STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335210	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Park Rehabilitation and Nursing Center	160 Seneca St Wellsville, NY 14895

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34587 Based on observation, interview, and record review conducted during the Standard survey completed 4/26/24, the facility did not ensure that residents received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan for two (Resident #5 and #39) of two reviewed for skin conditions. Specifically, there was the lack of an assessment and treatment initiation for a newly developed and reported skin ulceration (#39) and the lack of follow up on the wound consultant recommendations (#5). The findings are: The policy and procedure titled Skin/Pressure Ulcer Prevention & Intervention Program revised 04/14 documented weekly skin evaluations will be done on every resident. When skin/pressure ulcers are identified a Registered Nurse will assess the wound, document in the medical record, start a new wound tracking sheets and notify the practitioner for treatment. Whenever a resident develops a new skin/pressure ulcer the resident will be placed on the 24-hour report for interdisciplinary awareness and follow up. 1. Resident #39 had diagnoses that included cellulitis (bacterial skin infection) of right lower limb, type 2 diabetes mellitus and cerebral infarction (occurs because of disrupted blood flow to the brain). The Minimum Data Set, dated dated dated [DATE], documented Resident #39 was cognitively intact, usually understood and understands. The Minimum Data Set also documented Resident #39 had no arterial or venous ulcers. The Care Plan Activity Report entered on 12/20/23, documented Resident #39 was at risk for impaired skin integrity as evidenced by mycotic nails (fungal infection); incontinence; rash and other nonspecific skin eruption (groin). Interventions dated 12/7/23 documented to monitor skin surfaces for changes every shift. The care plan did not include the resident had an ulcer to the top of their right foot. The Physician's Orders dated 12/1/2023 to 4/25/2024, documented to monitor Resident #39's skin, complete head to toe skin checks and to notify RN (registered nurse) of any skin impairment every week. Review of Resident Treatment Administration Record dated 3/1/24 through 3/31/24 and 4/1/24 through 4/23/24 revealed there were no treatment orders in place to Resident #39's right foot. (continued on next page)

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

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Medical Doctor Progress Note dated 4/4/24, Medical Doctor #2 documented a diagnosis of chronic peripheral venous insufficiency (decreased blood flow). The progress noted documented no rashes or skin ulcers. Review of Nursing Progress Notes revealed: -4/10/24, Registered Nurse #2 Unit Manager documented they were called to Resident #39's room due to an open area noted on top of Resident #39's right second toe. Nurse Practitioner #1 was notified and an order to cleanse the toe with soap and water, pat dry and apply band aid. -4/15/24, Licensed Practical Nurse #4 documented therapy reported that Resident #39's right leg was swollen. Registered Nurse (unidentified) was made aware. -4/24/24, Licensed Practical Nurse #3 documented an area measuring 3.5 centimeters by 2 centimeters was noted on top of Resident #39's right foot. Nurse Practitioner #1 was updated, and new orders were received. Review of Nursing-Weekly Skin Assessments dated 4/4/24 through 4/25/24 revealed Licensed Practical Nurse #3 documented that Resident #39's skin was intact. During an observation and interview on 4/23/24 at 10:48 AM, Resident #39's was observed sitting in a wheelchair wearing gray socks to both of their feet with no shoes. The top of Resident #39's right sock was wet with a dark ring noted in the fabric. Resident #39 stated they had an open area the size of a quarter on the top of their right foot. When asked if a treatment was being applied Resident #39 stated, No! During an observation and interview on 4/24/24 at 11:26 AM, Resident #39 was sitting in wheelchair in their room, and there was no sock on their right foot. There was a quarter size open pink ulcer with irregular edges on the lateral top right side of their foot. The ulcer was weeping serous (clear, watery) fluid and the floor under Resident #39's foot was wet. During an interview on 4/24/24 at 11:45 AM, Certified Nursing Assistant #2 stated Resident #39 had a sore on the top of their right foot that they noticed last Friday (4/19/24) and they had reported it to Licensed Practical Nurse #5 last week, and today before breakfast they reported it to Licensed Practical Nurse #3. During an interview and observation on 4/24/24 at 11:54 AM, Licensed Practical Nurse #4 stated they had observed an open ulcer on Resident #39's right foot last week. Licensed Practical Nurse #4 observed the ulcer and stated it was the same ulcer they had seen last week but now the ulcer was larger and draining clear fluid. Licensed Practical Nurse #4 stated they thought a treatment was initiated last week. Licensed Practical Nurse #4 reviewed