| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 335182 | A. Building<br>B. Wing | 08/08/2025 |

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| Greenfield Health & Rehab Center | 5949 Broadway<br>Lancaster, NY 14086 |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>Based on observation, interview, and record review conducted during the Standard survey completed on 08/08/2025, the facility did not ensure residents were free from unnecessary drugs for one (1) (Resident #157) out of five (5) residents reviewed. Specifically, Resident #157's psychotropic medication (Xanax, an anti-anxiety medication) dose was increased erroneously and without evidence of adequate indications. The findings are: The policy titled Medication Regimen Review revised 9/2017 documented the consultant pharmacist will perform a drug regimen review on each resident residing at the facility for the objective to try to minimize or prevent adverse consequences or to prevent resident from receiving unnecessary drugs. The policy documented all medication orders will be review for unnecessary medications, adequate and appropriate indications for each ordered medication, and the appropriateness of the medication, dose, frequency and route of administration. The policy titled BMARC (Behavior Modifying Agent and Review Committee) revised 1/2022 documented the policy was to assure that all psychopharmacological agents were prescribed appropriately and monitored by the interdisciplinary team, all psychopharmacological medications were reviewed at the recommendations of the Behavior Modifying Agent and Review Committee. Resident #157 had diagnoses including dementia, anxiety and major depression. The Minimum Data Set (a resident assessment tool) dated 06/05/2025 documented Resident #157 had severe cognitive impairment, sometimes understood and sometimes understands. The Minimum Data Set documented Resident #157 had no delusions, no hallucinations, no rejection of care, no behaviors and received antianxiety medication. The comprehensive care plan revised 09/25/2024, documented Resident #157 used anti-anxiety medications (Xanax) related to anxiety disorder. Interventions included to administered anti-anxiety medications as ordered and monitor for side effects and effectiveness every shift. The Order Recap Report dated 08/08/2025 documented Resident #157 had an order for Xanax 0.25 milligrams every eight (8) from 01/09/2025 until 01/30/2025. On 1/30/2025 the report documented an active order for Xanax 0.5 milligrams every eight (8) hours. Review of the GP Progress Note signed by Physician Assistant #2, (Psychiatry Physician Assistant) documented :-01/29/2025 at 12:12 PM Resident #157 was recently readmitted from the facility and received Xanax as previous prescribed. Physician Assistant #2 documented Resident #157 had no significant anxiety since readmission and mood was stable. It was documented to continue Xanax 0.25 milligrams as previously taking in the community and no increase or additional psychotropic medications were recommended at that time. -04/30/2025 at 9:16 PM Resident #157 continued to do well on Xanax as previously prescribed. It was documented to continue Xanax 0.25 milligrams as previously taking in the community and no increase or additional psychotropic medications recommended. -07/23/2025 at 10:10 AM Resident #157 continues Xanax 0.5 milligrams every eight (8) hours and maintains good control of previous symptoms. The note also documented to continue Xanax 0.25 milligrams as previously taking in the community and there was no increase or additional psychotropic medications recommended. Review of Nurse Practitioner #1 progress notes dated 01/28/2025 - 07/09/2025 documented Resident #157 was to continue Xanax 0.25 milligrams every eight (8) hours for generalized anxiety disorder with goal to wean to the lowest dose. Review of the BMARC Committee<br>(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 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Follow-up (Behavior Modifying Agent and Review Committee) notes for Resident #157 documented:-01/29/2025 Xanax 0.25 milligrams every eight (8) hours for anxiety continues. The committee recommended no changes at this time.-04/30/2025 and on 07/23/2025 Xanax 0.5 milligrams every eight (8) hours continues, and the resident was stable on the lowest effective dose of medications at that time.There was no documented indications for the increase in the Xanax dosage. Review of the Medication Administration Record from 01/01/2025 to 08/07/25 Resident #157 received the Xanax as per medical provider's order. Review of the Progress notes dated 01/28/2025-02/04/2025 revealed there was no documented evidence Resident #157 was experiencing increased anxiety and/or gastrointestinal complaints. There was no documented evidence that a new order was received to increase Resident #157's Xanax dose or any indications for the need. During intermittent observations from 08/04/2025-08/07/2025 between the hours of 9:49 AM and 4:10 PM, Resident #157 was out of their room self-propelling the unit and participating in self-directed and group activities; being assisted with activities of daily living (toileting, medication