STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335212	A. Building B. Wing	01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villages of Orleans Health and Rehab Center	14012 Route 31 Albion, NY 14411

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 43802 Based on interview and record review conducted during a Complaint investigation (#NY00357991) during a Standard survey completed on 1/31/25, the facility did not ensure that a resident has the right to refuse treatment for one (1) (Resident #69) of five (5) residents reviewed for immunizations. Specifically, Resident #69's Representative did not give consent for a COVID-19 vaccine, and the resident received it. The finding is: The policy and procedure titled COVID-19 Vaccination for Residents, with a revised date of 12/2024 documented to obtain a verbal and/or written consent and/or declination from recipient or qualified representative and note in the immunization tab of the medical record prior to administration of the COVID-19 vaccination. The policy documented the administering nurse would verify consent prior to administering the vaccine. The policy and procedure titled Resident [NAME] of Rights, with a revised date of 8/2023 documented those resident rights included the right to consent to or refused treatment. Resident #69 had diagnoses that included dementia, schizoaffective disorder and diabetes. The Minimum Data Set (a resident assessment tool) dated 11/14/24 documented Resident #69 had severe cognitive impairment, was sometimes understood and sometimes understands. The comprehensive care plan dated 3/1/24 documented Resident #69 had advance directives, documented the resident had a Power of Attorney and a Health Care Proxy. The undated Vaccine Consent Form documented that Resident #69's Representative verbally declined the COVID-19 vaccination. The Immunization Report dated 1/26/25 documented that Resident #69 was administered the COVID-19 vaccination on 9/13/24 by Registered Nurse #4. The New York State Immunization Information System website information provided by the facility documented that Resident #69 received the COVID-19 vaccination on 9/13/24. The progress notes documented the following: (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-10/21/24 at 12:09 PM, the Director of Nursing documented that Resident #69 was assessed due to the COVID-19 vaccine given on 9/13/24. -10/21/24 at 12:46 PM, the Assistant Director of Nursing documented that per Resident #69's representative, the resident was not to receive any further vaccinations. Review of the Physician Visit notes dated on: - 10/23/24 at 6:26 AM, the Medical Director documented that Resident #69 was seen for an acute visit due Resident #69 receiving the COVID-19 vaccination and family had directed the facility not to have it. During an interview on 1/30/25 at 3:01 PM, Licensed Practical Nurse Unit Manager #8 stated that Resident #69's representative did not want the resident to receive the COVID -19 booster, there was miscommunication and Resident #69 received the booster in September 2024. A telephone interview was attempted with the former Assistant Director of Nursing/Infection Preventionist on 1/30/25 at 4:28 PM. During a telephone interview on 1/30/25 at 4:39 PM, Resident #69's Representative stated they received a few telephone calls from the facility that vaccines were coming around. They stated they were unsure who called them but they had declined the COVID-19 booster for Resident #69. They stated they also told Licensed Practical Nurse Unit Manager #8. Resident #69's Representative stated they were notified by Resident #69's Power of Attorney that during a visit with the resident, the resident told the Power of Attorney they received two shots that day. Resident #69's Power of Attorney questioned the nursing staff, and they replied that Resident #69 received the influenza and COVID-19 vaccination. Resident #69's representative stated that they advocate for Resident #69, as the resident could not advocate for themselves and by Resident #69 receiving the COVID-19 booster, their wishes were not honored. During a telephone interview on 1/30/25 at 5:00 PM, Registered Nurse #4 stated they would receive a list from the Assistant Director of Nursing for every resident and the vaccination they were to receive. Registered Nurse #4 stated that Resident #69's name was on the list, and they gave them the COVID-19 booster and influenza vaccination. They stated the Assistant Director of Nursing did not provide them with the actual acceptance/declination forms to review. If the form indicated decline, then the resident should have not been given the vaccination. They stated they do not know what Resident #69 vaccination acceptance/declination form indicated because it was not in front of them. Registered Nurse #4 stated the error appeared to be a communication error and they did not receive any education after the situation. They stated that if a resident does not want a vaccination, they had the right to refuse. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/30/25 at 5:14 PM, the Assistant Director of Nursing stated that when they assumed the role of Assistant Director of Nursing the former Assistant Director of Nursing/ Infection Preventionist gave them a stack of vaccination consent/declination forms for the residents. They stated they created a spread sheet and mistakenly added Resident #69 to the list to administer the COVID-19 booster. The Assistant Director of Nursing stated that Registered Nurse #4 did not have the consent sheets with them upon administration of vaccinations but just the list which residents and which vaccination they were to give. They stated that Registered Nurse #4 gave Resident #69 the COVID-19 booster due to the error and they did not mean for a resident to get a medication they did not want. After review of the Vaccine Consent Form for Resident #69, they stated that the form was not dated but it should have been. The Assistant Director of Nursing stated the Resident #69 rights, choices and wishes were unintentionally not honored by receiving a the COVID-19 vaccination. During an interview on 1/31/25 at 11:30 AM, the Director of Nursing stated the Assistant Director of Nursing oversaw the resident immunization efforts and Registered Nurse #4 would administer them. They stated the Assistant Director of Nursing inappropriately transcribed that Resident #69 was to have the COVID-19 booster on a list they made for Registered Nurse #4 to administer vaccinations. They stated since Resident #69 received the COVID-19 booster when their representative had declined the booster, it went against the resident wishes. During a telephone interview on 1/31/25 at 12:30 PM, the Nurse Practitioner stated that Resident #69 could not make their own decisions, their family declined the COVID-19 booster and the resident should not have received it. During an interview on 1/31/25 at 1:57 PM, the Administrator stated if a resident or their resident representative had declined to have a vaccination then the resident should not get the vaccination if the documentation was in place. The Administrator stated that it goes against a resident's choice. 10 NYCRR 415.3(f)(1)(ii)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43802 Based on observation, interview, and record review conducted during a Recertification survey completed 1/31/25, the facility did not provide a safe, clean, comfortable and homelike environment; and did not maintain comfortable temperatures levels between 71 degrees Fahrenheit to 81 degrees Fahrenheit for three (Orchard View, [NAME] View South, and [NAME] View North) of five resident units. Specifically, air temperatures were not maintained above 71 degrees Fahrenheit in resident common areas (Orchard View) and a resident shower room ([NAME] View South). Additionally, the [NAME] View North nurse's station structure/area that was visible and used by to residents had broken hinged doors, chipped laminate countertops, scratched and chipped paint; recliner chairs and straight back chairs that were in disrepair; and a 2-person sofa that was visibly soiled. The findings are: The policy titled Environmental Comfort and Safety dated 8/2024 documented the facility was committed to providing a homelike environment that promotes the well-being and comfort for all residents. For temperature control the ambient temperatures in resident rooms, dining rooms and common areas would be maintained within the range of 71-81 degrees Fahrenheit. The policy titled Homelike Environment dated 8/2024 documented the facility aimed to create a setting that feels welcoming and comfortable, that enhanced the quality of life for residents. Common areas would be decorated with furnishing that reflect a homelike atmosphere. 