Resident #39's Treatment Administration Record and stated there were no treatments ordered for Resident #39's right foot. During an interview on 4/24/24 at 12:03 PM, Licensed Practical Nurse #3 stated they were not aware of the ulcer to the top of Resident #39's right foot until today at 11:00 AM when Registered Nurse #1 informed them. They looked briefly looked at it and stated the ulcer was open and had drainage. Licensed Practical Nurse #3 stated they reported the ulcer to Registered Nurse #2 Unit Manager, who informed them that an accident/incident report had previously been completed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/24/24 at 12:20 PM, Registered Nurse #2 Unit Manager stated they were made aware of the open area to the toe on right foot at least a week ago and completed an incident report. Registered Nurse #2 Unit Manager stated they notified Nurse Practitioner #1 and was advised to leave area open to air. During a telephone interview on 4/26/24 at 9:38 AM, Licensed Practical Nurse #5 stated a Certified Nursing Assistant report to them on Friday, 4/17/24, that Resident #39 had a sore on their right foot and wasn't sure if it was there before. Licensed Practical Nurse #5 stated Resident #39 told them they had the open ulcer for a week. Licensed Practical Nurse #5 stated the ulcer was on the top of Resident #39's right foot, not near their toes and was about 1 centimeter by 1 centimeter with no drainage. Licensed Practical Nurse #5 stated they notified Registered Nurse #2 Unit Manager so they could find out what to do with it, as there was no treatment in place. Licensed Practical Nurse #5 stated they observed Registered Nurse #2 Unit Manager look at the ulcer before giving them instructions to place ointment and a band-aid over it. During a telephone interview on 4/26/24 at 10:00 AM, Nurse Practitioner #1 stated they did not recall if Registered Nurse #2 Unit Manager informed them of any new skin concerns. Nurse Practitioner #1 stated they would have documented the skin concern in a progress note if they were made aware of it. Nurse Practitioner #1 stated they would have expected to be notified of any new skin concerns. During an interview on 4/26/24 at 10:59 AM, Registered Nurse #1 stated Resident #39's skin concern was reported to them either Tuesday (4/23/24) or Wednesday (4/24/24) by a Certified Nursing Assistant. Registered Nurse #1 stated they looked at Resident #39's right foot and noted an open ulcer to the lateral top part of their foot and it was wet in appearance and they referred the Certified Nursing Assistant to have the Unit Manager or Charge Nurse look at it. During a follow up interview on 4/26/24 at 11:14 AM, Registered Nurse #2 Unit Manager stated when they were made aware of the open area on the top of Resident #39's right foot on 4/24/24, they were thinking of a different area. Registered Nurse #2 Unit Manager stated staff did report the open ulcer to the top of the foot to them. They should have started an incident report, assessed the ulcer, notified the medical provider, and had the Wound Consultant Medical Doctor #1 see Resident #39 so a treatment could be initiated. During an interview on 4/26/24 at 12:07 PM, the Director of Nursing stated they would have expected an incident report and an assessment to be completed immediately. The Director of Nursing stated a treatment should have been implemented immediately to protect the resident from contaminates and to prevent infection. 2. Resident #5 had diagnoses including unspecified open wound of the buttock, type 2 diabetes mellitus, and bipolar disorder. The Minimum Data Set (MDS-a resident assessment tool) dated 2/25/24 documented Resident #5 understood, understands and was cognitively intact. It was documented that Resident #5 was at risk for developing pressure ulcers. The Care Plan Activity Report initiated 1/21/24 documented Resident #5 had skin concerns which included a rash and other nonspecific skin eruption. Interventions included to monitor skin per the medical doctor's order. Interventions dated 1/31/24 included to observe skin surfaces and assess for changes every shift; wound team will assess wounds weekly with measurements and description of wounds, and administer treatment as ordered by medical doctor. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Wound Consultant Medical Doctor #1 recommendations documented the following: -4/4/24 erythema (redness) bilateral buttocks, apply Calmoseptine then cover with non-stick dressing. Plan of care discussed with facility staff. -4/9/24 apply Calmoseptine, needs less adhesive dressing please. Plan of care discussed with facility staff. - 4/16/24 apply topical Calmoseptine once daily. Plan of care discussed with facility staff. The physicians' orders with a start date of 4/9/24 documented to wash Resident #5's right buttock with warm water and soap. Pat dry. Apply Calmoseptine (moisture barrier/skin protectant) and cover with border gauze twice a day to unspecified open wound of the buttock. On 4/24/24, an order was documented by Licensed Practical Nurse #3 to wash Resident #5's buttocks with soap and water, pat dry. Apply Calmoseptine to area and cover with