administration) and sleeping in bed. Resident #157 was well kempt, pleasant, cooperative with staff and no behaviors were displayed. During a telephone interview on 08/07/2025 at 9:59 AM, Physician Assistant #2, (Psychiatry Physician Assistant), stated Resident #157 utilized Xanax because the resident perseverated on their gastrointestinal complaints versus anxiety issues. After review of review of their progress notes, Physician Assistant #2 stated they made a mistake in their documentation on 07/23/2025 and assumed the Xanax 0.5 milligrams was Resident #157's previous dosage. Physician Assistant #2 stated Resident #157 was taking Xanax 0.25 milligrams every eight (8) hours and the dosage was increased to Xanax 0.5 milligrams every eight (8) in January 2025 after a hospital stay. Physician Assistant #2 stated they were unsure why Resident #157's Xanax dosage was increased shortly after return from the hospital. During a telephone interview on 08/08/2025 9:50 AM, Physician Assistant #2 stated they did not recommend an increase in Resident #157's Xanax dosage and would not have expected a change in the dosage without a medical provider's order and family notifications. Physician Assistant #2 stated they attended the Behavior Modifying Agent and Review Committee (BMARC) meetings. During an interview on 08/07/2025 at 10:35 AM, the Pharmacy Consultant stated the Xanax dose was increased to 0.5 milligrams every eight (8) hours on 01/30/2025 after Physician Assistant #2 psychiatry visit. The Pharmacy Consultant stated they participated in the Behavior Modifying Agent and Review Committee (BMARC) meetings and Resident #157 was reviewed by the committee. The Pharmacy Consultant stated the committee notes on 04/30/2025 and 07/23/2025 documented the Xanax dose as 0.5 milligrams every eight (8) hours but there was no documentation regarding the increase or the indication. They stated the Behavior Modifying Agent and Review Committee (BMARC) documentation could be stronger. During a telephone interview on 08/08/2025 at 11:08 AM, the Pharmacy Consultant stated they could not locate any documented evidence and indication for the increase in the resident's Xanax dose. They stated they expected there to be documentation in the medical record for the clinical indication for increasing a psychotropic medication along with expected outcomes and goals for the resident. During a telephone interview on 08/07/2025 at 3:11 PM, Nurse Practitioner #1 stated on 01/30/25 they signed Resident #157's order for Xanax 0.5 milligrams every eight (8) hours. They stated they signed resident's medication orders via an application on their cellular phone and would only question a medication order if it was an odd dosage. Nurse Practitioner #1 stated they did not give a verbal order to increase the Xanax dose. The nurse that imputed the medication order into the electronic medical record transcribed the order inaccurately. After review of their progress notes, Nurse Practitioner stated they documented Resident #157 was receiving Xanax 0.25 milligrams every eight (8) hours. They stated their progress notes were not inaccurate for Resident #157 Xanax dosage rather Resident #157's order for Xanax 0.5 milligrams every eight (8) hours was the error, and the resident continued to receive the 0.5 milligram dose. During an interview on 08/07/25 at 3:35 PM, Registered Nurse #9 Unit Manager stated on 1/30/2025 they input an order for Resident #157 to have Xanax 0.5 milligrams<br>(continued on next page) |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | every eight (8) hours. They stated Resident #157's Xanax was due for a 30-day narcotic reorder and they transcribed the order inaccurately. The order should have been Xanax 0.25 milligrams not 0.5 milligrams every eight (8) hours. Registered Nurse #9 stated they did not receive a verbal order or recommendation from the medical provider to increase the Xanax dosage. During an interview on 08/08/2025 at 9:20 AM, Registered Nurse #9, stated they could not locate any documented evidence or indication for the need to increase the Xanax dose. They also stated they were unsure why the Behavior Modifying Agent and Review Committee (BMARC) did not note the medication was increased during their review. During an interview on 08/07/2025 at 3:41 PM after review of Physician Assistant #2's progress notes, the Director of Nursing stated there was some confusion in the providers documentation and they would expect that all documentation be accurate. During an interview on 08/07/2025 at 4:12 PM, Registered Nurse #10 stated they were familiar with Resident #157, and the resident does not display any behaviors. During an interview on 08/07/2025 at 4:16 PM, Certified Nurse Aide #8 stated they were familiar with Resident #157 and was often responsible for their care. They stated Resident #157 did not display any signs of increased anxiety except when they needed to use the bathroom. Certified Nurse Aide #8 stated the resident would settle after they were assisted to the bathroom and then ask to use the bathroom again about 25 minutes later. They stated Resident #157 did not have any aggression or behaviors that disturbed others. During an interview on 08/07/2025 at 4:22 PM, the Director of Nursing stated they could not locate any evidence regarding an indication for the increase in the resident's Xanax dose. They would expect to see evidence (behaviors) documented in progress notes to support the need. The Director of Nursing stated Resident #157 was taking the incorrect dosage. 