1. During an observation and interview on the Orchard View Unit on 1/27/25 at 9:56 AM, Resident #17 stated it was not warm enough in the facility. They were wearing a zip up hoodie sweatshirt, t-shirt, and pajama pants. On 1/27/25 temperatures obtained on the Orchard View unit using the surveyor's stem type thermometer included: -at 10:30 AM, 68.9 degrees Fahrenheit in the center of the common area -at 10:44 AM, 69.1 degrees Fahrenheit in the hallway outside room [ROOM NUMBER] and #27. Resident #10 was seated in the hallway and stated it was a little nippy in here today. -at 10:50 AM, 68.4 degrees Fahrenheit in room [ROOM NUMBER] there was one resident in room at this time. On 1/27/25 at 10:32 AM, Licensed Practical Nurse #10 was observed wearing their winter jacket on the unit. They stated it was very cold in the facility. They stated they started their shift at 6:00 AM and it's been cold since they arrived. On 1/28/25 temperatures obtained on the Orchard View unit included: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-at 9:08 AM, 70.1 degrees Fahrenheit in the hallway outside rooms [ROOM NUMBERS]. A resident seated in that area stated it was cold. -at 9:11 AM, 69.6 degrees Fahrenheit in the center of the common area, Resident #110 stated it was cold. On 1/30/25 at 8:15 AM, the temperature in the Orchard View common area was 67.5 degrees Fahrenheit, there were four residents seated in this area. Resident #10 stated it was chilly. During an interview on 1/30/25 at 8:18 AM, Certified Nurse Aide #6 stated it was cold in the facility, they were wearing black winter scarf because their neck got cold. During an interview on 1/30/25 at 9:30 AM, Licensed Practical Nurse #11 stated it was always cold in the facility. They covered the residents with blankets, and they had just got the electric fireplaces, but they weren't helping. During an observation interview on 1/30/25 at 9:33 AM, Resident #84 was seated in a recliner chair in the common area. They stated it was cold in the facility, and even with their coat on it was cold. The resident was observed wearing a thick buttoned up plaid flannel shirt/jacket. There were 12 other residents seated in the common area. During an observation and interview on 1/30/25 at 9:50 AM, the Director of Maintenance #1 stated the temperatures should be between 71-81 degrees Fahrenheit per the regulation. At 9:52 AM, the Director of Maintenance #1 used the facility's infrared thermometer and aimed it at a spot on the wall between rooms [ROOM NUMBERS], it was 70.0 degrees Fahrenheit, then aimed it at the floor in the middle of the common area and it was 68.0 degrees Fahrenheit. They stated that resident rooms were easier to control than the common areas on the units because they had their own separate control. They stated the common area temperatures depended on if the unit doors were open or closed and that they went around and closed those doors every morning, but it was hard to keep them closed because staff and residents go in and out. If the doors were open, the temperatures would go down. During an interview on 1/31/25 at 10:07 AM, the Licensed Practical Nurse Unit Manager #2 stated they bundled up the residents when they got cold, there were a couple residents who were always cold. If they thought the unit was cold, they would call the Director of Maintenance #1 to let them know, they were not sure how the temperatures were controlled. During an interview on 1/31/25 at 11:41 AM, the Director of Nursing stated they were not sure what the air temperatures were supposed to be, if they noticed a resident was cold, they would call Director of Maintenance #1. They were not aware if there was anything wrong with the heat. They have noticed the villages dining room being cold recently and maintenance had addressed that, with different interventions with the windows. They make sure the shades were down, and windows were shut. During an interview on 1/31/25 at 2:56 PM, the Administrator stated some areas of the building get a little colder when its colder outside. They expected temperatures to be between 71 and 81 degrees Fahrenheit. 2. During an initial observation on [NAME] View South Resident Spa shower room on 1/27/25 at 10:43 AM, upon entering the shower room the air/and room temperature felt cold. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/27/25 at 11:11 AM, Resident #78 stated the [NAME] View South shower room has no heat, it was always cold in there. During an observation on 1/28/25 at 3:09 PM [NAME] View South shower room felt cold, and a cold draft was present. The surveyor's stem type thermometer was used to measure the air temperature of that area, and the temperature was 62.2 degrees Fahrenheit. During an observation on 1/29/25 at 9:42 AM, the [NAME] View South shower room felt cold. During an interview at the time of the observation Resident #78 approached the Surveyor and stated they hadn't taken a shower in a week and would like to, but it was too cold in the shower room. Resident #78 added the staff were aware of the shower room being too cold. During an interview on 1/29/25 at 9:46 AM, Certified Nurse Aide #11 stated Resident #78 had complained of the shower room being too cold. Certified Nurse Aide #11 stated residents sometimes refuse or decline their showers due to the cold temperature in the shower room. Certified Nurse Aide #11 stated maintenance was aware of the shower room being cold. Certified Nurse Aide #11 stated it was important that resident felt comfortable while taking a shower. During an interview and observation on 1/29/25 at 10:27 AM-10:36 AM, Licensed Practical Nurse Unit Manager #8, stated there tends to be complaints about the temperature of the shower room on [NAME] View South in the winter, when it's cold. Licensed Practical Nurse #8 stated they felt a cold draft upon opening the door to the shower room. They stated the shower room was not homelike, and felt cold. They stated the temperature of the shower room was not acceptable for residents to be showered in there at that time. Licensed Practical Nurse #8 stated maintenance had been notified and it was suggested to keep shower room door open to allow heat in. During an observation and interview on 1/29/25 at 10:41 AM, in the [NAME] View shower room the Director of Maintenance pointed the facility's infrared thermometer at outside wall of the shower stale, obtaining a temperature of 61 degrees Fahrenheit and 65 degrees Fahrenheit on an inside wall in the shower room. The Director of Maintenance stated the room probably needed to be resealed and they could not feel any source of heat coming into that room. The surveyor's stem type thermometer obtained an air temperature of 65.5 degrees Fahrenheit at that time. Additionally, they stated were notified a couple of days ago about the shower room temperature. During a follow up interview on 1/31/25 at 8:26 AM, the Director of Maintenance stated room temperatures should be between 71-81 degrees Fahrenheit, including the shower rooms. They stated it was state regulation to maintain these temperatures to provide a comfortable and homelike environment to the residents. During an interview on 1/31/25 at 2:56 PM, the Administrator stated some areas of the building get a little colder when its colder outside. They expected temperatures to be between 71 to 81 degrees Fahrenheit. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During intermittent observations from 1/27/25-1/30/25 between 8:25 AM and 3:10 PM, the [NAME] View North nurse's station was in the middle of a large common area were the unit hallways and the dining room branched from. The five walled station was highly visible from the hallways, dining room and entrance onto the unit. The outside walls of the station were observed to have a laminated covering that was broken away in random areas, including the corners, of the five walls with exposed particle board. The countertop and edges were observed to also have chipped/missing laminate in numerous areas. There was an observed wooden support that was crooked under the countertop. Two hinged doors were present to enter the five walled station. They were observed to have chipped laminate, and one door had an area of peeling black (duct) tape at the bottom. Two recliners were observed to be inside of the walled station. A gray recliner was observed in the area with the footrest ripped and stuffing exposed, along with a blue recliner that was ripped at the arm rest with stuffing exposed. The recliners were placed at the inner wall and the wall was observed to have chipped and scratched paint. During an observation on 1/27/25 at 9:54 AM, Resident #52 was observed sitting within the nursing station with their head on the countertop. During an observation on 1/27/25 at 3:46 PM, 1/29/25 at 1:23 PM, and 1/29/25 at 4:00 PM, Resident #8 was observed to be sitting in the blue leather recliner that was in disrepair within the nursing station walls. During an interview on 1/29/25 at 1:23 PM, Certified Nurse Aide #14 stated that the nurse's station and the recliner chairs were not visually presentable, not