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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335180	A. Building B. Wing	11/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Safire Rehabilitation of Northtowns, L L C	2799 Sheridan Drive Tonawanda, NY 14150

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48624 Based on observation, interviews, and record review conducted during the Onsite Post Survey Revisit #1, the facility did not ensure all menus were followed for four (Residents #1, 2, 3 and 4) of 7 residents reviewed. Specifically, residents were not served a ground consistency diet as planned. This is a continuing deficiency from the abbreviated survey completed 11/12/2024. The findings are: The policy and procedure titled, Tray Identification dated 2/17/17, documented the purpose of the policy was to assist in setting up and serving the correct food trays/diets to residents. The Food Services Manager or Supervisor will check trays for correct diets before the food carts are transported to their designated areas. Nursing staff shall check each food tray for the correct diet before serving the residents. If there is an error, the Nurse Supervisor will notify the Dietary Department Immediately by phone so that the appropriate food tray can be served. The policy and procedure titled, Therapeutic Diets dated 1/10/2018 documented, when necessary, the facility will provide a therapeutic diet that is individualized to meet the clinical needs and desires of a patient/resident to achieve outcomes/goals of care. Available therapeutic diets should coincide with the therapeutic diets on the facility menu extensions. When appropriate, an individual will be educated by the Registered Dietician or designee about his/her therapeutic or consistency modified diet. Review of a facility provided document titled, Dietary Terminology Guide, with an effective date of 4/2022 documented the consistencies offered at the facility included: regular consistency as tolerated, ground included mechanically soft, dental soft, chopped, and pureed included strained or blenderized. 1. Resident #1 had diagnoses which included anemia in chronic kidney disease, dysphagia (difficulty swallowing), and cerebrovascular disease (a decrease of blood flow to the brain causing brain damage). The Minimum Data Set (MDS, a resident assessment tool) dated 9/16/24, documented Resident #1 had moderate cognitive impairment and sometimes understand others and sometimes was understood by others. (continued on next page)