10 NYCRR 415.4(a)(1) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>Based on observation, interview, and record review conducted during the Standard survey completed on 08/08/2025, the facility did not ensure that residents who had a catheter (tube inserted into the bladder) received the appropriate care and services for one (1) (Resident #113) of three (3) residents reviewed. Specifically, infection control practices were not maintained, and they were not provided with a urinary leg bag as they preferred and per facility practices. The finding is: Review of the policy titled Bladder Indwelling Urethral Catheter Site and Equipment Care dated 2/2024 documented drainage bag holders were available for all residents with Foley catheters. They were to be used if the resident does not use a leg bag. The Foley bag and tubing were placed inside the bag. Never let the tubing hang below the bag. Resident #113 had diagnoses including urinary tract infection, benign prostatic hypertrophy (enlarged prostate gland), and neuromuscular dysfunction of the bladder (a condition where the bladder does not empty urine). The Minimum Data Set (a resident assessment tool) dated 06/19/2025 documented Resident #113 was understood, understands and was cognitively intact. There were no refusals of care documented. The comprehensive care plan dated 6/13/25 documented Resident #113 had an indwelling catheter. Interventions included position the catheter bag and tubing below the level of the bladder and away from the entrance room door, check tubing for kinks, monitor and document intake and output as per facility policy. They care plan did not address the use of a leg bag when out of bed. Review of the Kardex (a guide used by staff to provide care) dated 08/04/2025 documented Resident #113 had a catheter, position the catheter bag and tubing below the level of the bladder and away from the entrance room door. The Kardex documented Resident #113 walked with a left hemi-walker, with a moderate assist of one (1) staff member for 85 feet. They care plan did not address the use of a leg bag when out of bed. Review of the nursing progress notes dated 07/01/2025 through 08/07/2025 lacked documented evidence that Resident #113 had refused a leg bag. Review of Nurse Practitioner #1's progress note dated 06/18/2025 documented Resident #113's chief complaint was urinary retention, and an infectious work up was ordered. The urinalysis appeared positive, and Resident #113 was diagnosed with a urinary tract infection.During an observation on 08/05/2025 at 7:50 AM, Resident #113 was lying flat in bed sleeping. The gravity drainage bag was in a blue privacy bag hanging on the door side of the bedframe. There was four (4) inches of catheter drainage tubing touching the floor next to the bed. During an observation and interview on 8/05/25 at 9:04 AM, Resident #113 was sitting up in bed with a gravity drainage bag in a blue privacy bag hanging on the bedframe. Resident #113 stated they preferred to have a leg bag on and always wore one when they were at home, but they rarely wore one at the facility. They stated the only time the staff would change their gravity drainage bag to a leg bag was when they would go out to appointments. Resident #113 stated at one point they asked the staff for a leg bag and was told a reason why they could not have one. They stated they did not remember the reason but remembered that they did not understand it. They preferred to wear a leg bag during therapy because they were afraid the catheter drainage tubing would get caught while they were walking and would cause the catheter to get ripped out of them.During an observation and interview on 08/06/25 at 12:38 PM, Resident #113 was sitting up in their wheelchair. There was a gravity drainage bag inside of a blue privacy bag that was attached underneath the wheelchair. There was 16 (inches) of catheter drainage tubing underneath the wheelchair touching the floor and Resident #113 had both of their feet on the tubing. Resident #113 stated they were never offered a leg bag in the morning, and they were not sure why they were not offered one.During an interview on 8/6/25 at 12:41 PM, Certified Nurse Aide #2 stated the catheter drainage tubing was on the floor and it should not have been like that. It should have been stuffed in the privacy bag under the chair because that was an infection control risk. During an interview on 8/7/25 at 10:44 AM, Certified Nurse Aide #4 stated usually any resident who had a foley catheter and that walks should have had a leg<br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | bag. It was the responsibility of either the certified nurse aide or the nurse to change the gravity bag to a leg bag. They stated they have seen catheter drainage tubing on the floor, and it should never have touched the floor because that was infection control. The certified nurse aides