home like and could be more sanitary. Certified Nurse Aide #14 stated that the [NAME] View North unit was not kept up as the other units were. During an interview and observation on 1/30/25 at 8:33 AM, a two-person sofa was observed to have a small hole on the seat, food debris and two black stains prior to entrance of the television lounge. In the television lounge Resident #108 was observed to be sitting in a green straight back chair that was ripped on the arm rest with stuffing exposed. Resident #71 was observed to be sitting in a brown leather recliner that had scratches down the left side. At Resident #71's left side was noted to be a pink straight back chair was ripped on the seat with the cushion exposed. During the interview at the time of the observation, Resident #71 stated that the pink straight back chair needed some maintenance and if the seat didn't get fixed, someone was going to go through it. During an interview on 1/30/25 at 3:01 PM, Licensed Practical Nurse Unit Manager #8 stated the gray and blue recliners were taken to the dumpster on 1/29/25 because the Director of Social Work saw how awful they were. They stated that there was peeling and chipping laminate on the nurse's station that did not present as homelike. Licensed Practical Nurse #8 stated the nurse's station was visible to the residents and visitors and should have been cleaner because it looked dingy. During an interview on 1/30/25 at 3:05 PM, Certified Nurse Aide #16 stated the nursing station was clean but looked old and needed to be remodeled. They stated residents had the right to look at nice things. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/30/25 at 3:10 PM, Resident #52's spouse stated they did not like the looks of the [NAME] View North unit, it was not homelike, and it was dirty. They stated the unit did not have enough chairs for the visitors to sit in. During an interview on 1/31/25 at 8:29 AM, the Director of Social Work stated that the [NAME] View North nurse's station could be visualized by residents, visitors and staff. They stated that the nurse's station was part of the resident's home, that the station had scuff marks in paint, and it was not new looking. The Director of Social Work stated that they did order some new recliners for the unit because the old furniture was not homelike for residents and visitors to be sitting in chairs that had rips with stuffing coming out of them. During an interview and observation on 1/31/25 at 10:02 AM, the Director of Housekeeping and Laundry was brought to the [NAME] View North Unit. After visualization of the nurse's station, they stated it did not have a home like appearance. They stated the station had been there for [AGE] years and needed to be replaced. They visualized the love seat at the entrance to the television lounge and stated it was clean but had two black marker stains on it. The two ripped straight back chairs were no longer present in the television lounge. During an interview on 1/31/25 at 11:25 AM, the Director of Nursing stated the [NAME] View North nurse's station could be seen as soon as one enters closed doors of the unit. They stated they did not like the station, it did not have a homelike appearance, and the laminate doors and countertops were peeling. During an interview on 1/31/25 at 1:57 PM, the Administrator stated they felt the [NAME] View North Nursing Station structure was sound and they had not received any complaints about the appearance of the station. They stated a homelike environment was a constant process and they look at all areas of the facility. During an interview on 1/31/25 at 2:05 PM, the Director of Maintenance stated they would describe the [NAME] View North nurse's station as panels, saw dust and glue. They stated that it was structurally safe, felt it was home like, but it was difficult to replace broken Formica. 10 NYCRR 415.5(h)(2,4)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 43802 Based on observation, interview, and record review conducted during a Standard survey completed on 1/31/2025, the facility did not ensure residents were free from physical restraints imposed for purposes of discipline or convenience that were not required to treat the resident's medical symptoms, used for the least amount of time and document ongoing re-evaluation of the need for restraints for one (Resident #370) of three residents reviewed for physical restraints. Specifically, Resident #370 had no assessment/evaluation for the initiation of the use of a position change alarm. Additionally, there was no documented evidence to address the reason that warranted the use of the device. The finding is: The policy and procedure titled Personal Alarms dated 10/2023 documented to establish guidance for the appropriate use of personal alarms to ensure resident safety while maintaining dignity and autonomy. The procedure documented to conduct a comprehensive assessment of each resident to determine the need for the personal alarm based on their individual risk factors and needs. Document the rational for using the personal alarm and any alternative interventions considered. The State Operational Manual issued 11/2024 defines position change alarms as an alerting device intended to monitor a resident's movements and emits an audible signal when a resident moved in certain ways. Additionally, a position alarm may limit a resident's movement when the resident was afraid to move to avoid setting off the alarm. Resident #370 had diagnoses including depression, dementia and compression fractures of the spine. The Minimum Date set (resident assessment tool) dated 1/23/2025 documented they were severely cognitively impaired and was sometimes understood and sometimes understands. Resident #370 required extensive assist of one person for ambulation and transfers, a bed/chair alarm was used daily and wandering behaviors were documented during the assessment period. The comprehensive care plan with an initiation date of 1/18/2025 and a revision date of 1/30/2025 documented Resident #370 had an actual fall related to adjustment to a new environment, confusion and unsteady gait. The care plan documented a goal that included restraints used to prevent resident's falls will be minimized or eliminated. Interventions included the use of an electric chair alarm and staff were to ensure the device was in place and functioning every shift. The Kardex (a guide used by staff to provide care) dated 1/30/2025 documented under Safety, the resident uses an electric chair alarm ensure the device is in place and functioning every shift. Review of the Order Recap Report dated 1/18/2025 documented check function of chair alarm every shift for safety. Review of the interdisciplinary progress notes dated 1/13/2025-1/30/2025 revealed there was no documented evidence that Resident #370 was assessed for the use and rational for the personal chair alarm. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 1/27/2025 at 2:11 PM Resident #370 was observed in the common area in front of the television the resident leaned forward in the wheelchair on several occasions activating the personal alarm. The resident would sit back in the wheelchair each time the alarm activated. During an observation on 1/29/2025 at 9:12 AM Resident #370 was observed in the main dining room in their wheelchair with a personal alarm on the seat of the wheelchair and the alarm box hanging from the back of the wheelchair, no unsafe movements were observed. During an observation on 1/29/2025 at 12:04 PM Resident #370 was observed in the main dining room in their wheelchair with the personal alarm on the seat of the wheelchair and the alarm box hanging from the back of the wheelchair. During these observations Resident #370 did not exhibit any attempts to self-transfer from the wheelchair. During an interview on 1/31/25 at 12:30 PM, Certified Nurse Aide #2 stated Resident #370 used and alarm because they would get up and try to walk without their walker and they were very unsteady on their feet. Resident #370 had a fall at home but could not recall if the resident had a fall in the facility. Certified Nurse Aide #2 could not recall any other interventions in place to prevent falls besides keeping them in the common area when out of bed, and using the chair alarm. During an interview on 1/31/2025 at 12:41 PM, Licensed Practical Nurse #1 stated Resident #370 had only been at the facility for a couple weeks. Licensed Practical Nurse #1 stated the resident wore an alarm because they believed the facility was afraid, the resident could fall, and the resident would get up on their own. Licensed Practical Nurse #1 was unsure if the resident fell when in the facility, or if any other fall prevention interventions were in place. They were unsure if there should be an assessment completed. During an interview on 1/31/2025 at 12:46 PM, Assistant Director of Nursing #1 stated the supervisors were responsible to determine if an alarm was needed based on the resident's fall assessment. Assessments should be done on admission, quarterly and as needed. The Assistant Director of Nursing #1 also stated they did not believe chair alarms were restraints as they don't restrict the resident. During an interview on 1/31/2025 at 1:17 PM, Director of Nursing #1 stated Resident #370 had a personal alarm because they had history of falls. Less restrictive devices that could be used were placing the resident in the common area, activity programs and recliner chairs. Director of Nursing #1 was unsure if other interventions were tried or not prior to placing the personal alarm and it would depend on the cause of the fall. They check with the staff to see how the resident is doing with the alarm but does not document those conversations. Director of Nursing #1 also stated it would be a good idea to document and or complete an assessment for the use of alarms. 