STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335172	A. Building B. Wing	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Comprehensive Rehab & Nursing Ctr at Williamsville	147 Reist Street Williamsville, NY 14221

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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 0561 Level of Harm - Potential for minimal harm Residents Affected - Many	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 43785 Based on observations, interviews, and record review conducted during the Standard survey completed on 12/6/24, the facility did not allow residents to choose activities, schedules, and health care consistent with his or her interests, assessments, and plan of care for one (Resident #64) of one resident reviewed. Specifically, Resident #64 was not provided with a tub bath per their preference as the facility did not have a functioning tub. The finding is: The policy and procedure titled Comprehensive Care Planning & Baseline dated 6/2021, documented a care plan will be individualized for each resident using a person-centered approach. Your Rights as a Nursing Home Resident in New York State dated 2022 documented, you have the right to self-determination includes but not limited to; be offered choices and allowed to make decisions important to you and receive services with reasonable accommodations for individual needs and preferences. The policy and procedure titled Tub Maintenance undated documented, repairs if needed are completed. If repair cannot be made, then this is communicated to maintenance department who calls in outside service company to make repair. The Maintenance Director will obtain necessary quote(s)for repair and the Administrator will be notified of quote and any scheduled repairs. Resident #64 had diagnoses including malignant neoplasm of prostate, diabetes mellitus type 2, and osteoarthritis. The Minimum Data Set (a resident assessment tool) dated 10/24/24, documented Resident #64 was moderately cognitively impaired. The Activity Interview for Daily and Activity Preferences form dated 7/23/24 for Resident #64 documented very Important to choose between a tub bath, shower, bed bath or sponge bath and preferred a tub bath. During an interview on 12/3/24 at 10:20 AM, Resident #64 stated they used to take tub baths at home and would prefer a tub bath, but the facility doesn't have a working tub, and stated they think it's been broken for a long time. (continued on next page)

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

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F 0561 Level of Harm - Potential for minimal harm Residents Affected - Many	During an interview on 12/4/24 at 10:09 AM, Resident #64's Primary Contact (family) stated Resident #64 always took baths at home and Resident #64 had informed them they would prefer a tub bath at the facility. During an interview on 12/4/24 at 10:51 AM, the Activities Department Director #1 stated they had interviewed Resident #64 upon readmission and completed the Activity Interview for Daily and Activity Preferences form based on the residents answers. They would expect the Nursing Department to meet the Resident's preferences and they stated they did not know the facility did not have a functioning tub. Observation on 12/3/24 at 10:12 AM Unit 6's bathtub had red bags covering it that were held in place by straps. The tub was unable to be utilized. Observations on 12/5/24 between 11:03 AM and 11:20 AM revealed the following: - Unit 2's bathtub had dark brown debris in the base of the tub with a chair and other equipment stored in the tub. - Unit 1 did not have a bathtub available. - Unit 5's bathtub had dried white and dark brown debris in the base of the tub. During an interview on 12/5/24 at 9:37 AM, [NAME] #1 stated they clean Unit 6 shower room and they believe the tub had not functioned for over two years. During an interview on 12/5/24 at 9:47, Certified Nurse Aide #3 stated Unit 6's tub had been broken for over a year and doesn't know if there were any functioning tubs in the facility. During an interview on 12/5/24 at 9:52 AM, Certified Nurse Aide #4 stated Resident #64 had not asked for a tub bath and they had not offered a tub bath because there were no functioning bath tubs in the facility. At 9:53 AM Certified Nurse Aide #4 asked Resident #64 what their preference was for bathing and Resident #64 stated they preferred a tub bath but know they can't have one because there were not any functioning tubs in the facility. During an interview on 12/5/24 at 1:11 PM, the Environmental Department Director stated there were no functioning tubs on the units in the shower rooms, but there were some tubs in the private rooms that work. They stated they do not know what was specifically wrong with each of the shower room tubs and had reported the concern to the previous Administrator. The Environmental Department Director stated the facility should have a functioning bath tub for resident's who prefer a bath and suggested Resident #64 may be able to use a private room tub for their preferences, if one was available. During a telephone interview on 12/5/24 at 1:46 PM, previous Unit Manager Licensed Practical Nurse #3 stated they were not aware Resident #64 preferred a bath, but they would not be able to meet the resident's preference because the facility doesn't have a functioning tub. (continued on next page)

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F 0561 Level of Harm - Potential for minimal harm Residents Affected - Many	During an interview on 12/5/24 at 3:38 PM, the Therapy Department Director stated Resident #64 does not have the physical mobility to utilize one of the private room tubs, because the tub was too low and would be a safety concern. They stated choosing a bath verses a shower was a resident's right of preference and the facility should have a functioning tub. During an interview on 12/5/24 at 4:51 PM, the Director of Nursing stated the facility did not have functioning bathtubs in the shower rooms and the bathtubs in the private rooms were too low and would pose as a safety hazard for Resident #64. They stated the facility should have a functioning bathtub for any resident that had a preference to use it. They stated they believed the last functioning bathtub in the facility broke approximately 2 years ago. During an interview on 12/5/24 at 5:00 PM, the Administrator stated they have been the Administrator since August 2024 and didn't know the facility didn't have a functioning bathtub and would have expected the Environment Department Director to have informed them. They stated it was important for all residents to have choices and bathing preferences and the facility was unable to accommodate Resident #64's preferences. 10 NYCRR 415.5 (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 0584 Level of Harm - Potential for minimal 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** 43785 Based on observations, interviews and record review conducted during a standard survey, completed on 12/6/24, the facility did not provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Specifically, 2 (Units 1 and 5) of 4 units reviewed for environment had issues with brown stained ceiling tiles in halls and resident rooms. Unit 5 the baseboards in the halls were dirty with visible dark debris, and the shower room had a strong fecal odor, soiled wet linens on the floor, and soiled shower curtain. The findings are: The undated document titled Quality Assurance Improvement Plan documented it was the purpose of the Quality Assurance/Performance Improvement committee to provide excellent quality resident/patient care and services. Quality is defined as meeting or exceeding the needs, expectations and requirements of the patients cost effectively while maintaining good resident/patient outcomes and perceptions of patient care. During an interview on 12/6/24 at 3:58 PM, the Director of Nursing stated they did not have a policy and procedure on homelike environment. 1a. Observations on Unit 5 revealed on 12/2/24 at 11:29 AM, 12/4/22 at 9:54 AM, and 12/6/24 at 9:13 AM, Resident room [ROOM NUMBER] had four ceiling tiles with brown circular stains. 1b. Observation on 12/6/24 at 9:15 AM, Unit 1 hall there were multiple ceiling tiles with large brown circular stains, and the wallpaper was visible buckling near the ceiling. Resident room [ROOM NUMBER] had multiple ceiling tiles with large brown stains. During interviews on 12/6/24 at 9:34 AM and 3:48 PM, the Environmental Department Director stated they were aware the ceiling leaked on multiple units, depending on the weather, and they were responsible for changing ceiling tiles. They stated they weren't aware that Resident room [ROOM NUMBER] had stained, soiled ceiling tiles and they should have been notified so they could be changed. They stated the facility should be maintained to provide a homelike, safe environment for the residents, and having rain pour in through the ceiling was not homelike. Additionally, they stated the roof of the entire facility needed replacing. 2a. During an observation on 12/2/24 at 8:57 AM and 9:36 AM, the Resident Spa on Unit 5 had a strong fecal odor, soiled wet linens on the floor and a soiled wet washcloth hanging from the towel bar. The shower curtain was soiled with a brown substance; dark brown/black debris on the floor outside the bathroom stall, and the third shower stall had a clump of brown debris, on the floor, that appeared to be fecal matter. 2b. During further observations on 12/3/24 at 8:20 AM, 12/4/24 at 10:31 AM, and 12/6/24 at 8:47 AM, the Resident Spa on Unit 5; continued to have a strong fecal odor, soiled wet linens on the floor and a brown smeared substance on the shower curtain. (continued on next page)

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F 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	During an observation and interview on 12/6/24 at 8:52 AM, in the Resident Spa on Unit 5, Certified Nurse Aide #5 stated the Aides were responsible for picking up the linens and bodily fluids after each shower. Housekeepers were responsible for sanitizing the shower once per shift. Certified Nurse Aide #5 stated the shower room smelled like feces and the wet soiled linens should not be left on the floor because it was an infection control issue. During an observation and interview on 12/6/24 at 9:05 AM, the Director of Housekeeping stated shower rooms should be sanitized by the housekeeper once per shift and they should be disinfecting the shower curtains or replacing them as needed. They stated the shower room smelled like feces. The Director of Housekeeping stated the Certified Nurse Aides were responsible for cleaning any bodily fluids and removing the soiled linens, but their housekeeping staff should have let them know if they noticed that it wasn't being done, and it should not have been left that way. 3a. During an observation on 12/4/24 at 10:23 AM, 12/6/24 at 9:08 AM, Unit 5 the baseboards along the floor in the hallways were dirty with dark debris present. During an interview on 12/6/24 at 9:08 AM, Unit 5 Secretary stated that it didn't always feel homelike on the unit, it depended on which housekeeper was working. They stated the baseboards on Unit 5 were not clean, they were dirty and needed to be cleaned or replaced. During an interview and observation on 12/6/24 at 9:13 AM, Certified Nurse Aide #7 stated Unit 5's environment was not clean. They stated floors were sticky and the baseboards were very grimy, and dirty. Certified Nurse Aide #7 stated the floors and baseboards were the first thing seen upon coming onto the unit and they should be cleaned for a homelike environment. Upon observing the ceiling tiles in occupied Resident room [ROOM NUMBER], Certified Nurse Aide #7 stated there were color changes to the ceiling tiles and it looked like mold was present. They stated when it rains outside, it rains in the building. During an interview and observation on Unit 5 on 12/6/24 at 9:29 AM, Licensed Practical Nurse #8 stated they have had family members voice concerns over the cleanliness of the facility. They stated the baseboards were dirty, and they should be cleaned or updated. Described the ceiling tiles in Resident room [ROOM NUMBER] as water stained, dry, brown in appearance with black sharpie colored or something present on tiles. They stated the residents live here and they shouldn't have to look at that, it's not homelike. During an interview on 12/6/24 at 9:56 AM, Licensed Practical Nurse #7 stated housekeeping doesn't clean like they were supposed to. They stated the cleanliness was nasty in here. They stated you can lose your shoe because the floors were so sticky and the baseboards were nasty with god knows, food, dirt. They stated the overall cleanliness and look of the building was not homelike. Additionally, they stated ceiling tiles shouldn't be soiled, it indicates a leak. Licensed Practical Nurse #7 stated when it rains water pours from the ceiling on Unit 5. Maintenance gets notified, they come and patch it up until the next time. (continued on next page)

