dietary Director #1 using the facility's digital thermometer. The results were as follows: - baked ziti was 119 degrees Fahrenheit - tasted lukewarm and was not palatable. - zucchini 110 degrees Fahrenheit - mushy, cold and bland. - coffee 124.5 degrees Fahrenheit - lukewarm, not hot. - cranberry juice 63 degrees Fahrenheit- lukewarm, not cold. - milk 59.5 degrees Fahrenheit - tasted warm, not palatable - fruit 41.4 degrees Fahrenheit - canned peaches were slightly warm, could have been colder. During an Interview at the time of the test tray completion with Dietary Director #1, they stated that the food temperature should be between 140 degrees Fahrenheit but no lower than 120 degrees Fahrenheit. They stated that some of the food was below 120 degrees Fahrenheit and that this could cause food borne illness to the residents. During the lunch tray line observation on 5/16/24 at 12:41 PM, Dietary Director #1 was observed returning to the kitchen, using their thermometer to take a temperature of the pre-poured milk on the tray at the tray line, then instructing dining staff to pour out the remaining cups of milk and pour fresh milk from the cooler. 2.During a lunch meal tray observation on 5/16/24 at 12:50 PM, the Third floor Unit dietary cart arrived at 12:56 PM and meal trays were all passed by 1:14 PM. A test tray was completed with the Dietary Director #1 at 1:15 PM. The temperatures were taken by Dietary Director #1 using the facility's digital thermometer. The results were as follows: -baked ziti was127.6 degrees Fahrenheit and tasted lukewarm. -sauteed zucchini was 94.5 degrees Fahrenheit and tasted lukewarm and watery. -milk was 54.2 degrees Fahrenheit and tasted warm. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/16/24 at 1:20 PM, Dietary Director #1 stated temperatures were at 180 degrees Fahrenheit when the food was pulled from the kitchen to the tray line. The baked ziti should have been between 120 and 140 degrees Fahrenheit. Cold temperatures should be served below 40 degrees Fahrenheit. 3.During a lunch meal tray observation on 5/16/24 at 1:02 PM, the Fourth floor Unit dietary cart arrived at 1:22 PM and meal trays were all passed by 2:19 PM. A test tray was completed with Dietary Director #1 at 2:19 PM. The temperatures were taken by Dietary Director #1 using the facility's digital thermometer. The results were as follows: -mandarin oranges was 75 degrees Fahrenheit and tasted warm. -coffee was 104.4 degrees Fahrenheit and tasted lukewarm to palate. -milk was 57.1 degrees Fahrenheit and tasted lukewarm to palate. During an interview on 5/17/24 at 12:57 PM, with Dietary Technician & Specialist #1, they stated they expected warm foods to be served at 135 degrees Fahrenheit or above and cold foods to be served at 40 degrees Fahrenheit or below and that residents would experience food borne illnesses if foods were not at the correct temperatures. 10 NYCRR 415.14(d)(1)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335164	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER: Humboldt House Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 64 Hager Street Buffalo, NY 14208	

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43802 Based on observation, interview, and record review conducted during an Extended survey completed on [DATE], the facility did not store food in accordance with professional standards for food safety for three (Second floor Unit, Third floor Unit, and Fourth floor Unit) of three nourishment unit refrigerators reviewed. Specifically, the nourishment kitchen refrigerators contained undated, unlabeled, expired food and drink items, and had liquid spills and dried substances on surfaces; the Fourth floor Unit refrigerator was not holding a safe food storage temperature and subsequently lacked a thermometer; the Second floor Unit refrigerator had no thermometer. The findings are: The policy and procedure titled Food Temperature Monitoring dated [DATE], documented that the temperature of each refrigeration unit used for food and beverage storage shall be monitored twice a day at the start of first shift and just prior to closing the area for the day. The policy and procedure titled Foods brought by Family/Visitors from the Nursing Services Policy and Procedure Manual for Long-Term Care revised [DATE], documented that food that was left with residents to consume later was to be labeled and stored in a manner that was clearly distinguishable from facility-prepared food and to be stored in re-sealable containers with tightly fitting lids in a refrigerator. Containers were to be labeled with the resident's name, the item and the use by date. Nursing and/or food service staff would discard any foods prepared for the resident that showed obvious signs of potential foodborne danger like mold growth, foul odor, past due package expiration dates. 1.During an observation of the Third floor Unit nourishment kitchen on [DATE] at 8:10 AM and 8:23 AM, revealed two plastic hot beverage mugs in the freezer with no identification as to what liquid they contained or which resident they belonged to, and two clear latex gloves filled with frozen clear liquid which were tied off at the opening. There were two hot beverage mugs in the fridge that were not identified by date, contents, name of resident they belonged to and there was a pitcher with frozen clear liquid contents. The refrigerator had dried spills on the shelves in the door and at the bottom of the fridge. 