were responsible for making sure the catheter drainage tubing was in the privacy bag and off the floor. During an interview on 08/07/2025 at 10:50 AM, Certified Nurse Aide #5 stated they think that the certified nurse aides sometimes put a leg bag on Resident #113 but sometimes they do not put it on them. They stated sometimes therapy will get Resident #113 up out of bed without putting the leg bag on them. If any resident with a catheter had the ability to walk, then the staff were supposed to put a leg bag on them. It was just something that they were trained to do and something that all new staff were trained to do. They stated they have seen the catheter drainage tubing on the floor before, but it should never touch the floor because it was an infection control problem. During an interview on 08/07/2025 at 11:05 AM, Licensed Practical Nurse #5 stated any resident with a foley catheter should have a leg bag when they were out of bed. It was just what certified nurse aides were trained to because then the residents have more freedom of movement. Licensed Practical Nurse #5 stated the catheter drainage tubing should not touch the floor and should have been in the privacy bag for sanitation purposes. During an interview on 08/07/2025 at 11:35 AM, Certified Nurse Aide #3 stated they were assigned Resident #113 on 08/06/2025 but someone in therapy got them up and took them to therapy in the morning. They stated that as the certified nurse aide responsible for Resident #113, they should have double checked that a leg bag was put on instead of the gravity bag. They stated that it was important to switch Resident #113 to the leg bag because then it would be safely secured when Resident #113 walks around. Certified Nurse Aide #3 stated when Resident #113 had a gravity bag, the catheter drainage tubing should not have been on the floor because of infection control. Everyone on the unit including nurses and certified nurse aides were responsible for making sure the drainage tubing was not touching the floor. During an interview on 08/07/2025 at 11:40 AM, Licensed Practical Nurse #6 Unit Manager stated any resident who had a foley catheter and ambulated (walked) should have a leg bag because it would be easier for them. They stated that the certified nurse aides should read the care plan and if the resident had a foley catheter and ambulated, then a leg bag should have been placed. They stated Resident #113 would refuse their leg bag. Licensed Practical Nurse #6 Unit Manager stated when using the gravity drainage bag, the tubing should have never touched the floor because that was infection control. They stated Resident #113 had a urinary analysis in June 2025 and it was positive for a urinary tract infection. They stated that it was a group effort on the unit including certified nurse aides and nurses to make sure the catheter drainage tubing was not touching the floor. During an interview on 08/07/2025 at 12:04 PM, Physician Assistant #1 Physiatrist stated their job was to evaluate any barriers a resident might have prevented them from full participation in therapy. They stated that residents with foley catheters should have a leg bag during therapy because the tubing and gravity bag could interfere with their ability to fully participate in therapy. During a telephone interview on 08/07/2025 at 2:49 PM, Nurse Practitioner #1 stated the catheter drainage tubing should never be on the floor because of migrating bacteria, increasing the risk for infection. They stated Resident #113 had a history of urinary tract infections with the most recent one being in June. During an interview on 08/07/2025 at 3:00 PM, Physical Therapist #1 stated it varied if Resident #113 had a leg bag on during therapy sessions. They stated Resident #113 was not wearing a leg bag the week prior because their genital region had irritation. During an interview on 08/08/2025 at 8:34 AM, the Director of Nursing/Infection Preventionist stated it was the expectation that residents with foley catheters who attended therapy or walked to be provided a leg bag. When they were doing any walking, it was for their dignity and so they did not accidentally trip over the tubing. They stated even though it was not necessarily care planned to provide a leg bag, it was something that all staff were taught to do when they were hired. The certified nurse aides were responsible for switching a resident to a leg bag. If a resident refused a leg bag, then it would be expected that it was documented in a nursing note. The stated that Resident #113 had some genital erosion at the foley<br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | catheter insertion site but the staff on the unit were never told to stop providing a leg bag. The Director of Nursing/Infection Preventionist stated the catheter drainage tubing should have never touched the floor because it was an infection control issue. The certified nurse aide should have put the drainage bag and tubing into the privacy bag. They stated that Resident #113 would move around in bed quite a bit, but the expectation was that the staff anticipate them moving around and check to make sure the drainage tubing and bag were still in the privacy bag. They stated both certified nurse aides and nurses were responsible for making sure the catheter drainage tubing and bag were off the floor. 10 NYCRR 415.12(d)(1) |