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F 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 12/6/24 at 10:35 AM, the Infection Preventionist stated it was an infection control problem to leave soiled/wet linens and feces on the shower floor, and feces on the shower curtain. It was important for those things to be cleaned and sanitized as soon as possible so staff don't track germs to other rooms and cross contaminate other residents. Bacteria could grow quickly in wet linens causing residents and staff to get sick. The infection Preventionist stated that wet ceiling tiles were unsafe because they could fall on a resident or drip dirty water onto them or their food. The mold that could grow from wet ceiling tiles is a risk to the air quality, they are unhealthy, unsanitary and don't look good. During an interview on 12/6/24 at 10:52 AM, the Director of Nursing stated they expected their nursing staff to clean up after each shower given. If they noticed bodily fluids, they should clean it right away and have housekeeping sanitize the room. During an interview on 12/6/24 at 11:20 AM, the Administrator stated they just had a discussion with the department heads about clearly defined job duties regarding shower rooms. They determined the Certified Nurse Aides were responsible for cleaning up any bodily fluids and wet linens after every shower. Then the housekeeper should sanitize the shower room at least a couple times a day. They did not want the residents to smell feces in the shower room. The Administrator stated that when they notice the ceiling leaking, they immediately clean up the water and they change the ceiling tiles. The facility has recognized the leaking roof was a problem, and it needs to be replaced. They stated that a leaking roof and stained ceiling tiles did not promote a homelike environment. 10 NYCRR 415.5(h)(1)(2)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 43785 Based on observation, interview and record review conducted during a Standard survey, completed on 12/6/24, the facility did not ensure information on how to file a grievance or complaint was available to the residents and that they had an established grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights. Specifically, Resident Council was unaware of the process and policy on how to file a grievance or a compliant. The facility did not have a policy to ensure prompt resolution of all grievances regarding resident rights that included all required information. The findings are: During a Resident Council meeting on 12/3/24 at 10:30 AM, 7 of 7 Resident Council attendees stated they did not know how to file a grievance or who acted as the Grievance Officer. The residents stated the facility does not always respond to concerns voiced (staffing concerns, and customer service issues). This involved Resident's #17, 34, 36, 61, 70, 82 and 96. During an interview on 12/6/24 at 11:18 AM, Activities Department Director stated they were not aware if the facility had of a Grievance Officer. They stated when concerns, grievances were expressed during Resident Council meetings, they believed the Social Worker addressed them. They stated some concerns go to a specific department or the Administrator. They stated they weren't aware of a grievance policy or where the grievance forms were kept. During an interview on 12/6/24 at 1:45 PM, the Director of Nursing stated it was important for residents to know how to file a grievance. They stated residents always need to be advocated for, so they feel comfortable while in the facility and that their concerns were addressed. The Director of Nursing stated blank grievance forms were kept at the receptionist desk and maintained by the Social Worker. During an interview on 12/6/24 at 2:25 PM, the Administrator stated Social Worker terminated their employment at the facility (12/2/24). During an interview on 12/6/24 at 3:01 PM, the Receptionist stated they had not had any blank grievance forms available in a long time. They stated no families or residents had asked for a form but they should have them available if needed. During an interview on 12/6/24 at 4:18 PM, the Administrator stated they didn't have a specific Grievance Officer and the Social Worker would be responsible for grievances. They stated grievance forms should be available at the reception so anybody can have access to them. The Administrator stated grievances provide a paper trail and allows for facility follow up. The Administrator stated grievances should be reviewed during morning meeting and they should have ensured grievances were followed up on. Additionally, they stated they hadn't changed the grievance process. During an interview on 12/6/24 at 4:40 PM, the Director of Nursing stated the facility did not have a grievance policy and procedure. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 12/6/24 at 5:26 PM, the Administrator provided a grievance binder that included filed grievance forms. Review of grievance forms within the binder revealed there was no department head follow up or signatures. The Administrator stated grievances were not being reviewed and process was not being followed. 10 NYCRR 415.3 (d)(1)(i)

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F 0607 Level of Harm - Potential for minimal harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 43785 Based on interview and record review conducted during the Standard survey completed on 12/6/24, the facility did not implement written policies and procedures for screening employees, that would prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property. Specifically, one (Employee #3, Housekeeping Aide) of eight employees that worked in the facility and were subject to the New York State Nurse Aide Registry Verification, was not reviewed through the New York State Nurse Aide Registry prior to their employment as required. The finding is: The undated policy and procedure titled New York State Nurse Aide Registry Check documented all individuals hired to work at the facility will undergo a review of qualifications, performance and will be checked against the New York State Aide Registry. The Human Resources or Administrative department will check all applicants against the New York State Nurse Aide Registry upon hire. Review of Employee #3's (Housekeeping Aide) personnel file revealed the employee was hired on 8/14/24. Review of the electronic timecard information provided by the facility revealed Employee #3 had worked in the facility on: - 8/15/24 from 10:00 AM to 2:00 PM. - 8/16/24 from 8:00 AM to 3:51 PM. - 8/17/24 from 7:54 AM to 4:02 PM. - 8/18/24 from 8:00 AM to 4:07 PM. Review of the New York State Nurse Aide Registry Verification Report for Employee #3 revealed the verification date on the report was 8/19/24. During an interview on 12/5/24 at 9:01 AM, the Human Resources Director and Staffing stated they were out of the building when Employee #3 went to General Orientation on 8/15/24 and conducted the Nurse Aide Registry Verification Report for the employee on 8/19/24 when they returned to the building. The Human Resources Director and Staffing further stated they were the only employee that conducted the New York State Nurse Aide Registry Verification Reports for the facility's employees. 10 NYCRR 415.4(b)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43785 Based on interview, and record review conducted during the Standard Survey completed on 12/6/24, the facility did not ensure that the resident's person-centered care plan was implemented to meet the resident's medical and nursing needs for six (Residents #10, #25, #36, #41, #43, and #65) of 28 residents reviewed for care planning. Specifically, Resident #10 did not have a care plan developed for skin integrity and had pressure ulcers; Resident #25 did not have a care plan developed for dentures; Residents #36 and #41 did not have a care plan developed for an alleged resident-to-resident altercation; Resident #43 did not have a care plan developed for skin care and incision care with treatments ordered, depression, cardiac, vision, dry nasal passages and supplements with medications ordered, and discharge planning; and Resident #65 did not have a care plan developed for bowel incontinence, safety, falls, and psychoactive medication use. The findings include: The policy and procedure titled Comprehensive Care Planning & Baseline with a revision date of 6/2021 documented a Care Plan will be individualized for each resident using a person-centered approach. The Comprehensive Care Plan will include measurable objectives and timetables to meet the resident's medical, nursing, and psychosocial needs that are identified from admission assessments, the comprehensive assessment and application of the Care Area Assessment. Additional problems, strengths or needs identified by the Interdisciplinary Team will be included in the Comprehensive Care Plan. The Comprehensive Care Plan will be completed no later than seven days following completion of the admission comprehensive assessment. The care plan must be individualized for each individual. All disciplines are responsible for reviewing the plan of care and documenting goals, interventions, monitoring notes and updating as needed. Chronic active diagnoses and acute changes in condition will be card planned by the appropriate discipline in a timely manner. 1. Resident #10 had diagnoses including multiple sclerosis (a disease where the immune system effects the protective covering of nerves), diabetes mellitus type 2, and pressure ulcers of the sacrum (area at the base of the tailbone) and ischium (area of the lower buttocks). The Minimum Data Set, dated dated dated [DATE], documented Resident #10 was cognitively intact, understood and understands. The assessment tool documented that Resident #10 had one stage III (wound that involves full thickness loss of tissue) pressure ulcer and one unstageable (full thickness skin and tissue loss where the depth of the wound is hidden by eschar [dead tissue] and slough [yellow/white soft, stringy, thick substance]) pressure ulcer upon admission. The comprehensive care plan, initiated on 11/4/24, documented Resident #10 had pressure ulcers on their left ischium and coccyx related to multiple sclerosis, diabetes mellitus and limited mobility. There were no care plan interventions developed for the pressure ulcers until 12/4/24. Review of the Wound Evaluation and Management Summary noted dated 11/25/24, the Wound Consultant documented that Resident #10 had chronic wounds on their sacrum and left ischium with history of osteomyelitis (a serious bone infection). It was documented that Resident #10 had a stage IV (full thickness skin and tissue loss that exposes bone, muscle, tendon, ligament, or cartilage) pressure ulcer to their sacrum and left ischium with moderate serous drainage (clear/yellow drainage from a wound). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/6/24 at 12:41 PM, the Director of Nursing stated that they added care plan interventions on 12/4/24 to Resident #10's comprehensive care plan for pressure ulcers after the surveyor requested a copy of the care plan. The Director of Nursing stated they added the care plan interventions because the care plan did not have any and they felt Resident #10 needed them. 2.Resident #25 had diagnoses including unspecified dementia, stroke, and lower back pain. The Minimum Data Set (a resident assessment tool) dated 10/17/24, documented Resident #25 was moderately cognitively impaired, and always understood and understands. Resident #25 required partial/moderate assistance with oral hygiene. The comprehensive care plan last revised 10/25/24, documented Resident #25 had an ADL self-care performance deficit related to muscle weakness, and limited physical mobility related to weakness. The care plan also documented the resident had oral/dental health issues related to poor oral hygiene, and to provide mouth care as per ADL personal hygiene. There was no documentation that the resident had dentures or how to care for them. Review of the Closet Care Plan (used by staff to guide care) updated on 11/25/24, revealed the area labeled personal care had blank boxes where upper and lower dentures should have been checked and there were no instructions for denture care. During an interview on 12/5/24 at 8:58 AM, Licensed Practical Nurse #1 stated that if a resident wore dentures, it should be documented on their care plan, so the staff knew to clean them. During an interview on 12/5/24 at 9:24 AM, Unit Manager, Licensed Practical Nurse #2 stated that the care plan should reflect if a resident wore dentures so the certified nurse aides would know to clean them. They stated it was important for dentures to be removed at night and soaked for proper hygiene, because bacteria could grow underneath them. They were not aware that Resident #25's dentures were not documented on their care plan. Unit Manager, licensed Practical Nurse # 2 stated that care plans had not been updated recently. They stated that care plans should be reviewed, at least annually if not quarterly, by the entire interdisciplinary team and involve the resident and/or their family. They stated they only worked in the facility for a few weeks, so they had not updated care plans yet. During an interview on 12/6/24 at 10:52 AM, the Director of Nursing stated that nursing care plans should be reviewed/updated quarterly, by the unit managers and the interdisciplinary team. Dentures should be documented on the care plan, so staff know to properly clean them. 3. Resident #36 had diagnoses including diabetes mellitus type 2, chronic obstructive pulmonary disease, and bipolar disorder. The Minimum Data Set, dated dated dated [DATE], documented Resident #36 was cognitively intact, and always understood and understands. The assessment tool documented that the resident did not have any behaviors. Resident #41 had diagnoses including diabetes mellitus type 2, end stage renal disease, and bipolar disorder. The Minimum Data Set, dated dated dated [DATE], documented Resident #41 was cognitively intact, and always understood and understands. The assessment tool documented that the resident did not have any behaviors. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a facility investigation summary dated 7/11/24, the Former Administrator documented that on 7/11/24 Resident #36 alleged that Resident #41 rolled up to them in their wheelchair in the lobby area of the facility. Resident #36 alleged that they told Resident #41 you are supposed to stay away from me (due to a previous allegation's intervention) and Resident #41 responded by hitting them in the arm. Resident #36 had no injuries and Resident #41 denied the accusation. The investigation documented the interventions included that both residents were re-educated and reminded to stay away from each other. The comprehensive care plan, date initiated 2/6/24, documented Resident #36 had impaired self-care skills related to muscle weakness. Interventions included that resident was independent with personal powered wheelchair. The care plan documented that Resident #36 had potential for alteration in mood related to diagnosis of bipolar, manipulation with staff and had accusatory behavior at times. There was no care plan development for the allegation of a resident-to-resident interaction including interventions to keep away from Resident #41. The comprehensive care plan, date initiated 9/16/22, documented Resident #41 had limited self-care skills related to weakness. Interventions included that Resident #41 was independent with standard wheelchair. The care plan documented that Resident #41 had a behavior problem related to non-compliance and poor safety awareness as they had a history of refusing therapies, medication, treatments, and care. There was no care plan development for the allegation of a resident-to-resident interaction with intervention to keep away from Resident #36. During a telephone interview on 12/5/24 at 1:26 PM, Previous Unit Manager, Licensed Practical Nurse #3 stated that they did not witness nor had knowledge about the alleged resident to resident incident that occurred on 7/11/24 between Resident #36 and Resident #41. Licensed Practical Nurse #3 stated that development and revision of a resident's comprehensive care plan was the responsibility of the unit manager along with the Director of Nursing. Licensed Practical Nurse #3 stated that prior to end of their employment at the facility, they were behind on their development and revisions of the comprehensive care planning because they would have to work as a floor nurse two to three times a week and did not have a working computer. Licensed Practical Nurse #3 stated that Residents #36 and #41 should have had the alleged resident to resident altercations with interventions added to their comprehensive care plans. During an interview on 12/6/24 at 12:41 PM, the Director of Nursing stated that Licensed Practical Nurse #3 would have been responsible for care plan development and was unsure why they did not develop a comprehensive care plan with interventions for the alleged resident to resident altercation between Resident #36 and #41 on 7/11/24. The Director of Nursing stated they would have expected a care plan to be developed and it was important so staff would know how to take care and maintain the safety of both residents. 4. Resident #43 had diagnoses including major depressive disorder, ileostomy, and gastro-esophageal reflux disease. The Minimum Data Set, dated dated dated [DATE] documented the resident was understood, understands, was cognitively intact and had active diagnoses including hypertension, wound infection, hyponatremia (define), hyperlipidemia (define), cerebrovascular accident, malnutrition, depression, and respiratory disorder. Physician order recap report for Resident #43 dated 10/1/24 through 12/31/24 documented the following: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Clean abdominal incision with normal saline pat dry cover with dry clean dressing -Nystatin- Triamcinolone external cream around abdominal incision for skin irritation -Atorvastatin Calcium 20 mg every day for Hyperlipidemia (elevated fat levels in the blood) -Azelastine HCL nasal solution 1 spray in each nostril two times a day for dry nasal passages -Claritin 10 mg daily for allergies -Vitamin B 12 500 micrograms twice a day as supplement -Vitamin D 25 micrograms twice a day as supplement -Gen Teal Tears Moderate Ophthalmic solution 0.3% 1 drop each eye for dry eyes -Isosorbide Mononitrate extended release 30 milligrams every day for angina (chest pain) -Magnesium Oxide 800 milligrams every day for supplement -Metamucil fiber oral packet every day for supplement -Olanzapine 10 milligrams at bedtime for behavior -Omeprazole 20 milligrams every day for gastro-esophageal reflux -PreserVision Multi vitamin every day for supplement -Sennosides-Docusate Sodium 8.6-50 milligram twice a day for constipation -Sertraline Hydrochloride 100 milligrams every day for depression -Silodosin 1 capsule every day for benign prostatic hyperplasia (enlarged prostate gland) -Sodium Chloride 1 Gram four times a day for supplement The comprehensive care plan for Resident #43 dated 10/24/24 identified as current by the Director of Nursing did not have care plan focus areas, goals or interventions for the diagnoses, medications and treatments identified in the physician orders above. In addition, there were no documented focus, goals or interventions for skin integrity, oral care, urinary incontinence, Enhanced Barrier Precautions (interventions designed to reduce transmission of multi-drug resistant organisms including gown and glove use during high contact resident care activities), and discharge planning. During an interview on 10/6/24 at 10:42 AM, Nursing Supervisor/Unit Manager Licensed Practical Nurse #5 stated the comprehensive care plan for Resident #43 should have been completed by November 7, 2024, and they were responsible to ensure the comprehensive care plan was completed to include diagnoses, medications, treatments, skin integrity, incontinence care, oral care, enhanced barrier precautions, advanced directives and discharge planning for continuity of nursing care and it wasn't done. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/6/24 at 12:11 PM, the Director of Nursing stated the comprehensive care plan for Resident #43 should have been developed by the 14th day after admission (11/7/24) and there was no care plan development with goals and interventions for the diagnoses, medications and treatments identified in the physician orders above. The Director of Nursing stated there were no documented focus, goals or interventions for skin integrity, oral care, urinary incontinence, enhanced barrier precautions, advanced directives and discharge planning and there should have been. The Director of Nursing stated they would have expected Unit Manager Licensed Practical Nurse #5 to have developed the comprehensive care plan by 11/7/24, and updated it as needed with changes. 5. Resident #65 had diagnoses that included dementia, protein-calorie malnutrition, and macular degeneration left eye (loss of the central field of vision because of deposits of the retina). The Minimum Data Set, dated dated dated [DATE] documented Resident #65 had severe cognitive impairment, was sometimes understood, and sometimes understands. Resident #65 was occasionally incontinent of urine and bowel, had a fall with major injury since admission, and was administered high-risk (antianxiety, antidepressant and opioid) medications. The comprehensive care plan for Resident #65, date initiated 7/3/24, identified as current by the Director of Nursing, did not have care plan focus areas, goals or interventions for bladder incontinence and falls until 12/4/24. There were no documented focus, goals or interventions for skin integrity, oral care, bowel incontinence, preferences, advanced directives, diagnoses, medications, and discharge planning. The closet care plan last updated on 10/2/24, documented the resident needed extensive assist of one person for toileting on the commode or bathroom, had an incontinence/toileting schedule, briefs were not indicated. No safety or behavior monitoring was indicated. During an interview on 12/6/24 at 9:13 AM, Certified Nurse Aide #7 stated they weren't responsible for changing or updating the residents care plans. They stated therapy and nursing were responsible. During an interview on 12/6/24 at 9:56 AM, Licensed Practical Nurse #7 stated a resident's care plan was important, so staff knew how to care for the residents. They stated the unit nurse manager was responsible to complete. During an interview on 12/6/24 at 10:18 AM, Unit 5 Nurse Manager, Licensed Practical Nurse #2 stated the interdisciplinary team collectively build a resident's comprehensive care plan. They stated assessments in the electronic record that are in red indicate that they were incomplete/overdue and there hadn't been a care plan meeting for residents since they started at the facility in November. They stated there was no structure or schedule to inform them when the resident's care plans were due for completion and review. Licensed Practical Nurse #2 reviewed Resident #65's care plan and stated that it was incomplete, outdated, or overdue. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/6/24 at 1:45 PM, the Director of Nursing stated every single discipline was responsible to complete the resident's comprehensive care plan within 14 days of admission and should be reviewed and updated as needed. They stated the interdisciplinary team should meet and review the comprehensive care plan at least on a quarterly basis. The Director of Nursing stated the unit managers were responsible for completing the nursing sections of the comprehensive care plan. The Director of Nursing reviewed Resident #65's care plan and stated their care plan was absolutely incomplete and wasn't aware until 12/4/24. The Director of Nursing stated they updated Resident #65's care plan on 12/4/24 after they discovered it wasn't completed. They documented that they added bladder incontinence and falls to Resident #65's care plan on 12/4/24. The Director of Nursing stated it was important that the comprehensive care plan was completed, updated timely for the entire interdisciplinary team to see, so quality of care, continuation of care and safety can be provided to the residents. 