2.During an observation of the Fourth floor Unit nourishment kitchen on [DATE] at 10:01 AM, revealed the thermometer in the freezer displayed at 40 Fahrenheit and there was a clear latex glove in the freezer. The fridge did not have a thermometer and contained a partial box of clear latex gloves with some pulled out and placed randomly on the shelf around the box and two large clear plastic bags that were tied and contained nourishments (single-serve milk shakes, juice, crackers, etc.), each item was labeled with a resident name, and they were dated [DATE]. Both bags contained more than 20 items. There was a sandwich in a pleated plastic bag on the bottom shelf that was unlabeled, undated and appeared to be bologna. All three shelves of the fridge were very wet, any item picked up dripped with a clear liquid. The bottom of the fridge, under the clear bottom bins, was filled with a brown liquid and there were brown dried stains on the bottom of the refrigerator along the door side. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 10:08 AM, Registered Nurse #2 stated that the leftover nourishments dated [DATE] should have been handed out to the residents on that date. RN #2 identified the sandwich as a bologna sandwich, possibly belonging to a certain resident and stated the latex gloves may have been placed in the refrigerator by a resident. During an interview on [DATE] at 11:17 AM, Dietary Supervisor #1 stated the nourishments in the Fourth floor Unit fridge dated [DATE] should have been given to the residents on that date and now needed to be thrown out. 3.An observation of the Second floor Unit nourishment kitchen on [DATE] at 10:24 AM with Registered Nurse #1 present revealed the following: -The freezer contained an opened box of freeze pops (unlabeled and undated) and a paper bag with two take-out dinner trays that were not dated. The bag had a resident's name written on it and was not dated. -The fridge contained an unopened 1 gallon container of 2% milk marked [DATE] with an expiration date of [DATE]; a store-bought package of seafood salad with a packaged date of [DATE] and a sell by date of [DATE]; a black plastic bag with a dinner tray meal with a metal fork in the container, undated, a single serve fruit punch with an expiration date of [DATE], a single serve orange juice with an expiration date of [DATE], and a single serve 1% milk with a sell by date of [DATE] - the bag and its contents were unlabeled. -The refrigerator lacked a thermometer. There was a document attached to the freezer door titled Unit Temperature Log, dated [DATE]. It documented the temperature range should be 38 to 40 Fahrenheit and action must be taken if the temperature was over 40 Fahrenheit. During an interview at the time of this observation, Registered Nurse #1 stated they expected the fridge to be checked at least once every 24 hours, foods should be discarded three days after opening, there should be no employee foods and no expired food and drink items in the unit fridge, and there should be a thermometer in the fridge. Registered Nurse #1 stated that someone could get food poisoning if they ate or drank an expired item. During an interview on [DATE] at 10:50 AM, Licensed Practical Nurse #1 stated that dietary staff were responsible to take the temperatures in the unit refrigerator and freezer. During an interview on [DATE] at 11:08 AM, Dietary Supervisor #1 stated that they and another dietary supervisor were responsible to check and document the temperatures for the refrigerators on each unit twice daily. When asked about the temperature for the Second floor Unit refrigerator and freezer, Dietary Supervisor #1 stated that the temperatures did not fluctuate and were always consistent. When asked to check the current temperatures, Dietary Supervisor #1 stated the temperature in the freezer was 9 Fahrenheit and they were unable to locate a thermometer in the refrigerator. During an observation of the Fourth floor Unit nourishment kitchen on [DATE] at 8:00 AM, revealed the thermometer in the fridge displayed a temperature of 46 Fahrenheit. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 9:50 AM, Dietary Technician & Specialist #1 stated that residents on all floor units received nourishment snacks three times daily and the nourishments in the Fourth floor Unit refrigerator dated [DATE] should have been thrown out prior to [DATE]. Dietary Technician & Specialist #1 also stated that a refrigerator should be kept at 40 Fahrenheit or below to keep drinks and food from spoiling. During an observation of the Fourth floor Unit nourishment kitchen on [DATE] at 11:02 AM, the refrigerator thermometer displayed a temperature of 48 Fahrenheit, the clear liquid was still present on shelves and the brown stains were still present on the bottom of the refrigerator. There were four partially full clear plastic cups with an orange liquid on the top shelf of the refrigerator, they felt warm to the touch, were unlabeled and undated. During an interview and observation in the Fourth floor Unit nourishment kitchen with Dietary Technician & Specialist #1 on [DATE] at 12:57 PM, they stated the fridge temperature was now at 51 Fahrenheit, the liquid in the four cups appeared to be orange juice, but they were unsure how long it had been in the refrigerator. Dietary Technician & Specialist #1 used a facility digital thermometer to take the temperature of the liquid in one of the cups and stated the temperature was 53.5 Fahrenheit. They also stated the freezer temperature was at 40 Fahrenheit and that should not be. They stated the freezer and refrigerator should not be used, as the temperature settings were