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| F 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide for the safe, appropriate administration of IV fluids for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review conducted during the Standard survey completed on 8/8/25, the facility did not ensure parenteral fluids were administered with professional standards of practice and in accordance with the physicians' orders, and the comprehensive person-centered care plan for one (1) (Resident #174) of one (1) resident reviewed for intravenous (IV) therapy. Specifically, there was a delay in the administration of intravenous (IV) antibiotics per the final hospital discharge summary, and a lack of orders to address central venous catheter (a long thin tube inserted into a large vein to provide long term access for medication, fluids, or blood draws; right internal jugular vein) maintenance and care (normal saline flushes and dressing changes). The finding is:The policy titled Central Venous Catheter Flush/SAS (saline, antibiotic, saline), last revised 5/2019 documented the Registered Nurse may flush venous catheters as ordered by the physician to prevent the clotting of blood within the catheter. The Registered Nurse must verify patient, cleanse port with alcohol, administer 10 cubic centimeters (ccs) of saline, infuse medication, cleanse port with alcohol, flush port with 10 cubic centimeters normal saline, then document. The policy did not address central venous catheter dressing changes. The policy titled Intravenous Antibiotic Administration, last revised 1/2020 documented intravenous antibiotics were utilized to achieve a constant, rapid, high blood level of drug therapy in the treatment of serious infection or infection that does not respond to antibiotics given but the oral or intramuscular route. Residents who required intravenous antibiotics would be provided those services. The policy titled admission procedure, last revised 10/2024, documented a nursing evaluation was completed on all new residents and readmission, information about resident admission was communicated in a timely manner to the appropriate departments. A skin check was completed by the team leader and reviewed by the Nursing Supervisor. The initial admission form was completed by the nurse. The Unit Manager/Desk Nurse/nurse transcribed the orders according to the approved transcription standard of care from preliminary/final discharge documents from hospital/facility or from the physician if entering from home. To secure additional information, the nurse shared the resident care plan with the incoming nurse, and they discuss information that must be gathered during the evening and night shifts. To assure continuity, the nurse manager or designee reviewed the resident care plan and served as coordinator of the plan.Resident #174 had diagnoses including diabetes mellitus, endocarditis (inflammation of heart valve), and cellulitis (bacterial skin infection). The comprehensive care plan dated 8/1/25 documented Resident #174 was cognitively intact and able to make their needs known. A focus area initiated on 8/5/25 documented Resident #174 was on intravenous medications related to endocarditis/bacteremia (presence of bacteria in the bloodstream).The Visual/Bedside Kardex (guide used by staff to provide care) dated 8/7/25 documented Resident #174 required touch assist of one (1) staff member for dressing, transferring, and bed mobility.The hospital final discharge summary report dated 8/1/25 documented Resident #174 was to receive ceftriaxone (antibiotic) 2 (two) grams intravenously once a day per their infectious disease consult and cardiology recommended outpatient TAVR (transcatheter aortic valve replacement) and [NAME] (device used for patients who could not tolerate blood thinners) after completion of Resident #174's intravenous antibiotics (8/18/25). Review of the active physician orders dated 8/1/25 revealed there were no orders to address central venous catheter maintenance and care to include but not limited to normal saline flushes and dressing changes; and there were no physician orders for the administration of intravenous (IV) antibiotics.Review of medication administration record dated 8/1/25 to 8/8/25 revealed orders initiated on 8/3/25 during the overnight shift (11:00 PM to 7:00 AM) to flush Resident #174's central line every shift with 10 (ten) cubic centimeters of normal saline and measure length of external catheter line and record every shift. Additional orders dated 8/4/25 were initiated to flush Resident #174s central line with 5 (five) cubic centimeters of normal saline, administer ceftriaxone (antibiotic medication) 2 gram<br>(continued on next page) |