10NYCRR 415.11(c)(1)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43785 Based on observation, interview and record review conducted during the standard survey, completed on 12/6/24, the facility did not ensure that residents who were unable to carry out activities of daily living, received the necessary services to maintain good grooming and personal hygiene for two (Residents #10 and #25) of six residents reviewed. Specifically, Resident #25 had visible food residue in their top and bottom dentures on multiple observations; Resident #10 had visible chin hair and long nails with brown debris underneath on multiple observations. The findings are: The policy and procedure titled ADL Care Guidelines dated 10/2021, documented care givers will review the resident's nursing care instructions at the beginning of each shift to assure that care is given according to the individual's plan of care. It also documented that the resident will be assisted with oral hygiene as appropriate, and dentures will be removed nightly and placed in a labeled denture cup with a cleaning tablet. The ADL policy documented female residents with excessive facial hair will be shaved at least weekly, if indicated and routine hand care will be done with bath and as needed. Fingernails should be cleaned underneath, and shaped. The policy and procedure titled Fingernail and Toenail Care, dated 7/3/2012, documented resident's fingernails would be monitored during their weekly skin assessments or on bath days. 1. Resident #25 had diagnoses including unspecified dementia, stroke, and lower back pain. The Minimum Data Set (a resident assessment tool), dated 10/17/24, documented Resident #25 was moderately cognitively impaired, and always understood and understands. Resident #25 required partial/moderate assistance with oral hygiene, and partial/moderate assistance with transfers out of bed to their wheelchair. Review of Resident #25's dental consult, dated 2/8/24, revealed they had a full upper denture and a partial lower denture, with a note staff to assist patient with daily cleaning of dentures, nightly and as needed. The comprehensive care plan last revised 10/25/24, documented Resident #25 had an ADL self-care performance deficit related to muscle weakness, and limited physical mobility related to weakness. The care plan also documented the resident had oral/dental health issues related to poor oral hygiene, and to provide mouth care as per ADL personal hygiene. There was no documentation that the resident had dentures or how to care for them. Review of the Closet Care Plan (used by staff to guide care) updated on 11/25/24, revealed the area labeled personal care had blank boxes where upper and lower dentures should have been checked and there were no instructions for denture care. Review of the Certified Nurse Aide task documentation for Resident #25 revealed from 12/3/24-12/5/24 oral hygiene was documented as Not Applicable. (continued on next page)

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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 12/2/24 at 9:22 AM, Resident #25 was in bed, there was visible food debris in both their upper and lower dentures. Resident #25 stated staff did not clean their dentures very often and could not recall the last time they were removed and cleaned. During observations and interviews, on 12/4/24 at 8:28 AM and 12/5/24 at 8:53 AM, Resident #25 had visible food debris in both their upper and lower dentures. They stated staff had not remove them to soak them. During an interview on 12/5/24 at 8:58 AM, Licensed Practical Nurse #1 stated that if a resident wore dentures, it should be documented on their care plan, so the staff knew to clean them. During an interview on 12/5/24 at 9:24 AM, Unit Manager, Licensed Practical Nurse #2 stated that the care plan should reflect if a resident wore dentures so the certified nurse aides would know to clean them. They stated it was important for dentures to be removed at night and soaked for proper hygiene, because bacteria could grow underneath them. They were not aware that Resident #25's dentures were not documented on their care plan. During an interview on 12/5/24 at 10:54 AM, Certified Nurse Aide #2 stated they looked at a resident's care plan to determine what type of oral care a resident needed. Certified Nurse Aide #2 stated that resident's dentures should be removed at night and placed in a denture cup to be sanitized. It was important for good hygiene and for their dignity to have clean teeth. They stated they did morning care on resident #25 that morning and they did not remove their dentures. Certified Nurse Aide #2 stated they could not recall the last time Resident #25's dentures were cleaned; they were in their mouth whenever they did the resident's morning care. During an interview on 12/6/24 at 10:52 AM, the Director of Nursing stated that nursing care plans should be updated by the unit managers. Dentures should be documented on the care plan, so staff know to properly clean them. They expected Certified Nurse Aides to remove residents' dentures every night to soak them because it was important for good hygiene and dignity. 2. Resident #10 had diagnoses including multiple sclerosis (a disease where the immune system effects the protective covering of nerves), diabetes mellitus type 2, and pressure ulcer (injury to the skin and tissues from prolong pressure to the area) of the sacrum (area at the base of the tailbone) and ischium (area of the lower buttocks). The Minimum Data Set, dated dated dated [DATE], documented Resident #10 was cognitively intact, understood and understands. Resident #10 required supervision/touching assistance with hygiene, and substantial/maximal assistance with bathing. The comprehensive care plan initiated on 11/4/24, documented Resident #10 had an ADL self-care performance deficit related to muscle weakness. Interventions included the resident was independent/set up for grooming and extensive assist of one for bathing. During observations on 12/2/24 at 12:43 PM and 12/3/24 at 11:11 AM, Resident #10 was observed to be lying in bed wearing their own personal night gown. Resident #10 was observed have long fingernails with brown debris underneath and 1/2 inch long white chin hairs. (continued on next page)

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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 12/4/24 at 9:42 AM, Resident #10 was observed to continue to have long nails with brown debris and chin hairs. Resident #10 stated they minded having long chin hairs and would like the staff to help remove them and they would also like to have their fingernails cut. Resident #10 added they would like to have their hands and nails cleaned but staff do not give them anything to wash them with. Resident #10 stated they were new to the facility and still were getting used to the ways staff did things. During an observation on 12/4/24 at 10:13 AM, Certified Nurse Aide #8 and #9 performed morning care for Resident #10 by washing, rinsing, and drying the resident's neck, underneath their breasts and armpits, peri area and buttocks. Resident #10 was dressed in their personal gown and was not gotten out of bed. Certified Nurse Aide #8 and #9 did not wash nor offer to clean Resident #10's hands and nails or assist with removal of their chin hair. During an interview and observation on 12/6/24 at 10:29 AM, Resident #10 was observed to continue to have long nails with brown debris and chin hairs. Resident #10 stated that no staff members had offered to cut and clean their nails or assist them with chin hair removal during the week. During an interview on 12/4/24 at 1:30 PM, Certified Nurse Aide #8 stated that they did not perform nail care to Resident #10 and that they usually were not responsible to provide nail care to residents. They stated they did not know who was responsible to provide nail care. Certified Nurse Aide #8 stated that they did not notice the debris under Resident #10's nails and should have looked at their hands during care. They stated they did not offer Resident #10 to wash their hands and they should have. Certified Nurse Aide #8 stated the Activities Department usually was the department that would shave and/or cut a resident's hair. Certified Nurse Aide #8 stated they also did not offer to assist Resident #10 with chin hair removal and probably should have. Certified Nurse Aide #10 stated it was important to offer a resident to wash their hands because they touched everything, and it was an everyday activity. They stated it was important to remove chin hair because it was an everyday appearance to make a resident more presentable. During an interview on 12/4/24 at 1:59 PM, Certified Nurse Aide #9 stated when they performed morning care to a resident, they washed everything including a resident's hands and nails. Certified Nurse Aide #9 stated they did not offer Resident #10 hand washing, nail care and chin hair removal because they were only helping Certified Nurse Aide #8. Certified Nurse Aide #9 stated they should have placed Resident #10's hands in water and offered the resident a razor/shaver. During an interview on 12/5/24 at 12:16 PM, Licensed Practical Nurse #10 stated that the Certified Nurse Aides were responsible to perform nail care on a resident's shower day unless the resident was a diabetic. They stated that residents should be offered hand hygiene every day; prior to and after they eat; and when they used the bathroom. They stated that Resident #10 should have been offered hand hygiene and chin hair removal during morning care for infection control and dignity issues. During an interview on 12/6/24 at 12:41 PM, the Director of Nursing stated that morning care for a resident consisted of washing a resident from head to toe, including washing their hands. They stated nail care should be completed by the nursing staff and offered to the residents whenever their nails were long, or debris was noted for infection control and hygiene issues. The Director of Nursing stated the Certified Nurse Aides should also be offering/performing chin hair removal/shaving when needed due to dignity and respect for the resident. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/6/24 at 1:47 PM, Certified Nurse Aide #4 stated they were responsible for care on Resident #10 on 12/6/24. They stated they knew they should perform or offer nail care to Resident #10 every day during morning care, but they did not. Certified Nurse Aide #4 stated they had performed chin hair removal on Resident #10 last week but did not assist or offer today or at all this week. Certified Nurse Aide #4 stated they usually were the staff member that shaved the residents on the unit, and they have the other Certified Nurse Aides do the nail care. 10NYCRR 415.12 (a)(3)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 43785 Based on observation, interview, and record review conducted during a Standard survey completed on 12/6/24, the facility did not ensure each resident with limited range of motion received appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion for one (Resident #30) of one resident reviewed for positioning and mobility. Specifically, the staff did not ensure that Resident #30's left and right palm guards (assistive device that positions the fingers away from the palm) were worn as recommended by occupational therapy. In addition, there was inconsistent documentation that range of motion exercises were provided to the resident per their care plan. The finding is: The policy and procedure titled Range of Motion and Ambulation revised 9/15/2020, documented that every effort would be made to ensure that residents do not lose range of motion, ability to walk or activities of daily living abilities unless the loss is unavoidable. Certified nursing assistants are expected to assist with range of motion in accordance with the care plan and document that range of motion has been provided prior to the end of their shift in the electronic medical record. The policy and procedure titled Splint revised on 10/19/2015, documented that physical therapy/occupational therapy will determine the need of splint for the resident. Nursing, resident, and family members as indicated will be instructed in the wearing schedule and would be written on the plan of care/care guide. Resident #30 had diagnoses which included cerebral vascular accident- (stroke), dysphasia (impairment of speech and verbal comprehension), and muscle weakness. The Minimum Data Set (a resident assessment tool) dated 11/26/24, documented Resident #30 had severe cognitive impairment, was rarely/never understood, and rarely/never understands. The Minimum Data Set documented Resident #30 had upper extremity functional limitation in range of motion on one side. The comprehensive care plan dated 12/13/17, documented that Resident #30 had limited mobility and was on a restorative nursing program. The program included assistive active range of motion (exercises performed by resident with some help from staff) to bilateral (both) lowers extremities and passive range of motion (exercises performed on the resident by nursing staff) to bilateral upper extremities three times weekly on Mondays, Wednesdays, and Fridays. Resident #30 wore right and left palm guards as tolerated except for range of motion, hygiene, meals and when asleep. Review of the Occupational Therapy Discharge Summary dated 9/20/24 documented nursing caregivers were instructed on the restorative nursing program which included bilateral upper extremities passive range of motion. The splinting/orthotic schedule was reviewed with nursing staff to preserve Resident #30's current level of function. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During intermittent observations on 12/2/24 at 3:27 PM, Resident #30's right hand was curled into a fist. The left hand was gripping the wheelchair seat, there were no palm guards in the resident's hands. On 12/4/24 at 9:16 AM, 3:54 PM, and 12/5/24 at 10:48 AM there were no palm guards in Resident #30's left or right hand. Review of the Order Audit Report dated 12/5/24 revealed an active standing physicians order dated 11/30/22 for right and left palm guards to be worn except for range of motion, hygiene, and while asleep. The Medication Administration Record dated 12/1/24-12/31/24 documented right and left palm guards were to be worn except for range of motion, hygiene and while asleep. There were no start or end dates and there were no staff initials that documented the palm guards were worn. There was an x documented from 12/1/24-12/31/24. Review of the Documentation Survey Reports for 9/2024,10/2024,11/2024 and 12/2024 revealed Resident #30 was on a restorative nursing program for upper extremity and lower extremity range of motion three times weekly on Mondays, Wednesdays, and Fridays. There were multiple blanks where the range of motion wasn't documented as completed. During observation and interview on 12/5/24 at 1:48 PM, Certified Nursing Assistant #5 stated that palm guards prevented worsening contractures (loss of joint mobility) and verified Resident #30 had no palm guards in their hands per the care plan. They checked Resident#30's room, and the palm guards were missing. They never realized that Resident #30 did not have them on this morning. Rolled up wash cloths should have been used for Resident #30 to hold onto until the palm guards were located. Certified Nursing Assistant #5 stated the night shift was responsible for dressing Resident #30 and they got the resident out of bed. Certified nursing assistant's provided range of motion with morning care or when they go back to bed in the afternoon. Documentation was completed after the task was provided or by the end of the shift. During an interview on 12/5/24 at 10:23 AM, Certified Nursing Assistant #6 stated Resident #30 tolerated the palm guards when they wore them. Certified nursing assistants were responsible to provide range of motion and the blanks in the documentation indicated range of motion was not done. During an interview on 12/5/24 at 2:06 PM, Licensed Practical Nurse #1 stated that Resident #30 should wear right and left palm guards. Licensed Practical Nurse #1 observed the resident and stated they were not wearing their palm guards. Licensed Practical Nurse #1 checked the residents care plan and stated the resident was care planned to wear the palm guards at all times except for range of motion, hygiene, meals and while sleeping. Licensed Practical Nurse #1 stated palm guards prevented contractures and skin potential breakdown. Certified nursing assistants were responsible to ensure residents had their devices when they were gotten up for the day. Certified Nursing Assistant #5 should have checked the care plan and Licensed Practical Nurse #1 would have expected to be notified if the palm guards were missing. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Comprehensive Rehab & Nursing Ctr at Williamsville	147 Reist Street Williamsville, NY 14221

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/5/24 at 2:30 PM, Licensed Practical Nurse #2, Unit Manager stated Certified Nursing Assistant #5 should have read the care plan and communicated to Licensed Practical Nurse #1 the palm guards were not in Resident #30's room. Licensed Practical Nurse #1 should have informed them, and they would have notified therapy to replace the palm guards. Licensed Practical Nurse #2, Unit Manager stated there was no process of monitoring documentation for range of motion and it was a team effort. During an interview on 12/6/24 at 10:36 AM the Director of Therapy #1 stated Resident #30's palm guards were recommended by occupational therapy and updated on the care plan. Certified Nursing Assistant #5 should have made sure the palm guards were on after reading Resident #30's care plan. Nurses were responsible to ensure that the certified nursing assistants put on the palm guards, performed range of motion, and completed the documentation. The blanks on the Documentation Survey Report indicated uncertainty that range of motion was being done as recommended. Palm guards were important because they prevented further contractures for Resident #30. During an interview on 12/6/24 at 2:10 PM, the Director of Nursing stated they expected that Resident #30 would wear the palm guards if they are care planned and Certified Nursing Assistant #5 should have put them on. The Unit Manager, Licensed Practical Nurses and all staff were responsible to make sure the resident's care plan was followed. The palm guards were a standing physician's order on the medication administration record which alerted the nurses to ensure the certified nursing assistants had put them on but did not have to sign for the palm guards. Range of motion exercises were expected to be done with morning care and documented when completed in the electronic medical record by the assigned certified nursing assistants. If the resident was unavailable or refused, they would expect the resident to be reapproached later. During an interview on 12/6/24 at 2:05 PM, the Administrator stated it was important to ensure that the residents care plan was being followed. 10NYCRR 415.12(e)(2)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 43785 Based on observation, interview, and record review conducted during the Standard survey completed 12/6/24 the facility did not ensure that residents with an indwelling foley catheter (tube inserted into the bladder to drain urine) received the appropriate care for one (Resident #45) of two residents reviewed. Specifically, staff did not maintain proper infection control practices for a resident with a foley catheter. The finding is: The policy and procedure titled Indwelling Catheter Care dated 2/2019, documented to keep the drainage tubing/catheter junction closed. Ensure the catheter is properly secured to upper thigh with securement device. 1. Resident #45 had diagnoses that included obstructive and reflux uropathy (obstruction in urinary tract), history of urinary infections and dementia. The Minimum Data Set (a resident assessment tool) dated 11/20/24 documented Resident #45 had moderate cognitive impairment, required substantial/max assistance with toileting and had an indwelling urinary catheter. The Clinical Physicians Orders dated 11/14/24 through 12/5/24 documented to flush foley with 30 milliliters of normal saline every day and as needed, and document foley output every shift. There were no other catheter care orders. The comprehensive care plan initiated 11/15/24 documented Resident #45 had an activities of daily living self-care performance deficit related to weakness. Interventions included extensive assist was required for toileting, bedpan use and foley care. The Kardex provided as of 12/6/24, documented Resident #45 required extensive assist was required for toileting, bedpan use and foley care. The Kardex posted in the resident's room on 12/5/24 during the observation did not indicate Resident #45 had a foley catheter. During an observation on 12/2/24 at 11:15 AM, Resident #45 was in bed. The foley catheter bag was attached to the bedframe and the bottom of the urinary drainage bag was directly on the floor; the spigot (spout used to empty urine from the collection bag) was not secured and was also touching the floor. The urinary drainage bag was dated 11/18/24 and the catheter tubing and bag contained yellow urine. During an observation on 12/5/24 at 9:18 AM, Resident #45 was in bed and the urinary drainage bag was attached to the bed frame, the catheter tubing and urine collection bag was on the floor. The urinary drainage bag was dated 11/18/24 and the catheter tubing contained cloudy yellow urine with mucous shreds. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 12/5/24 at 1:04 PM to 1:21 PM, Certified Nurse Aide #5 placed the urinary collection bag spigot inside an undated urinal to empty urine from the collection bag. After draining the urine from the bag, they tapped the inside of the urinal with the spigot several times, clamped the spigot and then reconnected the spigot to the urinary drainage bag without sanitizing it. Resident #45's foley catheter was not secured to the securement device (leg strap) on the residents left thigh. Certified Nurse Aide #5 stated the securement device should be used so the resident's urine can flow better. They stated they should have wiped the spigot with an alcohol pad after emptying the drainage bag for infection control purposes. They stated they didn't have any alcohol pads and it slipped their mind to clean the spigot. Additionally, they stated they could have gotten alcohol pads from the clean utility room or from the nurse. During an interview on 12/5/24 at 1:44 PM, Licensed Practical Nurse #4 stated the spigot should be drained over a graduate, cleaned with alcohol to remove bacteria and germs for infection control purposes. During an interview on 12/5/24 at 2:00 PM, Unit 500 Manager Licensed Practical Nurse #2 stated an alcohol wipe should be utilized after draining urine from spigot to ensure nothing yucky was being left behind for infection control purposes. During an interview on 12/6/24 at 8:59 AM, the Infection Preventionist stated the process for emptying a foley catheter would be to perform hand hygiene, wear gloves, pull the spigot out of its holder, cleanse the spigot with an alcohol swab, empty the bag contents into a cylinder or urinal, cleanse the spigot again with an alcohol swab and replace into the holder. The Infection Preventionist stated they would expect the nursing staff to be careful not to hit the insides of the urinal/graduate with the spigot. The urinary drainage bag spigot should never be out of its holder laying on the floor nor should the foley drainage bag and tubing ever be laying directly on the floor because it could introduce bacteria into the bladder. During an interview on 12/6/24 at 9:56 AM, Licensed Practical Nurse #7 stated the foley catheter bag and tubing should not be touching or on the floor. The foley drainage bag should be replaced if it had been on the floor. Additionally, they stated the catheter drainage bag should be dated and changed every month or as needed. During an interview on 12/6/24 at 10:18 PM, Unit 500 Manager Licensed Practical Nurse #2 stated they expected foley catheter drainage bags and tubing to be kept off the floor for infection control purposes. It was the nursing teams responsibility to ensure catheter drainage bag and tubing weren't on the floor. During an interview on 12/6/24 at 1:45 PM, the Director of Nursing stated they expected foley catheter drainage bags and tubing to be kept off the floor. They stated the spigot should not touch the graduate and should be cleaned, disinfected after use for infection control purposes. 