set to the highest possible setting, and both were too warm. They stated they would notify nursing and maintenance staff immediately to not use this unit refrigerator and to have it fixed. During an observation in the Fourth floor Unit nourishment kitchen on [DATE] at 8:32 AM, revealed the refrigerator no longer had a thermometer in it, and the clear liquid on the shelves was still present, as was the brown liquid under the drawers and the dry spills on the bottom along the door. Using a digital thermometer, the temperature in the refrigerator measured at 62 Fahrenheit, and the temperature in the freezer measured at 52 Fahrenheit. During an interview on [DATE] at 9:56 AM, the Interim Maintenance Director stated the fridge and freezer, at minimum, needed new seals, and a request was out to administration. During an interview on [DATE] at 9:59 AM, the Administrator stated the Fourth floor Unit nourishment refrigerator was for resident use and the facility process was that dietary supervisors were to check the temperatures twice daily and should notify maintenance via the facility's electronic maintenance request system if the temperatures were not safe. When asked specifically about this refrigerator and told what the observed temperatures had been, the Administrator stated the refrigerator should be replaced. 415.14 (h) SubPart ,d+[DATE] Food Service Establishments ,d+[DATE].31(a and b), ,d+[DATE].43(e), ,d+[DATE].44

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43802 Based on interview and record review conducted during the Extended Survey completed on 5/23/24, the facility did not ensure each resident was offered the pneumococcal and influenza immunizations. Additionally, the facility did not ensure the residents medical record includes documentation that indicates education regarding the benefits and the potential side effects of the immunizations was provided for four (Resident #10, #54, #406, #456) of five residents reviewed. Specifically, there was no documented evidence that residents #10, #54, #406, and #456 were offered/declined, and educated on the influenza, pneumococcal immunizations. The findings are but not limited to: The policy and procedure titled Pneumococcal Vaccine dated 10/23 documented all residents are offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. The policy documented that assessments of pneumococcal vaccination status are conducted within five business days of admission to the facility. Education of benefits, potential side effects of the vaccine and the residents' declination shall be documented in resident's medical record. The policy and procedure titled Influenza Vaccine dated 03/23 documented all residents who have no medical contraindications to the vaccine will be offered annually. If a resident refuses the vaccine, that shall be documented in the resident medical record. 1.Resident #10 was admitted with diagnoses of diabetes, chronic obstructive pulmonary disease, and morbid obesity. The Minimum Data Set (a resident assessment tool) dated 2/24/24 documented Resident #10 was cognitively intact. Review of Resident #10's medical record on 5/16/24 revealed there was no evidence regarding pneumococcal and influenza immunizations to include offering, declinations, and education. 2.Resident #54 was admitted with diagnoses of type two diabetes, major depression disorder, and hypertension. The Minimum Data Set, dated dated dated [DATE] documented Resident #54 was cognitively intact. Review of Resident #54's medical record on 5/16/24 revealed there was no evidence regarding pneumococcal and influenza immunizations to include offering, declinations, and education. 3.Resident #406 was with diagnoses of chronic obstructive pulmonary disease, Parkinson's disease, dementia. The Minimum Data Set, dated dated dated [DATE] documented Resident #406 was moderate cognitively impaired. Review of Resident #406's medical record on 5/16/24 revealed there was no evidence regarding pneumococcal and influenza immunizations to include offering, declinations, and education. 4. Resident #456 was admitted with diagnoses of type 2 diabetes, Charcot's joint (a rare and disabling disorder resulting in nerve damage to the feet), and morbid obesity. The Minimum Data Set, dated dated dated [DATE] documented Resident #456 was cognitively intact. (continued on next page)

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	335164	A. Building B. Wing	05/23/2024

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #456's medical record on 5/16/24 revealed there was no evidence regarding pneumococcal and influenza immunizations to include offering, declinations, and education. During an interview on 5/16/24 at 1:06 PM, the Infection Preventionist/Assistant Director of Nursing stated the admitting nurse was responsible for obtaining pneumonia and influenza immunization (October 1st to March 31st) statuses. The infection preventionist stated ultimately, they would be responsible to ensure the immunization statuses were obtained and documented up to date. During an interview on 5/17/24 at 1:00 PM, the Director of Nursing #1 stated the residents should have been offered immunizations by the admitting nurse. They stated that it was important to offer all residents to consent or decline the immunizations because the residents were at high risk for infections. During an interview on 5/21/24 at 1:04 PM, the Regional Director of Nursing stated they were unable to locate immunization documents for pneumonia and influenza for Resident's ##10, #54, #406, and #456. 10 NYCRR 415.19 (a) (1)