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| F 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | intravenously one time a day for endocarditis until 8/20/25, then flush with 5 cubic centimeters of normal saline and to change extension tubing, clave (needleless connector), endcap (antiseptic barrier), and dressing every week. Review of undated initial admission skin check revealed Resident #174's had a central Resident #174's located in their right upper chest.Review of a provider progress note dated 8/4/25 at 1:16 PM revealed Nurse Practitioner #1 documented that Infectious Disease was consulted while Resident #174 was in the hospital and the resident was ordered Rocephin (ceftriaxone-antibiotic) 2 gram intravenous daily. Review of the facility identified 24-Hour Report sheets dated 8/1/25 to 8/4/25 revealed there was no documented evidence that Resident #174 had a central venous catheter, received maintenance flushes to central venous catheter, and they received intravenous antibiotic medication.During an observation and interview on 8/5/25 at 9:00 AM, Resident #174 was sitting in their wheelchair shirtless. A central venous catheter was observed in their right upper chest with a dressing dated 8/4/25. Resident #174 stated their central venous catheter had not been flushed for two days after their arrival, and they did not receive their intravenous antibiotic until 8/4/25. Resident #174 stated they gave the facility staff a large packet of discharge paperwork when they arrived and was unsure why staff had not provided the intravenous (IV) antibiotic. Resident #174 stated they needed to finish the course of the intravenous antibiotic to clear up the infection before they could have a heart valve replacement. Resident #174 added their family had questioned why they had not received the intravenous antibiotic the first two days of admission and questioned a nursing supervisor. During an interview on 8/6/25 at 9:45 AM, Registered Nurse #2 Unit Manager stated when a new admission entered the facility, their medication list was reviewed by the Desk Nurse or Nursing Supervisor, the team leader/Licensed Practical Nurse completed the admission paperwork and skin check, the Nursing Supervisor reviewed the admission paperwork, and all documents were filed away for them (Unit Manager) to review the next day. Registered Nurse #2 Unit Manager reviewed Resident #174's active medications and stated Registered Nurse #3 activated the orders upon admission. At this time, Registered Nurse #5 Desk Nurse walked over and stated they put Resident #174's medications into the system based on the preliminary report sent to them which did not have ceftriaxone (antibiotic) listed as a discharge medication, but did not activate them because they left at 4:00 PM on 8/1/25 and Resident #174 had not admitted to the facility yet. Registered Nurse #2 Unit Manager stated Registered Nurse #3 Nursing Supervisor activated Resident #174's medications that were entered by Registered Nurse #5; Licensed Practical Nurse #2 completed the paperwork and skin check portion, but they were unsure who reviewed the official discharge summary from the hospital. They stated the discharge paperwork should have been reviewed by the overnight Nursing Supervisor. Additionally Registered Nurse #2 stated they reviewed the discharge paperwork on 8/5/25 when they returned to the facility and noted Resident #174 had a central venous catheter, so whoever reviewed the discharge paperwork should have questioned why they had a central venous catheter but did not have any orders to flush the line. Registered Nurse #2 stated the preliminary discharge summary did document that Resident #174 was to be on intravenous antibiotics until 8/18/25, so they also should have questioned why there was no order for intravenous antibiotics. During an interview on 8/6/25 at 11:30 AM, Registered Nurse #3 Nursing Supervisor stated on 8/1/25 they activated orders that were entered by Registered Nurse #5 prior to the resident arriving as they were just trying to help out before they left. Registered Nurse #3 Nursing Supervisor stated they did not personally look at the discharge summary, they assumed they were all good. They left at 6:30 PM and the overnight Supervisor was in charge of completing the admission. Registered Nurse #3 stated whoever reviewed the paperwork and discharge summary should have questioned why there were no orders for the central venous catheter care or intravenous antibiotics. During an interview on 8/6/25 at 11:52 AM, the Director of Nursing stated prior to a new admission coming to the facility they receive a preliminary report that the Desk Nurse reviewed. The Director of Nursing stated Resident #174's preliminary report did not have their central venous catheter and intravenous antibiotic medication listed. Registered Nurse #6 Nursing Supervisor worked on 8/3/25 and discovered the discrepancy<br>(continued on next page) |

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|---|---|---|---|
| | 335182 | A. Building<br>B. Wing | 08/08/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Greenfield Health & Rehab Center | 5949 Broadway<br>Lancaster, NY 14086 |