border gauze twice a day. Review of Resident Treatment Administration Record dated 4/9/24 through 4/24/24 revealed the treatment was completed as ordered not per the Wound Consultants recommendations. During an interview on 4/23/24 at 8:32 AM, Resident #5 stated they had a pressure ulcer on their rear end. Resident #5 stated they had one on each buttock, one was opened and the other was closed. During an observation on 4/24/24 from 4:00 PM to 4:12 PM, Registered Nurse Supervisor #1 reviewed the treatment orders on Resident #5 Treatment Administration Record and gathered supplies. Registered Nurse Supervisor #1 washed hands applied gloves and removed the dressings to bilateral medial (inner) buttocks. While the bordered adhesive gauze was being removed the adhesive from the gauze dressing denuded (removed surface layer) the resident's skin and causing two new abrasions (surface layer of skin broken) to the left and right buttocks. The abrasions were less than 1 centimeters red and moist. Registered Nurse Supervisor #1 did not obtain measurements of new abrasions at that time. During an interview on 4/24/24 at 4:32 PM, Registered Nurse Supervisor #1 reviewed the wound consultant recommendations in the electronic medical record and stated the recommendations do not indicate the use of adhesive gauze. During an interview on 4/24/24 at 4:43 PM, Registered Nurse #2 Unit Manager stated they received the wound consultants progress notes a couple days after wound rounds and they were responsible to review. Registered Nurse #2 Unit Manager stated they weren't aware of Resident #5's wound consultant recommendations and should have been. During an interview on 4/25/24 at 2:03 PM, Wound Consultant Medical Doctor #1 stated recommendations to change a treatment were completed during wound rounds. Wound Consultant Medical Doctor #1 stated that Resident #5 was bothered by the adhesive dressing, caused discomfort, and that was why an adhesive dressing wasn't recommended. 10NYCRR 415.12

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34587 Based on interview and record review conducted during a Complaint investigation (Complaint #NY00315852) completed during the Standard survey on 4/26/24, the facility did not ensure that each resident's drug regimen was free from unnecessary drugs. An unnecessary drug is any drug used without adequate monitoring; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued. Specifically, for one (Resident #130) of six residents reviewed there was a lack adequate monitoring of a PT-INR (Prothrombin Time/International Normalized Ratio- a blood test to measure how long it takes for blood to form a clot) for a resident on anticoagulant therapy (medication that causes thinning of the blood) resulting in adverse consequences. The finding is: Review of the facility policy and procedure titled Anticoagulant Therapy revised on 3/19, documented that Prothrombin Time/International Normalized Ratio results would be faxed into the nursing office, faxed into the electronic medical record under the result section, and placed on the Warfarin (an anticoagulant medication) Therapy Sheet in the medical doctor's book. The policy and procedure documented the nurse would immediately give the lab results to the provider or make a follow up call if no response or no order were received. The policy and procedure documented that when a new anticoagulant order was received the order would be entered as a medication order and lab order as International Normalized Ratio level. Review of the facility policy and procedure titled Laboratory Test Documentation revised on 3/18, documented that the nurse would review the order in the electronic medical record and add the lab test with date to the lab calendar and the Laboratory Test Results Log. The policy and procedure documented that once the lab results were received the nurse would communicate the results to the provider and sign that it had been completed, as well as writing a note on the lab result sheet and entering a progress note in the electronic medical record. Resident #130 had diagnoses that included gastrointestinal hemorrhage (bleeding), anemia, and presence of prosthetic heart valve. The Minimum Data Set (a resident assessment tool) dated 4/10/23 documented the resident was understood, understands, and was cognitively intact. The Minimum Data Set documented that Resident #130 took an anticoagulant medication for seven days during the seven day look back period. Review of the Comprehensive Care Plan dated 4/3/23, documented that Resident #130 had a risk for bleeding and other complications secondary to the use of anticoagulants. Interventions included the resident would be monitored for signs and symptoms of bleeding, such as tarry or black stools, drop in hemoglobin or hematocrit (blood level that indicates the amount of iron that will aid the blood cell in carrying oxygen) or bruising to skin with injury. Interventions also included that Resident #130 would be assessed for signs and symptoms of a deep venous thrombosis (blood clot). Review of the hospitalization Discharge Summary Notes dated 4/3/23 at 8:30 AM, documented that Resident #130 was to have Warfarin 5 milligrams daily and to titrate the dose by following the Prothrombin Time/International Normalized Ratio level. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Physician Orders dated 4/1/23 to 4/30/23, documented that Resident #130 had an order for Warfarin 5 milligram tablet once daily in the evening for the presence of a prosthetic heart valve. There was no change in Warfarin orders for Resident #130 from 4/3/23 to 4/30/23. The Physician Orders documented that Resident #130 was to have a Prothrombin Time /International Normalized Ratio laboratory drawn on 4/6/23. There were no further Prothrombin Time /International Normalized Ratio laboratory orders from 4/7/23 to 4/30/23. There was no therapeutic range included on the order. Review of a laboratory report dated 4/6/23 documented Resident #130's Prothrombin Time was 16.3 (normal 10.0-12.9) and International Normalized Ratio was 1.4 (therapeutic 2.0-3.0). Registered Nurse #3's initials and noted 4/7/23 were handwritten on the laboratory results. There was no further documented evidence that a Prothrombin Time/International Normalized Ratio was completed prior to Resident #130's hospitalization on [DATE]. Review of facility medical provider progress notes dated 4/9/23 at 3:35 PM, Physician Assistant #1 documented Resident #130 was on Warfarin 5 milligrams at bedtime and obtain a Prothrombin Time/International Normalized Ratio on Tuesday. On 4/15/23 at 10:38 PM, Medical Doctor #1 documented Resident #130 had valvular heart disease and to continue with Warfarin and check the International Normalized Ratio level. Review of Nursing Progress Notes dated 4/3/23 through 4/30/23 revealed: -On 4/30/23 at 1:05 AM, Licensed Practical Nurse #6 documented that Resident #130 had blood in their stool. -On 4/30/23 at 3:28 AM, Licensed Practical Nurse #6 further documented that Resident #130 had more blood in their brief and the provider was notified with new ordered to send Resident #130 to the hospital for evaluation. -On 4/30/23 at 10:37 AM, Licensed Practical Nurse #7 documented that Resident #130 was admitted to the hospital for a coagulation disorder. There was no documented evidence that a Prothrombin Time/International Normalized Ratio was completed, or a provider was notified of a Prothrombin Time/International Normalized Ratio level from 4/3/23-4/30/23. Review of the hospital History and Physical notes dated 4/30/23 at 1:18 PM, documented that Resident #130 presented to the emergency room with bright red blood in their rectum consistent with external hemorrhoids. Resident #130's International Normalized Ratio blood level was greater than 8.5 on 4/30/23 at 3:58 AM and active problems included: bright red bleeding per rectum-likely hemorrhoidal in the setting of coagulopathy (an impairment in the ability to form a clot in the blood), supratherapeutic (amount of a drug higher than usual to treat a disease effectively) International Normalized Ratio connected to Warfarin use without monitoring. During a telephone interview on 4/23/24 at 1:58 PM, Resident's #130 Health Care Proxy stated that the resident was sent to the hospital in April of 2023 due to bleeding. The Health Care Proxy stated that when Resident #130 arrived at the emergency room their International Normalized Ratio was at 8 and the emergency room doctor noted the facility was not monitoring Resident #130's International Normalized Ratio levels. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 4/24/24 3:24 PM, Physician Assistant #1 stated they were a medical provider for Resident #130 and recalled that Resident #130 was admitted to the hospital for a supra therapeutic International Normalized Ratio of about 8. Physician Assistant #1 stated that Resident #130 had a lack of monitoring their Prothrombin Time/International Normalized Ratio during their April 2023 facility admission prior to hospitalization due to a lapse in communication between themselves, the physician, and the facility nursing department. Physician Assistant #1 stated that the lack of Prothrombin Time/International Normalized Ratio monitoring was an accident or an oversight and they did not note that during their independent reviews of Resident #130's medical record that the Prothrombin Time/International Normalized Ratio blood level was not being monitored. They stated that the nursing department did not initiate the Laboratory Test Log to aide in the blood level monitoring and they would have expected the nurses who administered the Warfarin to check the log prior to administration of the medication to ensure the correct dose was given. Physician Assistant #1 stated Warfarin medication monitoring should have been done by having an International Normalized Ratio blood level completed at least weekly or every two weeks until the resident's blood level stabilized. Physician Assistant #1 stated that Prothrombin Time/International Normalized Ratio monitoring was important because not monitoring a resident's blood level could lead to harm, bleeding, or blood clotting, if the blood level was not within therapeutic range. During a telephone interview on 4/24/24 4:30 PM, Registered Nurse #3 stated they were the former Unit Manager at the facility. Registered