10 NYCRR 415.4(a)(2)(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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 43802 Based on interview and record review conducted during a Standard Survey completed 1/31/25, the facility did not ensure that all alleged violations including abuse were reported immediately, but not later than two hours after the allegation was made to the State Survey Agency for one (Resident #70) of seven residents reviewed. Specifically, the Director of Nursing was notified of an allegation of resident sexual abuse, and it was not reported to the New York State Department of Health as required. The finding is: The policy and procedure titled Abuse, Neglect, Mistreatment and Misappropriation of Resident Property last revised 10/19 documented the facility prohibits abuse. Abuse: Shall mean, inappropriate physical contact with a resident. Inappropriate physical contact includes but is not limited to sexual molestation. When to report: In response to allegations of abuse the facility must: Ensure that all alleged violations involving abuse are reported immediately, but not later than 2 hours after the allegation is made, if the events that caused the allegation involved abuse to officials in accordance with State law through established procedures. 1. Resident #70 had diagnoses that included congestive heart failure, type 2 diabetes mellitus, and unspecified schizophrenia (mental disorder). The Minimum Data Set (a resident assessment tool) dated 10/6/24 documented Resident #70 was cognitively intact was understood and understands, and did not display any behaviors. The comprehensive care plan initiated 12/5/2024 documented Resident #70 had a behavior problem related to confabulations and accusatory statements against staff. Interventions included: administer medications as ordered, anticipate and meet the resident's needs, assist to develop more appropriate methods of coping and interacting, encourage to express feelings appropriately, if reasonable discuss behaviors, explain/reinforce why behavior is inappropriate and/or unacceptable, use female caregivers as able and two staff approach. During an interview on 1/27/25 at 12:52 PM, Resident #70 stated they had been sexually abused while at the facility. They stated a black male lifted their shirt, took their hands and rubbed Resident #70's breasts up and down. Resident #70 stated they were stunned when this happened. They felt ashamed, embarrassed and didn't talk about it at first. Resident #70 stated once they said something about it in therapy, everyone knew about, and staff asked them about it. Physical Therapy Treatment Encounter Note dated 12/5/2024 electronically signed by Physical Therapy Assistant #1 documented they notified Director of Rehab and Social Worker that Resident #70 reported a male certified nurse aide (not recently) was inappropriately touching their breasts. They documented Resident #70 was reporting anxiety/fear over this issue and discussing this issue. Physical Therapy Assistant #1 documented that Resident #70 was incontinent of urine that morning and had asked Resident #70 why they hadn't asked the male aide to assist them. They documented that Resident #70 stated I don't want a man to help me. Immediately after that conversation with Resident #70, Resident #70 told Physical Therapy Assistant #1 about the incident. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of soft file provided by the Director of Nursing during standard survey completed 1/31/25 revealed there was no evidence the abuse allegation was reported to the New York State Department of Health. During an interview on 1/27/25 at 1:35 PM, the Director of Nursing stated when they talked to Resident #70 about the abuse allegation, there were no facts to support the allegation at that time and no further investigation was completed. During an interview on 1/31/25 at 8:31 AM, the Assistant Director of Nursing stated the Director of Nursing was responsible for reporting allegations of abuse to the Department of Health. The Assistant Director of Nursing stated they knew there were timeframes for reporting abuse to the Department of Health but wasn't aware of them and would have to speak to the Director of Nursing. During an interview on 1/31/25 at 9:34 AM, Licensed Practical Nurse #8 Unit Manager, stated all abuse allegations need to be reported to the Director of Nursing, and Administrator. They stated the police, medical provider, family may need to be notified and there was a two-hour time limit to report abuse to the Department of Health. During an interview on 1/31/25 at 11:25 AM, Licensed Practical Nurse #5, Supervisor, stated any abuse allegation made by a resident need to be reported to a supervisor, the Assistant Director of Nursing and/or the Director of Nursing. They stated the Director of Nursing was responsible to report allegations of abuse to the Department of Health, depending on the allegation within two hours or twenty-four hours. During an interview on 1/31/25 at 1:07 PM, the Director of Nursing stated Licensed Practical Nurse #8, Unit Manager notified them on 12/5/24 at unknown time of Resident #70's allegation of abuse. The Director of Nursing stated they did not report Resident #70's abuse allegation to the Department of Health. They felt that after speaking with Resident #70 they didn't have evidence to support their allegation. The Director of Nursing stated they notified the Administrator of the allegation the same day on 12/5/24. Additionally, the Director of Nursing stated, should have gone with my gut and reported. During an interview on 1/31/25 at 3:07 PM, the Administer stated they were made aware of Resident #70's allegation by Director of Nursing. The Administer stated typically any abuse, neglect, mistreatment was to be reported within two hours. 10 NYCRR 415.4(b)(2)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43802 Based on interview and record review conducted during a Complaint Investigation (#NY00338010) conducted during the Standard survey completed on 1/31/25, the facility did not ensure that all alleged allegations of abuse, neglect, or mistreatment were thoroughly investigated for two (Resident #70 and #320) of seven residents reviewed. Specifically, there was a lack of evidence thorough investigations were completed into an allegation of sexual abuse (#70) and a femur fracture of unknown origin (#320). The findings are: The policy and procedure titled Abuse, Neglect, Mistreatment and Misappropriation of Resident Property, with a revised date of 10/19, documented both state and federal regulations require the facility to investigate incidents and complaints generated from residents and/or visitors. Documentation is required with respect to accidents and incidents that must be recorded. The policy documented with respect to allegations of abuse, mistreatment, and neglect, facilities must document that the allegations are thoroughly investigated, including any incident that is not consistent with routine operation of the facility or routine care of the resident, such as bruise, or any injury of unknown origin. The supervisor who has been informed of the allegation was to complete the initial investigation report and forward a copy to the Administrator. That notification is in addition to immediate notification to the Director of Nursing. The policy and procedure titled Resident Accident-Incident Report, with a revised date of 4/17, documented to obtain employee statements that would be needed to investigate the accident/incident. For an investigation of injuries of unknown origin, the charge nurse on duty at time of accident/incident occurs, will initiate accident incident investigation form. The policy documented that beginning with the shift the accident/incident occurred, charge nurse will get statements from the caregivers on that shift. The nurse will go back two more shifts within the 24-hour period prior to the accident incident, date the investigation form and list caregivers for the other two shifts and pass investigation on to the next shift for the other caregiver's statements. 