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| F 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | that triggered them to do a deep dive into Resident #174's hospital stay, and that was when it was discovered Resident #174 should have been on intravenous antibiotics and had a central venous catheter. The Director of Nursing stated they would have expected one of the Nursing Supervisors working on 8/1/25 overnight to have reviewed the whole packet the hospital provided including the final hospital discharge summary and realized the discrepancies sooner. The Director of Nursing stated maintenance flushes were missed and the line could have occluded. The Director of Nursing stated there were three (3) overnight Nursing Supervisors that worked on 8/1/25, but they were unsure who took part in what during the shift.During a telephone interview on 8/6/25 at 3:04 PM, Licensed Practical Nurse #2 stated they worked from 6:00 PM on 8/1/25 to 7:00 AM on 8/2/25 but did not review Resident #174's discharge summary, they were not in charge of admissions that night.A call was placed and message left on 8/6/25 at 2:28 PM for Registered Nurse #7 Nursing Supervisor with no return call. (Nursing Supervisor on 8/1/25 from 6:30 PM to 7:00 AM). During an interview on 8/6/25 at 3:04 PM, Licensed Practical Nurse #4 stated they completed the admission paperwork and skin check for Resident #174 and documented the resident had a right upper chest central venous catheter on the skin assessment form. Licensed Practical Nurse #4 stated they left at 6:30 PM on 8/1/25 and reported to the oncoming nurse, Registered Nurse #4, that Resident #174 had a central venous catheter, and Resident #174 had mentioned being on intravenous antibiotics. During a telephone interview on 8/6/24 at 3:44 PM, Registered Nurse #8 Nursing Supervisor stated they worked on 8/1/25 from 4:00 PM to 8:00 PM but had not participated in any of the new admissions on that day. Registered Nurse #8 stated they arrived to work on 8/4/25 at 4:00 PM and Resident #174's family member was questioning why the intravenous antibiotics had not been administered. Resident #174's intravenous antibiotic medication had just been delivered so they informed Resident #174s family member and bought the medication to the unit. Registered Nurse #8 stated it was the responsibility of the overnight Nursing Supervisor to review all new admission paperwork and hospital discharge summaries if the desk nurse was no longer available and make sure any discrepancies were corrected. During a telephone interview on 8/7/25 at 8:15 AM, Registered Nurse #4 stated they worked on 8/1/25 at 6:30 PM and received report from Licensed Practical Nurse #4 that the admission assessment was completed for Resident #174, and they had a central venous catheter in their right upper chest. Registered Nurse #4 stated they did not question at the time why orders never popped up for them to flush the central venous catheter and they should have. Typically, the computer would flag the nurse to flush central lines as they are flushed with normal saline every shift for maintenance. During an interview on 8/7/25 at 9:13 AM, Pharmacy Consultant stated they completed the medication reconciliation for Resident #174 on 8/3/25 based on the preliminary discharge summary uploaded into Resident #174's electronic medical record. Pharmacy Consultant stated Resident #174 was on an oral antibiotic for cellulitis but missed two days of their intravenous antibiotics and saline flushes. Pharmacy Consultant stated Resident #174's central line could have become occluded. During a telephone interview on 8/7/25 at 2:44 PM, Nurse Practitioner #1 stated they reviewed Resident #174's uploaded discharge summary and reviewed medications listed. They saw further down in discharge summary that intravenous antibiotic medications were to be continued and questioned why there were no orders for the medication. Nurse Practitioner #1 stated they would have expected whoever completed Resident #174's admission to review the final discharge summary report, question the discrepancies, and correct the issue. Nurse Practitioner #1 stated they were unaware Resident #174 did not have orders to flush their central line and had missed flushes for two and a half days. They stated they would have expected the nurse to question why there was a central venous catheter present but no orders for maintenance; the line could have occluded and would have needed to be replaced. During an interview on 8/8/25 at 9:31 AM, the Administrator stated the facilities admission process had changed last year to involve all new admissions having two admission packets to ensure everyone received a copy of the discharge paperwork that needed one. The Administrator stated they would have to change the process slightly to include final reports and<br>(continued on next page) |

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| F 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | make sure staff were not utilizing the preliminary reports provided prior to admission.During an interview on 8/8/25 at 11:38 AM, Licensed Practical Nurse #4 stated they were the Nursing Supervisor on 8/4/25 and they had initiated maintenance orders for Resident #174's central venous catheter because it needed to be flushed with normal saline every shift to avoid occlusion. 10 NYCRR 415.12 (k)(2) |