Nurse #3 stated that when a resident was on Warfarin they would notify the provider, ensure that International Normalized Ratio laboratory test was being completed and dose changed if needed. Registered Nurse #3 stated a resident would have Prothrombin Time/International Normalized Ratio blood level drawn based upon the medical provider admission orders then weekly after that. Registered Nurse #3 stated they did not recall Resident #130, or if they ever notified a medical provider of the 4/6/23 Prothrombin Time/International Normalized Ratio lab result but remembered something being wrong with their International Normalized Ratio level. During an interview on 4/25/24 at 4:01 PM, Registered Nurse Supervisor #1 (former Director of Nursing) stated Resident #130 had a PT-INT (Prothrombin time/International Normalized Ratio) drawn on 4/6/23 and the laboratory results were noted with the initials of Registered Nurse #3. Registered Nurse Supervisor #1 stated they were unsure if Registered Nurse #3 addressed the laboratory results (4/6/23) with a provider because there were no medical provider initials on the results and there was no nurse progress note. Registered Nurse Supervisor #1 stated there were no further orders or results for Prothrombin Time/International Normalized Ratio laboratory tests for Resident #130 prior to their hospitalization on [DATE]. Registered Nurse Supervisor #1 stated that Resident #130's International Normalized Ratio therapeutic range should have been between 2-3. Registered Nurse Supervisor #1 stated they expected when nurses administered medication, they also looked at laboratory results that affect the medication. 10 NYCRR 415.12(l)(1)

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F 0836 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. 34587 Based on observation, interview, and record review during the Standard survey completed on 4/26/24, the facility did not operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes. Specifically, the facility was not in compliance with Section 915 of the 2020 Fire Code of New York State, which requires carbon monoxide detection in all rooms and sleeping areas with fuel-burning appliances, and on-going preventative maintenance of carbon monoxide detectors. This affected two (Unit A and Unit B) of two resident units. The findings are: According to the 2020 Fire Code of New York State, patient rooms in nursing homes are defined as sleeping units. In residential and commercial buildings that contain a fuel burning appliance, carbon monoxide detection shall be installed in all rooms, occupiable space, dwelling units, sleeping areas, and sleeping units that contain a fuel-burning appliance. Additionally, the 2020 Fire Code of New York State stated carbon monoxide detectors shall be maintained in good working order in accordance with Section 915 of this code, National Fire Protection Association (NFPA) 720 (Standard for the Installation of Carbon Monoxide Detection and Warning Equipment), and the manufacturer's instructions/recommendations. Review of the Carbon Monoxide Alarm User's Manual, of the battery operated carbon monoxide alarms that were installed in the building, documented, Regular Maintenance. This unit has been designed to be as maintenance free as possible, but there are a few simple things you must do to keep it in working properly. Test at least once a week. Clean the carbon monoxide alarm at least once a month: gently vacuum the outside of the carbon monoxide alarm using your household vacuum's soft brush attachment. A can of clean compressed air (sold at a computer or office supply store) may also be used. 1a. Observations on 4/22/24 between 9:53 AM and 2:53 PM revealed plug-in style battery operated carbon monoxide alarms were installed in the corridors on Unit A. 1b. Observations on 4/23/24 between 7:57 AM and 3:25 PM revealed plug-in style battery operated carbon monoxide alarms were installed in the corridors on Unit B and the corridor between Unit A and Unit B. During an interview on 4/24/24 at 8:09 AM the Maintenance Director stated, all carbon monoxide detectors in the building were battery operated, the detectors were tested on ce a month, and the facility had documentation for the testing of the carbon monoxide detectors. The Maintenance Director further stated the facility was not vacuuming the carbon monoxide detectors. During an interview on 4/25/24 at 9:08 AM the Maintenance Director stated only one brand of carbon monoxide detector was installed throughout the building and the facility had no documentation for the cleaning of the carbon monoxide detectors. (continued on next page)

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F 0836 Level of Harm - Potential for minimal harm Residents Affected - Many	Review Carbon Monoxide testing logs revealed the building's carbon monoxide alarms were tested monthly from 5/22/22 through 3/25/24. Further review of the logs revealed the logs contained no documentation that the carbon monoxide alarms had been vacuumed monthly from 5/22/22 through 3/25/24. 42 CFR 483.70(b) 10NYCRR: 415.29(a)(2), 711.2(a)(1) 2020 Fire Code of New York State, Section 915: 915.3.1, 915.6