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

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

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Comprehensive Care Plan dated 10/1/24, documented Resident #1 was on a ground diet and required light assistance with eating, was to be out of bed as tolerated, and to monitor for pocketing (holding food in mouth without swallowing increasing the risk of choking if becomes dislodged). The Speech Therapy plan of treatment dated 12/10/24 documented recommendations for Resident #1 that included mechanical soft/ground textures, thin liquids, supervision of oral intake/occasional. Upright posture during meals and greater than 30 minutes after meals. Resident #1's dietary card dated 12/17/24 documented they were to have 2 ounces of ground beef pot roast, 4 ounces of au gratin potatoes, 4 ounces of ground Prince [NAME] blend vegetables, 1 slice of ground cream pie. Supervision: monitor for pocketing out of bed as tolerated for meals. During a lunch observation 12/17/24 at 12:50 PM Resident #1's was eating lunch in the dining room and was supervised by Certified Nurse Aide #1. Their meal consisted of pot roast with gravy, a vegetable blend, au gratin potatoes and pie. The beef pieces were stringy, about 1-2 inches in length and were not of ground consistency; the vegetables and potatoes appeared to be soft in texture but were not of ground consistency. The cream pie was a whipped cream consistency with a graham cracker crust. The resident had eaten 50 percent of the meal at the time of the observation. During an interview on 12/17/24 at 12:54 PM, Resident #1 stated their meat was not ground and should be so that it was easier for them to swallow. They stated their vegetables and potatoes were soft enough for them to swallow and did not have an issue swallowing the cream pie. On 12/18/24 at 1:25 PM Resident #1 stated that sometimes their food was ground and sometimes it was not. During an interview and observation on 12/17/24 at 1:05 PM the Registered Dietician stated the meat on Resident #1's tray was not ground, the vegetables and potatoes were soft enough they did not need to be ground, as well as any cream pie with a graham cracker crust. They stated it was important to ensure the consistency and proper diet of resident's food to decrease any risks of choking or malnutrition. During an interview on 12/18/24 at 1:30 PM, Certified Nurse Aide #1 stated Resident #1 needed supervision and minimal assistance with eating. They stated they felt the beef was soft enough for the resident and made sure the resident did not take too big of mouthfuls. During an interview on 12/18/24 at 1:37 PM, Registered Nurse #1, Unit 3 Supervisor stated were responsible for viewing the resident's tray for accuracy before serving but they had educated the staff and relied on the Certified Nurse Aides to inform them of any discrepancies. Additionally, they stated that no Certified Nursing Aides had informed them of any issues with consistency. 2. Resident #2 had diagnoses of dysphagia following cerebral infarction, hemiplegia (one sided paralysis) and hemiparesis (one sided weakness). The Minimum Data Set, dated dated dated [DATE] documented Resident #2 had mild cognitive impairment, could understand others, and could be understood by others. Resident was dependent on staff for eating. Review of a Comprehensive Care Plan dated 10/17/24 documented Resident #2 required a mechanically soft diet, a total assist for all meals and was to be up in chair for all meals. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Speech Language Pathologist Evaluation and plan of treatment dated 10/24/24, documented that Resident #2 was to be on a regular mechanically ground diet. The goals documented for Resident #2 to have safe swallowing with the least restrictive diet. Review of a diet card dated 12/17/2024 documented Resident #2 was to have 3 ounces of ground beef pot roast with 2 ounces of gravy, 4 ounces of au gratin potatoes, 4 ounces of ground Prince [NAME] blend vegetables, 1 slice of ground cream pie. During an observation and interview on 12/17/2024 at 1:25 PM, Resident #2 was observed eating lunch in the dining room with assistance from staff. Their meal consisted of pot roast with gravy, a vegetable blend, au gratin potatoes and pie. Certified Nursing Assistant #2 stated the diet card did not match the meal tray and the beef pot roast, vegetables and pie should have been ground. They stated they did not go to the kitchen because the resident did not like the pot roast. They stated they did offer them something different, but they did not want anything else. The resident had eaten a few bites of the pot roast and some of the vegetables. During an interview on 12/17/24 at 3:03 PM, the Speech Therapist stated a resident would be put on a therapeutic diet for ground foods because it would be easier to chew and decrease the risk of them choking. During an interview on 12/18/24 at 1:45 PM, the Registered Dietician stated in the beginning Resident #2 had a hard time adjusting to ground consistency but had adjusted. 3. Resident #3 had diagnoses of dysphagia after a cerebral vascular accident, diabetes, and Barrett's esophagus (lining of the esophagus becomes red and thickened due to acid reflux). The Minimum Data Set, dated dated dated [DATE] documented Resident #3 had mild to moderate cognitive impairment, could understand others and could be understood by others. Resident #3 was totally dependent on staff for eating. Review of a Comprehensive Care Plan dated 5/27/24 documented Resident #3 required a ground diet and a total assist from staff for all meals. Review of Speech Language Pathologist progress note dated 9/11/24 documented that Resident #3 was downgraded to a ground diet, nectar, due to mild dysphagia, thin liquids, ground consistency. Review of a diet card dated 12/17/24 documented that Resident #3 was to have 3 ounces of ground beef pot roast with 2 ounces of gravy, 4 ounces of au gratin potatoes, 4 ounces of ground Prince [NAME] blend vegetables, 1 slice of ground cream pie. Extensive Assistance, small sips, and bites, evaluate head of bed at least 30 degrees during meal and for 30 minutes post meals. During a lunch meal observation on 12/17/24 at 12:50 PM Resident #3 was sitting in a Geri chair in the main dining room. Certified Nurse Aide #2 was sitting with the resident and providing total assistance. Resident #3's meal tray consisted of pot roast with gravy, au-gratin potatoes, vegetable blend and a slice of cream pie. The resident had eaten about 50 percent of their meal and the food was not of ground consistency. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/17/24 at 12:58 PM, Certified Nurse Aide #2 stated the diet card documented Resident #3's food should have been ground. They stated they should have notified the kitchen the food was not ground but they never answered the phone. They stated today they improvised and cut the meat up in small pieces for the resident and the gravy helped make it easier for the resident to chew and swallow. They said they did not notify their supervisor because the beef was tender, and they cut it into small pieces for the resident. They stated that sometimes the resident's food was ground, but not always. During an interview on 12/18/24 at 12:38 PM Registered Nurse #2 Unit 2 Supervisor, stated they did not know the policy and procedure documented that they were responsible to view the resident's tray for accuracy before serving. They stated they monitored the staff to ensure they checked all diet cards and trays and educated them on what to do if there was an issue but no issues were brought to their attention. 4. Resident #4 had diagnoses of dysphagia following cerebrovascular disease, acute kidney failure. The Minimum Data Set, dated dated dated [DATE], documented Resident #4 was severely cognitively impaired and could not understand others or be understood by others. Resident #4 required setup assistance while eating. The Comprehensive Care Plan dated 10/25/24 documented Resident #4 required a ground diet. Review of a diet card dated 12/17/24 Resident #4 was to have 2 oz of ground beef pot roast, 4 ounces of au gratin potatoes, 4 ounces of ground Prince [NAME] blend vegetables, 1 slice of ground cream pie. During a lunch meal observation on 12/17/24 at 1:20 PM Resident #4 was eating in a supervised dining room. The resident's meal consisted of beef pot roast, vegetables, au-gratin potatoes, and a slice of cream pie. The foods were not of a ground consistency. Resident #4 had consumed all their meal. During an interview on 12/17/24 at 1:22 PM, Certified Nurse Aide #3 stated Resident #4's food was not ground as the diet card specified. Certified Nurse Aide #3 stated they should have ordered a new tray and took the incorrect tray down to the kitchen and had it corrected. During an interview on 12/18/24 at 1:35 PM, the [NAME] Supervisor stated they took full responsibility for the beef pot roast meals that were served to the residents on 12/17/24 with the wrong consistency. They stated they may have not heard the dietary aides call it out. During an interview on 12/18/24 at 1:47 PM, the Director of Food Service stated foods should have been served in the form that met the residents' individual needs. They stated as the Director of Food Services they were responsible to monitor the staff to ensure they verified the diet card with the meal tray. During an interview on 12/18/24 at 1:55 PM, the Director of Nursing stated their expectations would be for staff to ensure the diet card matched the meal tray. If it did not, they need to go to the kitchen and get the accurate items and consistency for the resident. They stated this was important to decrease the risk of harm or even possible death. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/18/24 at 2:05 PM, the Administrator stated their expectations were for the entire staff to review diet cards before trays went out on the floor. Staff who pass the tray on the units should double check and the nurses should monitor and ensure accuracy. NYCRR 415.14 (c) (1-3)