10 NYCRR 415.12(d)(1)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43785 Based on observations, record review and interviews during a Standard survey completed 12/6/24, the facility did not ensure acceptable parameters of nutritional status, such as usual body weight for one (Resident #65) of two residents reviewed. Specifically, Resident #65 had a significant weight loss and there was a lack of meal and nourishment acceptance being documented or recorded. In addition, the medical provider was not made aware of the significant weight loss. The finding is: 1. Resident #65 had diagnoses that included dementia, protein-calorie malnutrition, and macular degeneration left eye (loss of the central field of vision because of deposits of the retina). The Minimum Data Set, dated dated dated [DATE] documented Resident #65 had severe cognitive impairment, required supervision/touch assist for eating, weight was 105 pounds and weight loss marked no or unknown. Additionally, Resident #65 was on a therapeutic diet. During breakfast and lunch meal observations on 12/5/24 at 9:11 AM and 12:53 PM, Resident #65 was sitting in the unit dining room with meal. Meal ticket on tray it was noted alert- extensive assist feeding. No staff present at table to provide assist during meal. Staff that were present were observed assisting other residents in the unit dining room. Meal ticket did not indicate what supplements they were to receive. Shake was observed on breakfast tray and boost was present on lunch tray. The Order Summary Report dated 12/6/24 documented No Added Salt diet, Regular texture, thin consistency with start date 7/3/24. Obtain admission weight and height, one time only for admission. Review of the Medical Orders for Life Sustaining Treatment (MOLST) last updated 9/18/24, revealed Resident #65 had a do not attempt resuscitation, do not intubate, send to hospital order when medically necessary. There were limited medical interventions which included no feeding tube, administer intravenous fluids, and use antibiotics to treat infections. The comprehensive care plan for Resident #65 initiated on 7/3/24 identified as current by the Director of Nursing, documented the resident had potential for nutritional risk related to body mass index 19.6, dietary restrictions secondary diagnosis of hypertension (high blood pressure), leaves greater than 25 percent of some meals uneaten at times. Dated 8/20/24 significant weight loss and 11/8/24 weight loss trend noted. Goal was to maintain adequate nutritional status as evidenced by maintaining weight within 1-5 pounds of current weight. Interventions included monitor meal consumption records, monitor weights as per policy, provide and serve supplements: shake at lunch and dinner, monitor acceptance and effects. On 8/29/24 shake was changed to Boost plus, on 9/20/24 shake added at breakfast and on 11/8/24 magic cup added every lunch. Report significant weight losses to medical doctor and interdisciplinary care team for input. Additionally, Resident #65 had limited self-care skills related to weakness, required extensive assist for feeding. Review of the Closet Care Plan last revised on 10/2/24 documented eating as extensive assist of 1 on unit. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Weights and Vitals Summary dated 12/6/24 revealed the following weights and weight status: -7/2/24 admission weight was 114 pounds. -8/20/24 weight was 107 pounds. -9/13/24 weight was 105 pounds which showed a change/loss of 7.9 percent or 9 pounds since 7/2/24. -10/7/24 weight was 103 pounds which showed a change/loss of 9.6 percent or 11 pounds since 7/2/24. -11/11/24 weight was 100.5 pounds which showed a change/loss of 11.8 percent or 13.5 pounds since 7/2/24. -12/6/24 weight 98 pounds which showed a change/loss of 14 percent or 16 pounds since 7/2/24. Review of the Initial Nutrition Assessment completed by the Dietary Technician dated 7/3/24, revealed admission weight on 7/2/24 was 114 pounds with a body mass index of 19.6. Diet order of No Added Salt regular consistency thin liquids provides 1600-1700 kilocalories, 65-75 grams protein and 1200 milliliters fluids. Shakes at lunch and dinner provided 600 kilocalories, 22 grams protein and 360 millimeters of fluids. Estimated needs were 1554-1813 kilocalories, 51.8-62.2 grams of protein and 1544 milliliters of fluid per day. Actual intake for solids, liquids, and supplements to be monitored. Review of the dietary progress note dated 8/29/24 revealed weights reviewed, 8/20/24 weight was 107 pounds indicating a significant loss from previous weight. Intake of meals 26-100 percent. Shake provided at lunch and dinner with acceptance generally greater than 50 percent. Shake was changed to Boost plus for increased kilocalories. Monitor acceptance and effects. Review of the dietary progress note dated 9/20/24 revealed weights reviewed, 9/13/24 weight was 105 pounds indicating a 2-pound loss from previous weight. Intake of meals 26-100 percent. Supplements provided, acceptance 25-100 percent. Shake was added at breakfast for increased kilocalorie, monitor acceptance and effects. Review of the Quarterly Nutrition assessment dated [DATE] completed by the Dietitian revealed documented weight on 9/13/24 was 105 pounds with no significant weight change noted. Current diet and supplements provided met residents estimated needs. Intake was fair to good. Meal plan supplemented with Boost plus twice daily and shake daily. Weight indicates some decline since admission. Review of the dietary progress note dated 11/11/24 revealed weights reviewed, 11/8/24 weight 100.5 pounds with weight loss trend noted. Intake of meals usually 26-75 percent. Supplements provided with meals, acceptance generally 100 percent. Magic cup added daily to lunch for increased kilocalorie, monitor acceptance and effects. Review of the undated Nutrition-Amount Eaten 30 day look back revealed out of 90 meals only 20 were documented for meal intakes. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the undated Nutrition-Supplement for Breakfast: Boost plus, Lunch: Boost Plus, Dinner: Boost Plus 30 days look back revealed out of 30 days only 13 days were documented and out of 90 supplement opportunities only 25 were documented. Review of all the departments progress notes dated between 9/2/24- 12/6/24 revealed no evidence that the medical provider or the resident representative were notified of Resident #65's significant weight loss. Review of the medical provider notes dated 9/18/24, 9/19/24, 10/24/24, and 11/15/24 revealed no evidence of notification of weight loss. 9/19/24, 10/24, and 11/15/24 documented review of systems, denied weight loss. Review of the Speech Screening dated 7/4/24 revealed swallowing regular consistency with thin liquids within functional limits. Review of Occupational Therapy Screen dated 10/14/24 revealed recommendation to Nursing for feeding was extensive assist with minimal help. During an interview on 12/2/24 between 12:12 PM-12:28 PM Resident #65's family member stated they felt the resident had lost weight. Resident #65's family member stated the resident needs assistance to eat due to confusion and impaired vision. They stated they weren't sure that the resident was receiving the required help and they had expressed this before to nursing. During an interview on 12/5/24 at 1:44 PM, Licensed Practical Nurse #4 stated they should be made aware of weight loss so they can monitor for adequate meal intake. They stated if weight loss was indicated on the 24-hour nurse report they would ask the Certified Nurse Aides what the resident consumed so it could be documented in the progress notes. Licensed Practical Nurse #4 stated the Certified Nurse Aides are responsible for documenting acceptance percentages of meals in the electronic medical record. Licensed Practical Nurse #4 stated they were not aware that Resident #65 had a weight loss. During an interview on 12/6/24 at 10:18 AM, Unit 500 Manager, Licensed Practical Nurse #2 stated the Dietitian enters weights in the electronic medical record, tracks resident's weights and alerts the Unit Managers of weight changes. They stated they were not aware Resident #65 had a weight loss and should have been notified so nursing follow up could be completed. They stated if a meal ticket indicates extensive assist, resident requires assistance with set up and eating to ensure the resident is consuming food properly. During an interview on 12/6/24 at 11:35 AM, Nurse Practitioner #1 stated they had not been informed of Resident #65's weight loss since admission. They stated if they were made aware of weight concerns, they would have document it and followed up. They stated they would expect to be notified of weight changes so it can be discussed with family, weights can be monitored more closely, medication can be reviewed, and determination can be made if it's a decline in disease process. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/6/24 at 12:11 PM, the Dietary Technician stated that residents' weights are reviewed every month, as needed or per medical order. They stated when weight loss is noted they see the resident, make necessary changes such as adding supplements, updating preferences, making a referral to occupational therapy and/or speech, and discuss with interdisciplinary team the need for an appetite stimulant. The Dietary Technician stated weight loss is discussed during morning meeting with the interdisciplinary team and the medical provider would be updated by them or the Dietitian. They stated they update the medical provider by placing something like a note in the medical providers book on the units. The Dietary Technician stated after the medical provider makes recommendations nursing reports the recommendations/orders to them. The Dietary Technician stated there probably wouldn't be any documentation on them notifying the medical provider of weight loss. They stated they did not have a good reason and that it would be documented from now on. Upon reviewing Resident #65's electronic medical record the Dietary Technician stated Resident #65 had a weight loss and did not believe the medical provider was notified. They stated they would consider an 11.84 percent weight loss in 4 months a significant weight loss and that a medical provider should have been updated. The Dietary Technician stated it was important to monitor residents' weights for their overall well-being, determine if their MOLST needs to be updated and if the medical provider needs to be involved. Additionally, the Dietary Technician stated Resident #65's weights should have been monitored more frequently due to their weight trending down. During a telephone interview on 12/6/24 at 12:29 PM, the Dietitian stated supplement and meal acceptance is based on observation and what is placed in the electronic medical record. They stated the documentation of acceptance is inconsistent and lacking. The Dietitian stated they are not able to get a clear picture of the residents' acceptance of supplements and meals based on the information given. The Dietitian stated the medical provider and nursing should be notified of significant weight loss or when weight loss can't be explained immediately, so various interventions such as labs, medication changes, referrals can be done. They stated Resident #65's weight loss was significant and should have been reported by them or the Dietary Technician. During an interview on 12/6/24 at 1:45 PM, the Director of Nursing stated that the certified nurse aides and nurses are responsible to ensure supplements are being administered and recorded. The Director of Nursing stated they expected percentages to be documented so that nursing and dietary could review acceptance. They stated supplements are an important means of nutrition and they are important for calorie intake, maintaining resident's weights, hydration, and skin. The Director of Nursing stated a medical provider should be notified of weight loss immediately by dietary or the unit manager. During a telephone interview on 12/6/24 at 2:23 PM, Medical Doctor #1 stated they would expect to be notified of weight loss as soon as it is noticed so interventions can be implemented. They stated they were not made aware of any weight loss for Resident #65. They stated if Resident #65 were having frequent loose stools this could contribute to weight loss and malnutrition. They stated Resident #65 could be lactose intolerant and that dietary should be involved. 