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| F 0847<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review conducted during a Standard survey completed on 08/08/2025, the facility did not ensure the Binding Arbitration Agreement explicitly granted the resident and their representative the right to rescind the agreement within 30 calendar days of signing the agreement for three (3) (Resident #104, #118 and #152) of three (3) resident reviewed for the arbitration task. Specifically, the facility's Binding Arbitration Agreement stated the resident/representatives had seven (7) calendar days to rescind the agreement. The findings are:Review of the facility's undated Arbitration Agreement documented, the parties understand and agree that upon execution, this Arbitration Agreement becomes part of the admission Agreement. Section eleven of the agreement documented the parties understand and agree that the resident may cancel the Arbitration Agreement within seven (7) days of its execution by written notice to the facility. 1. Resident #104 had diagnoses that included fracture of the hip, hypertension and depression. The Minimum Data Set, dated [DATE] documented Resident #104 was cognitively intact.Review of the Arbitration Agreement dated 10/03/2024 documented Resident #104 signed the agreement on 10/03/2024. The agreement stated the resident may cancel the Arbitration Agreement within seven (7) days. 2. Resident #118 had diagnoses that included hypertension, atrial fibrillation and depression. The Minimum Data Set, dated [DATE] documented Resident #118 was cognitively intact.Review of the Arbitration Agreement dated 06/26/2025 documented Resident #118 signed the agreement on 06/26/2025. The agreement stated the resident may cancel the Arbitration Agreement within seven (7) days. 3. Resident #152 had diagnoses that included heart failure, hypertension and atrial fibrillation. The Minimum Data Set, dated [DATE] documented Resident #152 was cognitively intact.Review of the Arbitration Agreement dated 05/21/2025 documented Resident #152's Power of Attorney signed the agreement on 05/21/2025. The agreement stated the resident may cancel the Arbitration Agreement within seven (7) days.During an interview on 08/08/2025 at 10:43 AM, the Director of Admissions stated they were responsible to explain the admission package including the Arbitration Agreement to the residents and/or their designated representatives upon their admission to the facility. They stated the residents and/or their representatives signed the Arbitration Agreement separately from other parts of admission package. The Director of Admissions stated they would explain the agreement, read the resident/representative the agreement and offer for the resident/representative a video to watch about Arbitration Agreements. The Director of Admissions stated they would explain to the resident/representative they had seven days to rescind the agreement if they chose to. The Director of Admissions stated they had worked at facility for a year and a half, and the [NAME] President of Business Development had trained them on Arbitration Agreements. The Director of Admissions stated they were unaware of the regulation that a resident should be granted 30-days to rescind their signed Arbitration Agreement. During an interview on 08/08/2025 at 10:39 AM, the Administrator stated Arbitration Agreements were handled by the Director of Admissions and the [NAME] President of Business Development. After review of the facilities Arbitration Agreement, the Administrator stated per the agreement a resident/representative had seven (7) days to rescind the agreement. They stated they were unaware of regulations regarding the length of time a resident had to rescind the agreement. The Administrator stated the facility's legal team along with the [NAME] President of Business Development were responsible for drafting the agreement. The Administrator further stated the facility did not have a policy for Arbitration Agreements and the Arbitration Agreement itself would be the policy. During a telephone interview on 08/08/2025 at 11:23 AM, the [NAME] President of Business Development stated they would support the admission Department as needed with Arbitration Agreements. They stated the facility's legal team developed the Arbitration Agreement as well as the facility's admission paperwork. They stated the facility was also provided education about<br>(continued on next page) |

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| F 0847<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Arbitration Agreements by the Coordinator of Education from the facility's legal team in August of 2024. The [NAME] President of Business Development stated, at the advice of the facility's legal team, the facility would use two different Arbitration Agreements. They stated that if a resident was a short-term rehabilitation resident they were provided the Arbitration Agreement where they would only be given seven days to rescind the letter and if the resident was admitted for long term care, they would be provided an agreement where they would have 30 days to rescind the agreement. The [NAME] President of Business Development stated they were not aware the federal regulation was all residents were required to be given 30 days to rescind the agreement and would have to look into the regulation.10 NYCRR 415.30 |