10 NYCRR 415.12(i)(1)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43785 Based on observation, interview, and record review conducted during a Standard survey completed 12/6/24, the facility did not store, prepare, distribute, and serve food in accordance with professional standards for food service safety. Specifically, one of one Kitchen had issues with foods being either unlabeled or outdated in the refrigerator. The findings are: The undated facility policy and procedure titled Food Storage Refrigerator/ Freezer documented purpose is to ensure foods are stored properly to minimize spoilage and contamination, and to ensure taste and quality of food. All refrigerated foods should be labeled/ dated and discarded after three (3) days. The facility policy and procedure titled Food Safety Requirements Policy - use and storage of food and beverage brought in for resident's food procurement dated 11/2017 documented the policy is to provide safe and sanitary storage, handling, and consumption of all food. This includes the storage, preparation, distribution, and serving food in accordance with professional standards for food safety. The food service supervisors, cooks, dietary aides, or any persons who are in the kitchen working with any type of food, are responsible for adhering to the food safety requirements. During an observation of the main kitchen on 12/2/24 at 8:51 AM revealed the reach in refrigerator labeled #6 across from the walk-in refrigerator had nine plastic containers revealing the following: -3/4 quart of mixed fruit was not labeled or dated and had black debris floating on the mixed fruit and on the inside sides of the container. -1/4 quart of sliced pears was not labeled or dated and had green/grey debris on the pears. -1 1/2 quarts of chopped peaches were not labeled and marked with a date of 11/11. -1 1/2 quarts of chopped peaches were not labeled and marked with a date of 9/24/24. -2 quarts of chopped pears were not labeled or dated. -1/4 quart of chopped peaches were not labeled or dated. -1/2 pitcher of unidentifiable brown liquid was not labeled or dated. -1/4 pitcher of unidentifiable yellow liquid was not labeled or dated. -2 1/2 quarts of orange pudding like consistency was not labeled or dated. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/2/24 at 9:16 AM, dietary [NAME] #1 stated all food items should be labeled and dated when opened and disposed of after 3 days. They stated all the items identified must be disposed of as they do not know when they were placed in the refrigerator. They stated they believe the black floating debris in the mixed fruit and green/grey debris on the pears is mold and must have been in the refrigerator greater than 3 days. During an interview on 12/2/24 at 9:32 AM, the Dietary Department Director stated all opened food items are to be labeled and dated and disposed of after 3 days from opening. They stated the dietary aides are responsible to date and label the items, although they are ultimately responsible to ensure the staff are following the facility's policies and procedures, and regulations. They stated they believe the black debris and green/grey debris identified in the containers was mold and would have been opened greater than 3 days. They stated this is for food safety to prevent contamination and molding. 10 NYCRR 415.14(h) 14-1.43(e)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 43785 Based on observation, interview and record review conducted during the Recertification survey completed on 12/6/24, the facility did not ensure a Quality Assurance and Performance Improvement program (QAPI) developed, implemented, monitored, maintained effective systems, and used feedback to develop an appropriate plan of action to correct identified deficiencies and regularly reviewed, analyzed, and acted on available data to make improvements. Specifically, the facility did not maintain effective systems to maintain compliance and had repeated deficiencies from the previous Recertification Survey 4/21/23 and Post Survey Revisit 7/12/23. In addition to identified systematic problems regarding grievances and functional/usable bathtubs. The findings are: Repeated Citations Refer to the following citations cited 4/21/23: F 584 Safe/Clean/Comfortable/Home Like Environment F 656 Develop/Implement Comprehensive Care Plan F 677 ADL (activities of daily living) Care Provided for Dependent Residents F 812 Food Procurement, Store/Prepare/Serve Sanitary F 880 Infection Prevention and Control F867 Quality Assurance and Performance Improvement Activities (7/12/23). Additionally, Refer to F 585 Resident Rights/Grievances Refer to F 561 Resident Rights/Self-determination. Review of the policy and procedure titled Quality Assurance/Performance Improvement revised 8/16, documented the facility will conduct quality assurance/improvement and assessment committee meeting at least quarterly to identify area of service that are non-complaint, or with potential for improvement. The facility will ensure that there is an effective, facility-wide performance improvement program to evaluate resident care and performance of the organization. The policy documented that the facility would have an ongoing plan, consistent with available community and facility resources, to provide or make available services that meet the medically related needs of its residents. (continued on next page)

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Comprehensive Rehab & Nursing Ctr at Williamsville	147 Reist Street Williamsville, NY 14221

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of an undated facility document titled Quality Assurance Improvement Plan, provided by the Administrator during the entrance conference process documented that a dashboard for individual performance improvement projects were used to communicate progress and outcomes of individual QAPI (Quality Assurance Improvement Plan) projects. The QAPI (Quality Assurance Improvement Plan) lead is responsible for maintaining documentation of the minutes of all meetings. The plan documented that the QAPI (Quality Assurance Improvement) committee monitors progress to ensure that interventions or actions were implemented and effective in making and sustaining improvements. Once the performance improvement program goals have been met, it will be placed on a permanent tracking log for ongoing measurement to assure the performance improvement project doesn't get forgotten. Review of Recertification Survey Statement of Deficiencies (form 2567) issued by the New York State Department of Health with an exit date of 4/21/23 revealed the facility was cited for the following: -F 656 the lack of development of comprehensive care plans for residents. The facilities corrective action plan included that the Assistant Director of Nursing would report monthly to the QAPI committee to determine if any further process changes or approaches were needed. This would happen for three months or longer depending on compliance outcomes. -F 677 the lack of chin hair removal and long fingernails. The facilities corrective action plan included the floor charge nurse along with the Assistant Director of Nursing would report their finding for three months and corrective action will be taken as necessary by the QAPI committee. -F 812 foods unlabeled/outdated in the refrigerators. The facilities corrective action plan included the Food Service Director along with the QAPI committee will submit weekly audit findings for three months or until problems were resolved. -F 584 the facility did not ensure that housekeeping and maintenance services were adequate to maintain a sanitary, orderly, and comfortable interior. The facilities corrective action plan included the audit results will be reported to the Quality Assurance and Performance Improvement committee for monthly for three months and the frequency of on-going audits will be determined based on the audit results. - F 880 issues involved transmission-based precautions and adequate hand hygiene. The facilities corrective action plan included audit results would be reported to the Quality Assurance and Performance Improvement committee monthly for three months and frequency of on-going audits will be determined based on the audit results. Review of Post Recertification Survey Revisit Statement of Deficiencies (form 2567) issued by the New York State Department of Health with an exit date of 7/12/23 revealed the facility was cited for the following (includes but not limited to): (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-F 812 the facility did not store, prepare, distribute, and serve food in accordance with professional standards for food service. System implemented to ensure continued compliance included: the administrator will meet with the Director of Food Service and Director of Maintenance daily to review any kitchen/food service-related repairs and assign priority tasks. Audits will be performed by the Director of Food service daily for 1 month then weekly for 2 months. The Consultant will also conduct random onsite audits of the above areas for three months and report findings to the QA&A Committee. Frequency of on-going audits will be determined by the Committee based on audit results. -F 867 the Quality Assurance and Performance Improvement Committee the facility did not institute and follow corrective actions that were to put in place to ensure that the following deficiencies would not reoccur. An audit tool was to be developed to track completion of all audits; audits will be submitted to the administrator/designee for review weekly for 12 months to ensure compliance; Audit results will be reported to the QA&A Committee monthly. Frequency of on-going audits will be determined by the Committee based on the results; the Consultant will also conduct random onsite audits of the cited areas for three months and attend the meeting monthly for 3 months. Review of the Quality Assurance and Performance Improvement Meeting Minutes dated 10/25/23 documented that all staff were educated and aware of the importance of a clean and sanitized kitchen and weekly plan of correction audits were ongoing. The meeting minutes documented that infection control, quality assurance and discharge records were reported upon at the meeting. The minutes did not include if the plan was effective. Review of the Quality Assurance/Performance Improvement Meeting Agenda date 10/16/24 documented that infection prevention and control, dietary, environmental services, plant operations and medical record review were reported upon at the meeting. The minutes did not include if the plan was effective. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During the QAPI/Quality Assessment and Assurance (QAA) interview on 12/6/24 at 2:25 PM with the Administrator and Director of Nursing, the Administrator stated they could not provide any further documents (QAPI items- meeting agendas, minutes, meeting attendance records or PIP's (performance improvement projects) from the previous Administration other then what was presented (10/25/23, 1/24/24 and 2/28/24). They stated they became the Administrator of record in August 2024 and since they started the committee had conducted a PIP (performance improvement project) on Enhanced Barrier Precautions. The Administrator stated there was continued noncompliance with infection control practices and their performance improvement project was ineffective. The Director of Nursing stated their PIP (performance improvement project) for nail care and facial hair removal remained ineffective as noncompliance continues. The Director of Nursing stated the facility no longer had a Nurse Educator or an Assistant Director of Nursing and there was great turnover of the staff. This made it hard to continue to audit and educate the new staff. The Director of Nursing stated their PIP (performance improvement project) for developing comprehensive care plans was ineffective and the entire care process needed to be revised. The Administrator added there was a lack of staffing resources (employees) available in the facility making it difficult to keep the comprehensive care plans up to date. The Director of Nursing stated the PIP (performance improvement project) for outdated and unlabeled food in the kitchen was ineffective because of continued issues identified. The Director of Nursing stated that there had been a massive staff turnover in the kitchen and education needed to provide to those new staff members. The Administrator stated even though the plan of correction phase was over from previous surveys; constant/or at least as needed auditing and oversite needed to be continued. The Administrator stated new employees needed to be audited and educated on previous deficiencies issue to ensure the same errors/issues are not occurring over and over. The Administrator stated they felt there was sufficient staff to provide efficient and quality of care to the residents, however the facility lacked regional staff oversight and support at a higher level and the day-to-day support of the extra corporate managerial support was lacking. 2a. During an interview on 12/5/24 at 4:51 PM, the Director of Nursing stated the facility did not have functioning bathtubs in the shower rooms on the resident units and the bathtubs in the private rooms were too low and would pose as a safety hazard for residents. They stated the facility should have a functioning tub and believed the last functioning tub in the facility broke approximately 2 years ago. During an interview on 12/5/24 at 5:00 PM, the Administrator stated they were not aware the facility did not have a functioning bathtub. b. During an interview on 12/6/24 at 2:25 PM, the Administrator stated Social Worker terminated their employment at the facility (12/2/24). During an interview on 12/6/24 at 4:18 PM, the Administrator stated they didn't have a specific Grievance Officer and the Social Worker would be responsible for grievances. During an interview on 12/6/24 at 2:25 PM, the Administrator stated Social Worker terminated their employment at the facility (12/2/24). During an interview on 12/6/24 at 4:40 PM, the Director of Nursing stated the facility did not have a grievance policy and procedure. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 12/6/24 at 5:26 PM, the Administrator stated resident grievances were not being reviewed and process was not being followed. 10 NYCRR 415.27 (c)(1)(2)(3)(iv)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 43785 Based on observation, interview and record review conducted during a Standard survey completed 12/6/24, the facility did not ensure provision of a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections, for two (Resident #10 and #43) of four residents reviewed for enhanced barrier precautions (interventions designed to reduce transmission of multi-drug resistant organisms including gown and glove use during high contact resident care activities) during care. Specifically, Resident #10 had chronic pressure ulcers (injury to the skin and tissues from prolong pressure to the area) and the Certified Nurse Aides did not wear proper personal protective equipment during morning care. Additionally, Resident #42 had an ileostomy (a surgical operation in which a piece of the intestine is diverted to an opening in the stomach wall) and the nurse did not wear proper personal protective equipment during care. The findings are: Review of the policy and procedure titled Enhanced Barrier Precautions dated 4/2024 documented that residents in nursing homes are at increased risk of becoming colonized and developing infection with multi-drug resistant organisms, especially those with risk factors like indwelling medical devices or wounds. It is the policy of the facility to implement enhanced barrier precautions for the prevention of transmission of the organisms. The policy documented that enhanced barrier precautions involve gown and gloves use during high-contact resident care activities for residents who were at increased risk of multi-drug resistance acquisition. High contact resident activities include dressing, bathing, providing hygiene, device care or use, and wound care. 1. Resident #10 had diagnoses including multiple sclerosis (a disease where the immune system effects the protective covering of nerves), diabetes, and pressure ulcers of the sacrum (area at the base of the tailbone) and ischium (area of the lower buttocks). The Minimum Data Set (a resident assessment tool) dated 11/11/24, documented Resident #10 was cognitively intact, understood and understands. Resident #10 required substantial/maximal assistance with bathing and had one stage 3 (wound that involves full thickness loss of tissue) pressure ulcer and one unstageable (full thickness skin and tissue loss where the depth of the wound is hidden by eschar [dead tissue] and slough [yellow/white soft, stringy, thick substance]) pressure ulcer. The comprehensive care plan revised on 12/4/24, documented Resident #10 had pressure ulcers related to multiple sclerosis, diabetes mellitus and limited mobility. Interventions included to administer treatments and medications and to follow facility policies/protocols for prevention/treatment of skin breakdown. There was nothing in the care plan about Enhanced Barrier Precautions. Review of the Wound Evaluation and Management Summary noted dated 11/25/24, the Wound Consultant documented that Resident #10 had chronic wounds on their sacrum and left ischium with history of osteomyelitis (a serious bone infection). It was documented that Resident #10 had a stage IV (full thickness skin and tissue loss that exposes bone, muscle, tendon, ligament, or cartilage) pressure ulcer to their sacrum and left ischium with moderate serous drainage (clear/yellow drainage from a wound). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 12/2/24 at 12:43 PM, Resident #10 was noted to have a precaution sign on the door indicating stop, staff to wear gloves and gown during care. A plastic bin was observed to be outside the resident door in the hallway filled with gowns and masks. During an observation on 12/4/24 at 10:13 AM, precaution signage remained on the door and the plastic bin was now located inside the door entrance to the right-hand side. Certified Nurse Aide #8 and #9 performed morning care to Resident #10 by washing, rinsing, and drying the resident's neck, underneath their breast and armpits, peri area and buttocks. Resident #10 was observed to have open areas to their sacrum and left ischium that were not covered with any dressings. Certified Nurse Aide #8 and #9 did not wear gowns during the morning care observation. During a wound care observation on 12/4/24 at 10:42 AM, immediately following the completion of morning care, Licensed Practical Nurse #10 donned a gown prior to initiating the care. Resident #10's left ischium wound was noted to be moist with area of slough in the wound bed. Serosanguinous drainage (watery drainage mixed with blood from a wound) was noted on the gauze pad as the wound was cleansed with wound cleaner and prior to the application of the ordered ointment the wound began to actively bleed. During an interview on 12/4/24 at 1:30 PM, Certified Nurse Aide #8 observed the precaution signage on Resident #10's door and stated they did not pay attention to the signage on the door. They stated they should have worn a gown during morning care. Certified Nurse Aide #8 stated Resident #10 had a wound and because they did not wear a gown, they did not protect themselves from possible germs. During an interview on 12/4/24 at 1:59 PM, Certified Nurse Aide #9 observed the precaution signage on Resident #10's door and stated the sign meant that they were to wear a gown when providing care to Resident #10. They stated that themselves and Certified Nurse Aide #8 did not wear gowns during morning care for Resident #10 because they were not used to being observed performing their duties and they both were nervous being observed. Certified Nurse Aide #9 stated the purpose of wearing gowns for residents that were on enhanced barrier precautions was for infection control reasons. During an interview on 12/5/24 at 12:16 PM, Licensed Practical Nurse #10 stated enhance barrier precautions were when any type of care was given to a resident that had a wound and the area was exposed. Licensed Practical Nurse #10 stated that Resident #10 had chronic pressure ulcers. They stated that at any point during care Resident #10's dressing could come off and that it often did. Licensed Practical Nurse #10 stated staff needed to wear a gown when providing care to Resident #10 because the area could become infected at any time. 2. Resident #43 had diagnoses including major depressive disorder, ileostomy, and gastro-esophageal reflux disease. The Minimum Data Set (a resident assessment tool) dated 10/28/24 documented the resident was understood, understands, was cognitively intact. The comprehensive care plan for Resident #43 dated 10/24/24 identified as current by the Director of Nursing, did not have a focus area, goals or interventions for enhanced barrier precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 12/2/24 at 11:10 AM, revealed signage on Resident #43's room door for precautions with directions to don a face mask, gloves, and a gown. There was a multi-pocket storage container hanging on Resident #43's door with gowns, gloves, masks, and face shields available. There was a bin located outside Resident #43's doorway in the hallway with additional personal protective equipment including masks, gloves, and gowns. During an observation and interview on 12/4/24 at 9:42 AM, Licensed Practical Nurse #9 donned gloves and a mask and performed changing Resident #43's ileostomy bag/flange, they did not wear a gown. Licensed Practical Nurse #9 stated Resident #43 was on Enhanced Barrier Precautions because of the ileostomy. They stated they applied gloves and a mask and should have also donned a gown before changing the ileostomy flange, for infection control, and they stated they have no excuse why they didn't, just that they had forgotten to put on a gown. During an interview on 12/6/24 at 10:42 AM, Nursing Supervisor/Unit Manager Licensed Practical Nurse #5 stated Resident #43 was on Enhanced Barrier Precautions because they had an ileostomy and would have expected Licensed Practical Nurse #9 to have donned gloves, mask and a gown prior to changing Resident #43's ileostomy bag/flange for infection control purposes to protect the resident. During an interview on 12/6/24 at 8:59 AM, the Infection Preventionist stated Enhance Barrier Precautions were used for residents that had any invasive device and/or opening such as wounds or ostomies/colostomies. They stated the purpose of Enhance Barrier Precautions was to shield the care giver from bacteria and to protect the resident from introduction of bacteria. The Infection Preventionist stated personal protective equipment (gloves and gowns) needed to be worn during any direct contact with the resident such as dressing, bathing, or care to the area. They stated they would have expected the nurse to wear a gown when preforming colostomy/ostomy care and would have expected the Certified Nurse Aides to wear a gown when performing morning care to a resident with an open wound. During an interview on 12/6/24 at 12:11 PM, the Director of Nursing stated Resident #43 was on Enhanced Barrier Precautions for the ileostomy and would have expected Licensed Practical Nurse #9 to have donned a gown in addition to the gloves and mask prior to changing the ileostomy bag/flange for infection control purposes. During a further interview at 12:41 PM, the Director of Nursing stated that gowns and gloves were to be worn during any type of care or transfers when a resident had any skin wounds. They stated they were familiar with Resident #10 and Certified Nurse Aides absolutely should have worn gowns during morning care. The Director of Nursing stated the purpose for Enhanced Barrier Precautions was the resident could have an infection without one knowing. They stated that wearing gowns not only protected the resident from possible infection but also the staff from possible infection. 10NYCRR 415.19(a)(2)