1. Resident #70 had diagnoses that included congestive heart failure, type 2 diabetes mellitus, and unspecified schizophrenia (mental disorder). The Minimum Data Set (a resident assessment tool) dated 10/6/24 documented Resident #70 was cognitively intact was understood and understands, and did not display any behaviors. The comprehensive care plan revised 10/11/2024 documented that Resident #70 used antidepressant medication related to depression and schizophrenia. Interventions initiated 10/1/2024 included to administer antidepressant as ordered, and monitor/document/report adverse reactions to antidepressant therapy. The care plan prior to the abuse allegation on 12/5/24 did not document the resident had behaviors director towards others or a history of making accusatory or false statements. Review of progress notes dated 10/31/24 through 12/12/2024 revealed there was no evidence that Resident #70 displayed behaviors or that an allegation of abuse was made, reported and or investigated. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Physical Therapy Treatment Encounter Note dated 12/5/2024, electronically signed by Physical Therapy Assistant #1 documented they notified the Director of Rehab and Social Worker that Resident #70 reported a male certified nurse aide (not recently) was inappropriately touching their breasts. They documented Resident #70 was reporting anxiety/fear over this issue and discussing this issue. Physical Therapy Assistant #1 documented that Resident #70 was incontinent of urine that morning and had asked Resident #70 why they hadn't asked the male aide to assist them. They documented that Resident #70 stated I don't want a man to help me. Immediately after that conversation with Resident #70, Resident #70 told Physical Therapy Assistant #1 about the incident. Review of soft investigation file provided by the Director of Nursing contained a Daily Census of 12/4/2024 of [NAME] South, total residents on unit 12 printed 12/5/24 at 12:31 PM. Handwritten notes present on Daily Census documented: assessed-no injuries (redness, discoloration, open areas), no complaints offered pain/discomfort, no signs/symptoms of fear, anxiety or stress, unable to give details on touching; Interviewed 12/5/24, no issues with any male staff member; Upset when told Monday they weren't ready to discharge due to safety. The file contained a copy of Resident #70's face sheet, brief interview for mental status evaluation, copy of updated care plan, a mini-mental state examination effective 10/1/24 with score of 27 out of 30 and an undated list of residents who require a two staff approach. The file did not contain interviews, and/or statements with staff and other residents. There was no investigation summary completed ruling out the abuse. During an interview on 1/27/25 at 12:52 PM, Resident #70 stated they had been sexually abused while at the facility. They stated they had only been at the facility for a short time when the abuse happened. They stated a black male lifted their shirt, took their hands and rubbed Resident #70's breasts up and down. Resident #70 stated it happened around bedtime, they couldn't remember their face, did not know the person's name and had not seen them since. Resident #70 stated they were stunned when this happened. They stated took happened at bedtime a short time after they were admitted to the facility, 12 weeks or more ago. They didn't talk about it at first and once they said something about it in therapy, everyone knew about, and staff followed up with them. During an interview on 1/29/25 at 11:06 AM, Certified Nurse Aide #11 stated approximately a month ago while taking care of Resident #70, Resident #70 stated to them they were assaulted by a guy on overnights. Certified Nurse Aide #11 stated that Resident #70 demonstrated with their hand a rubbing motion over their chest and down their side. Certified Nurse Aide #11 stated they reported the allegation immediately to Licensed Practical Nurse Unit Manager #8. Certified Nurse Aide #11 stated Licensed Practical Nurse Unit Manager #8 told them they were already aware of the allegation. Certified Nurse Aide #11 stated after reporting allegation, nothing further was discussed with them about the allegation. Additionally, Certified Nurse Aide #11 stated they would consider Resident #70's allegation, sexual abuse. During an interview on 1/31/25 at 8:40 AM, Social Work Director #1 stated they recall hearing about an abuse allegation made by Resident #70. They believed the Director of Nursing had mentioned it during morning meeting or in passing. Social Work Director #1 stated that Resident #70 demonstrated and stated to them that a male lifted their shirt and rubbed their chest. The Social Work Director #1 stated Resident #70 didn't display any emotions on how they felt about it, and they were not asked to write a statement about this. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/31/25 at 9:34 AM, Licensed Practical Nurse Unit Manager #8, stated they were not working the day Resident #70 made the sexual abuse allegation. Licensed Practical Nurse Unit Manager #8 stated they were notified by the Director of Nursing of Resident #70's allegation. They stated when they asked Resident #70 about the allegation, Resident #70 stated a man came into their room and touched their breasts in an inappropriate manner. They stated Resident #70 stated they never wanted that man to touch them again. Licensed Practical Nurse Unit Manager #8 stated they did not document on Resident #70's allegation because the Director of Nursing had stated they had started a soft file on the allegation. Licensed Practical Nurse Unit Manager #8 stated there were men that work in the facility and there were male residents that wander. During an interview on 1/31/25 at 12:09 PM, Physical Therapy Assistant #1 stated on 12/5/24 Resident #70 stated a male certified nurse aide, not recently, had touched their breasts inappropriately and that Resident #70 did not know the certified nurse aide name. Physical Therapy Assistant #1 stated Resident #70 stated they hadn't seen this aide in a while but reported being fearful and anxious over seeing them again. Physical Therapy Assistant #1 stated they notified the Director of Therapy, the Social Worker and the Director of Nursing of Resident #70's abuse allegation. The Physical Therapy Assistant #1 stated they did not remember if they were asked to write a statement. During an interview on 1/31/25 at 1:07 PM, Director of Nursing stated they were thought they were notified of Resident #70's abuse allegation on 12/5/24 by Licensed Practical Nurse Unit Manager #8. They stated they did not recall at what time they were notified. The Director of Nursing stated they completed a skin assessment on Resident #70 and assessed the other residents on the unit. The Director of Nursing stated that Resident #70 stated someone had touched their breasts. The Director of Nursing stated they did not feel it was sexual in nature. Resident #70 was upset over being told they weren't leaving the facility. The Director of Nursing stated they reviewed a whole week back of schedules and there were no male caregivers on Resident # 70's unit. The Director of Nursing stated they did not notify the medical provider or emergency contact, and can't give any excuse for that, I usually do. They stated Resident #70 did have capacity. The Director of Nursing stated they did not write down any verbal conversations or get statements from any staff and should have. Additionally, they stated they notified the Administrator the same day, 12/5/24 of the allegation. During a telephone interview on 1/31/25 at 2:29 PM, Medical Doctor #1 stated they expected to be notified of abuse allegations and did not recall being informed of Resident #70's sexual abuse allegation. They stated an investigation should be done to make sure the resident's needs, and safety were being maintained. During an interview on 1/31/25 at 3:07 PM, the Administrator stated the Director of Nursing made them aware of the abuse allegation made by Resident #70. They stated there was nothing collaborating Resident #70's allegation. The Administrator stated they would expect the Director of Nursing to start an investigation, obtain statements from residents, staff, assess the residents involved and document their findings, position on the abuse allegation. 2. Resident #320 had diagnoses that included a fracture of the left femur, dementia and atrial fibrillation (an irregular heart rate that causes poor blood flow). The Minimum Data Set, dated dated dated [DATE] documented Resident #320 had severe cognitive impairment, usually understands and was usually understood. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The comprehensive care plan dated 3/29/24, documented Resident #320 had self-performance deficit related to limited mobility. Interventions included that Resident #320 may require a two-person approach due to combativeness. The care plan documented that Resident #320 was high risk for falls related to confusion and vision/hearing problems. Interventions included to anticipate needs, place call light within reach, lock bilateral wheelchair breaks, offer toileting every two hours and fall mats on both sides of the bed. The Kardex (guide used by staff to provide care) dated 4/1/24, documented Resident #320 was dependent for wheelchair mobility; a maximal assist of one assist for toileting, bathing, dressing and hygiene; and a moderate assist of one for bed mobility and transfers. The Kardex documented that Resident #320 may require a two-person approach due to combativeness. Review of the facility's undated Investigation Summary signed by the Director of Nursing, documented on 4/4/24 they were notified by a supervisor that Resident #320 has sustained a femur fracture to their left leg and the resident was sent to the emergency department. The summary documented that on 4/2/24 that the Director of Nursing was called to assess an area of bruising to Resident #320's left upper thigh and then again on 4/3/24. It was documented that there was swelling noted to Resident #320's left leg from the hip to knee with complaints of pain. X-rays from the pelvis to the foot were then ordered. The investigation documented there were three licensed practical nurse witnesses and six certified nurse aide witnesses. Facility Employee Statement forms were included in the facility's investigation folder from all three licensed practical nurse and six certified nurse aides that were listed in the Investigation Summary. After review of all the Employee Statement forms the following inconsistency was noted: -Licensed Practical Nurse #14 statement dated 4/7/24 at 7:00 AM, documented on 4/1/24 Resident #320 was noted with a yellow bruise the size of a hand from the knee to thigh and was reported to the house supervisor. Review of the facility's Staffing Worksheet from 3/30/24-4/1/24 revealed there was no documented evidence all staff working on the unit were interviewed. There were two additional nurses and five additional certified nurse aides that worked from when the bruise was documented as originally noted on 4/1/24. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/31/25 at 10:56 AM, the Director of Nursing stated on 4/2/24 staff alerted them to an area of discoloration to Resident #320 left inner thigh. They stated they assessed Resident #320 and noted the resident had older yellow tinge discoloration, at that time there was no pain or change in range of motion to the residents left leg. The Director of Nursing stated on 4/3/24 the staff alerted them again to assess Resident #320. They stated Resident #320 had more bruising, swelling and pain to their left leg. Resident #320 was ordered an x-ray, was found to have a left femur fracture. The Director of Nursing stated they started the investigation and interviewed staff members that could have had contact with the resident 48 hours back from 4/4/24. The Director of Nursing stated they had no further Employee Statements to present and had completed some telephone interviews some staff. They stated they did not document the telephone interviews but should have. The Director of Nursing stated they did read the employee statements at the time of investigation. The Director of Nursing was given Licensed Practical Nurse #14 statement dated 4/7/24 at 7:00 AM to review. The Director of Nursing stated it probably would have been a good idea to interview all staff that could have had interactions with Resident #320 48 hours prior to 4/1/24 because that is when the bruise was first noted and therefore, they did not complete a thorough investigation. During an interview on 1/31/25 at 1:57 PM, the Administrator stated their expectation for an investigation when a resident was noted to have a fracture of unknown origin was for one (an investigation) to be conducted. They stated they would have expected all staff that could have taken care of the resident to be interviewed, and the investigator would typically go back 48 hours from when an injury was noted. The Administrator stated staff statements should be detailed and include the date time and if something unusual was noted. They stated they would expect telephone interview to be documented and saved by the investigator. 10NYCRR 415.4(b)(3)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43802 Based on observations, interviews, and record review conducted during a Complaint (Complaint #NY00349205, #NY00338010) investigation during the Standard survey completed on 1/31/25, the facility did not ensure that the resident environment remained as free from accident hazards as was possible and that each resident received adequate supervision and assistance devices to prevent accidents for six (Orchard View lounge area, Canal View lounge area, [NAME] View South lounge area, Main Lobby , Villages Dining Room, Garden View lounge area) of seven resident areas and three (Resident #s 11, 115 and 320) of five residents reviewed for accidents. Specifically, the facility did not identify as potential accident hazards electric fireplaces with hot surfaces that were in resident accessible areas (Villages Dining Room, Canal View lounge area, Garden View lounge area, Orchard View lounge area, [NAME] View South lounge area, and the main lobby). Additionally, a cognitively impaired resident with exit seeking behaviors eloped from the facility undetected (Resident #115); safety devices (bilateral foot pedals and calf protector/foot board) were not place as planned (Resident #11) and Resident #320 was transferred by a staff member and an untrained family member. The findings are: 1. Observation during the initial building tour on 1/27/25 from 9:30 AM until 11:30 AM revealed the facility had seven wall-mounted electric fireplaces. They were in the Villages Dining Room (two), Canal View lounge area, Garden View lounge area, Orchard Unit lounge area, [NAME] View South lounge area, and the main lobby. The six electric fireplaces located on resident units were Brand A and the one in the main lobby was Brand B. At the time of the initial building tour, all electric fireplaces were producing heat, except for the electric fireplace in the main lobby. During the initial building tour on 1/27/25 at 10:45 AM, the Director of Maintenance stated the electric fireplace in the main lobby was set to a thermostat, and it automatically produced heat when the temperature in the room dipped below the thermostat's setpoint. During observations and interviews of the electric fireplaces for (6) six resident areas revealed the following: Orchard View lounge: 1/30/25 at 10:25 AM revealed Resident #115 was sleeping in a wheelchair within inches of where heat emanated from the bottom the electric fireplace that was mounted on the wall. The electric fireplace was producing heat at this time, which came from the bottom center of the unit. The bottom of the unit was at Resident #115's shoulder level, had no shielding from the metal, and was very hot to the touch. At the time of the observation, Certified Occupational Therapy Assistant #1 stated to the Surveyor who was touching the electric fireplace, It's hot, it'll burn you. Certified Occupational Therapy Assistant #1 stated the electric fireplaces were installed throughout the facility about one month ago and they were usually producing heat. They stated they had periodically noticed that Resident #115 tended to wheel themselves up to the electric fireplace. Certified Occupational Therapy Assistant #1 stated the electric fireplaces were concerning because some residents had dementia and loss of sensation for hot surfaces. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/30/25 at 10:30 AM, Certified Nurse Aide #1, stated Resident #115 often wheeled themselves up to the fireplace. They stated they did not receive safety training from the facility when the electric fireplaces were installed. -1/30/25 at 12:07 PM, the electric fireplace in the Orchard View lounge was on and blowing warm air. A sticker on the front of the electric fireplace said, warning surface can get hot when the heater is on. The surface along the bottom center of the fireplace was hot to the touch, the surveyor had to pull their hand away after a few seconds. The temperature was measured of that area, and it ranged from 157.8 degrees Fahrenheit to 167.5 degrees Fahrenheit. During an interview on 1/30/25 at 12:13 PM, Licensed Practical Nurse #11 stated the electric fireplaces were always on and were told they were on the max setting. They never saw any residents touching it, but there were a couple residents who liked to sit by it for warmth. They were never told to keep the residents away from them. They were grateful they put the fireplaces in because it was cold in here. During an interview on 1/30/25 at 12:19 PM, Certified Nurse Aide #6 stated the electric fireplaces were always on. They stated they have touched it to see how much heat it put out, but didn't think it was hot enough to burn a person. They were never told to keep residents away from it. Canal View lounge: 1/20/2025 at 12:02 PM there was an electric fireplace mounted on the wall in the common area (lounge) under the TV. There were no residents near the electric fireplace at the time of the observation. The area at the bottom was producing heat, felt warm and measured 156 degrees Fahrenheit. During an interview on 1/30/25 at 12:17 PM, Certified Nurse Aide #3 stated a resident had asked them to turn up the heat and they were checking the fireplace to see how warm it was. Certified Nurse Aide #3 stated they felt heat at the bottom and was unsure how the electric fireplace worked. They stated they did not receive safety training from the facility when the electric fireplaces were installed. [NAME] View South lounge: 1/27/25 at 1:29 PM and 1/29/25 at 12:39 PM, the wall mounted electric fireplace was observed with warning label stating surface can get hot when heater was on. The electric fireplace was producing heat at this time, which came from the bottom center of the unit. At those times, the surveyor touched the metal area of the electric fireplace, emitting hot air with their fingers and immediately pulled back their hand as the surface was too hot to touch. On 1/30/25 at 12:03 PM, wall mounted electric fireplace was powered on and no heat was emitting from the unit at this time. Director of Maintenance stated this electric fireplace had a thermostat, and if the room was warm enough the electric fireplace would not run. Main Lobby: 1/30/25 at 12:04 PM, there was an electric fireplace was recessed into a wall. The electric fireplace had metal vents on top of a display of artificial blue fire flame lights and it was blowing out very hot air. The surveyor's digital thermometer was placed across the vents blowing out the hot air and it measured 230 degrees Fahrenheit. The vent grates were touched by the surveyor and immediately needed to be pulled away. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/30/25 at 12:09 PM, Certified Nurse Aide #10 stated they have not received any training or in-service on the use of the electric fireplaces and would contact maintenance if they had any concerns or questions. During an interview and observation on 1/30/25 at 12:15 PM, Certified Nurse Aide #10 stated they did not know how long the electric fireplace had been in the Main Lobby and did not know how it worked. At 12:19 PM Certified Nurse Aide #10 went into the lobby and placed their hand about three inches from where the air was blowing out. Certified Nurse Aide #10 stated the air was hot, and it was hot enough to burn someone especially if they touched it. During an interview on 1/30/25 at 12:16 PM, Licensed Practical Nurse #8, Unit Manager stated they have no responsibility with the functionality of the electric fireplaces on [NAME] View South and the Main Lobby. They stated they have seen the Director of Maintenance check them first thing in the morning during their rounds. Licensed Practical Nurse #8 stated they have never observed any residents on [NAME] View touching the electric fireplace and no concerns have been brought to their attention about the electric fireplaces being too hot. During an observation and interview on 1/30/25 at 12:26 PM-12:31 PM in the Main Lobby, the Administrator placed their hand on front of metal grate, of the electric fireplace emitting heat and stated they wouldn't want to keep their hand on it. They stated their natural response was to pull their hand away from the metal grate as it was too warm. The surveyor's thermometer was placed on the metal surface across the vent emitting hot air and it measured 240-245 degrees Fahrenheit. The temperature was verified by the Administrator. The Administrator stated anybody could touch the electric fireplace and they wouldn't recommend anyone holding their hand on the metal grate. The Administrator stated the Main Lobby was a highly unoccupied resident area. Villages Dining Room dining room: 1/30/25 at 12:05 PM, the wall mounted electric fireplace by the Servery revealed the bottom center metal grate surface temperature felt warm and ranged between 142 degrees Fahrenheit (F) to 163.3 degrees Fahrenheit. During an interview on 1/30/25 at 12:09 PM, Certified Nurse Aid #3 stated the Maintenance Director was responsible to turn on the electric fireplaces and adjust the temperatures. They stated they had not received any education on how far the residents needed to be kept away from the electric fireplaces. During an interview on 1/30/25 at 12:13 PM, Registered Nurse #2 the nursing staff did not have access to the electric fireplace remote. Registered Nurse #2 stated that they did receive verbal education by the Director of Nursing on the electric fireplaces to keep residents at a safe distance away but could not state specifically how far they had been instructed to keep the residents away from them. During an interview on 1/30/25 at 12:23 PM, Certified Nurse Aide #15 stated they were briefly educated on the electric fireplace and were told not to place residents too close to the electric fireplaces. They stated that the electric fireplace was hot underneath. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation with the Director of Maintenance in the Villages Dining Room on 1/30/25 at 12:00 PM the Director of Maintenance pointed the facility's infrared thermometer into the electric fireplace from the bottom center and it read 100 degrees Fahrenheit. The Surveyor's stem type thermometer was set on the metal surface on the bottom center and measured 142.6 degrees Fahrenheit. At this time, the Director of Maintenance placed their hand on the bottom center of the unit, kept it there for greater than five seconds. The Director of Maintenance stated they felt there were no safety risks related to the electric fireplaces, as they had not seen any resident touch the units in a way that could burn them. The Director of Maintenance stated the two electric fireplaces located in the Villages Dining Room were set to on and produced heat constantly. They stated the electric heaters in the resident units and main lobby were set to a thermostat, which was set to 82 degrees Fahrenheit. The Director of Maintenance stated when the electric fireplaces were first installed in December 2024, they performed daily checks on them. The checks were now performed monthly. They stated their checks were performed by pointing the facility's infrared thermometer upward into the unit through the bottom center, where the heat came from. Additionally, on 1/31/25 at 10:10 AM, the Director of Maintenance stated the building's electric and hydronic heating systems were fully functional. It was their idea to purchase and install the electric fireplaces, and they did it for resident enjoyment. The most recent log titled Wall Heaters, dated 1/23/25, documented the seven electric fireplaces were operational and their temperatures ranged from 150 to 165 degrees Fahrenheit. During an interview on 1/31/25 at 2:39 PM, the Administrator stated the electric fireplaces had a safety UL (Underwriter's Laboratory) rating. They stated they knew there was a maximum temperature according to regulations, but were unable to specify the maximum temperature, and stated they liked the electric fireplaces because they were homelike. Garden View: 1/30/25 at 12:06 PM the electric fireplace was mounted on the wall approximately 3 feet from the floor. The electric fireplace was very hot to the touch on the bottom, and the surface temperature the metal vent and measured 175.8 degrees Fahrenheit. During an interview on 1/30/25 at 12:08 PM, Licensed Practical Nurse #6 stated they had observed residents approach the fireplace to warm themselves, but no one had attempted to touch it. Licensed Practical Nurse #6 stated the fireplace had a hot surface and could potentially burn someone if they touched it. During an interview on 1/30/25 at 12:10 PM, Certified Nurse Aide #12 stated the electric fireplace felt very hot to them and some of these residents don't know they shouldn't touch it. The policy and procedure titled Electric Heaters, issued 12/2024, documented only electric heaters that meet fire safety standards and are UL (Underwriter's Laboratory) listed or have equivalent safety certification can be used. Electric heaters should be used under supervision, especially in areas accessible to residents, to prevent accidents or misuse. Regular inspections and maintenance of electric heaters will ensure they are in good working condition and do not pose any safety hazards. Compliance with local and state regulations regarding the use of electric heaters will be ensured, including any restrictions or guidelines specific to healthcare settings. The Maintenance Supervisor is responsible for ensuring compliance with all safety standards. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The user manual for Brand A electric fireplace documented this heater is hot when in use, to avoid burns, do not let bare skin touch hot surfaces. Keep combustible materials such as furniture, pillows, and clothes at least three feet from front, sides, and rear of the heater. Extreme caution is necessary when any heater is used by or near children or invalids, and whenever the heater is left operating and unattended. The user manual also documented to turn the heater fan on, press the heat button. Press and hold the heat button for five seconds to cycle through heat settings, which ranged from 62 to 82 degrees Fahrenheit. The user manual for Brand B electric fireplace documented always keep clothing, papers, and other combustibles at least three feet away from the front of this heater, and away from the bottom, sides, and rear of this heater. This heater is for residential use only, not for commercial use. Never leave this heater unattended. This heater is hot when in use. Avoid injury, do not touch hot surfaces or attempt to move this heater while it is hot. The user manual also documented the flame effect must be on for the heater to function, press the heat button once for low heat (750 [NAME]) and press heat button again for high heat (1500 [NAME]). Temperature can be set from 62 to 82 degrees Fahrenheit. 2. Resident #115 had diagnoses including nontraumatic intracerebral hemorrhage (brain-bleed), legal blindness, and heart failure. The Minimum Data Set (resident assessment tool) dated 7/15/24, documented Resident #115 was severely cognitively impaired, was understood and usually understands. There was no wandering behaviors documented. Review of Census data revealed Resident #115 was moved from another unit of the facility to their current room on the Orchard unit on 7/18/24. The comprehensive care plan initiated 5/3/24 documented Resident #115 had limited physical mobility related to weakness with a revision on 7/10/24 to allow for ambulation with a rolling walker with 1 assist by a Certified Nurse Aide for distance as tolerated. Locomotion, initiated 5/3/24 and revised 5/7/24, was to be with a standard wheelchair. Resident #115's comprehensive care plan initiated 5/23/24 documented they had impaired cognitive functioning or impaired thought process and the interventions to be addressed by Certified Nurse Aides were that they needed to be cued, reoriented and supervised as needed. Wandering Risk Assessments completed for Resident #115 documented for 7/15/24 that Resident #115 ambulated with 1 Assist and the assessment did not have a way to reflect that Resident #115 was capable of self-propelling in their manual wheelchair. The 7/15/24 assessment did not indicate a history of wandering and scored as a low risk for wandering. A progress note dated 7/15/24 documented that Resident #115 was encountered twice self-propelling through the double doors and down the hallway away from the villages asking staff am I going the right way?. Resident redirected both times back to unit. Nursing made aware. A progress note dated 7/22/24 documented Resident #115 was encountered going through the double doors with another resident stating they were going outdoors. Both residents were educated that they needed a staff member with them to be outside and were re-directed to their unit. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A progress note dated 7/23/24 completed by Licensed Practical Nurse #3 documented that Resident #115 was missing at 7:20 PM and a search was started on the unit, then notified the supervisor and alerted all staff of the missing resident. A progress note dated 7/23/24 documented that Licensed Practical Nurse #12 found Resident #115 in the facility parking lot sitting in their wheelchair and brought Resident #115 back into the building and to their unit at 7:45 PM. Resident #115 was assessed by a Registered Nurse, was calm and cooperative with no distress or injuries noted. A progress note dated 7/23/24 documented that a wander alert device was applied to Resident #115's left ankle. Review of further Wandering Risk Assessments revealed the next assessment was completed on 7/24/24, the day following the elopement. The 7/24/24 assessment noted a room change as a recent experience. That room change took place on 7/18/24, prior to the elopement. The 7/24/24 assessment again noted Resident #115 as ambulating with 1 assist and did not reflect that Resident #115 was capable of self-propelling in their manual wheelchair independently. Resident #115 scored as moderate risk for wandering. During multiple observations on 1/30/25, Resident #115 was observed self-propelling in their wheelchair independently by using their feet to propel the manual wheelchair around the unit and their safety alert device was in place. During an interview on 1/31/25 at 10:59 AM, Licensed Practical Nurse/Unit Manager #2 stated Resident #115's Wandering Risk Assessment was updated after the two encounters in the hallway on 7/15/24 and should have been updated again on 7/22/24. After the 7/22/24 documented encounter, Resident #115's case should have been discussed by the Interdisciplinary team and supervision should have been increased. During an interview on 1/31/25 at 10:34 AM, Occupational Therapist #1 stated they were the staff person who encountered Resident #115 on 7/22/24 in the hallway going through the double doors from the villages side of the building with another resident and they stated they did report this encounter to nursing staff, at the time of redirecting the two residents to their unit. They did not recall who specifically they reported to. During an interview on 1/30/25 at 10:32 AM, Certified Nurse Aide #6 stated they were one of two staff who were on break in their cars in the parking lot and observed Resident #115 self-propelling in their wheelchair around the end of A-wing and into the parking lot on 7/23/24 at about 7:40 PM. They stated Resident #115 told them they had gotten out through the courtyard glass door and then through the fence gate. Certified Nurse Aide #6 stated they believed that the fence gate was not locked, and that gate usually was locked. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/30/25 at 10:53 AM, Licensed Practical Nurse #3 stated they noticed that Resident #115 was missing from the unit on 7/23/24 at about 7:20 PM. They reported this to the Registered Nurse Supervisor on shift and a search of the facility commenced. Licensed Practical Nurse #3 stated they were going down the main hall from the main lobby area toward the front door of the facility, when Licensed Practical Nurse #12 was bringing Resident #115 through the front doors. Licensed Practical Nurse #3 stated Resident #115 was very tickled by their experience and stated they had exited through the door and then the fence to get to the parking lot. They stated Resident #115 told them they were told if the door was unlocked, they could go outside. Licensed Practical Nurse #3 stated they believed Resident #115 had just recently moved to the Orchard unit from the Garden unit, at the time of the elopement. They also stated they were not aware of any other times Resident #115 had attempted to leave the unit and that Resident #115 was not wearing a wander alert device at the time. During an interview on 1/30/25 at 9:12 AM, Director of Nursing #1 stated they investigated this elopement and concluded Resident #115 used the glass door in the main lobby area to exit to the garden and from there the fence gate. They stated the glass door was usually unlocked until about 8 PM daily. They stated the fence gate was unlocked because the grass had been mowed and the pad lock had not been re-locked. They stated Licensed Practical Nurse #12 had noticed Resident #115 in the parking lot and observed them self-propelling around the corner of A-wing, the service wing of the facility. During an interview on 1/31/25 at 12:02 PM, the Administrator stated that supervision levels for Resident #115 should have been increased on 7/15/24 after the resident was encountered self-propelling through the double doors to the hallway from the villages section of the facility. After reading the progress note for 7/22/25 regarding Resident #115 being encountered with another resident exiting the villages through the double doors, the Administrator stated a wander alert device should have been placed at that time for Resident #115's safety. The Administrator stated the other resident was one who was allowed to use the garden area independently. The policy and procedure titled Elopement/Missing Resident revised 7/2024 documented the facility would provide a safe and secure environment for all residents and any resident identified as a risk for elopement will be reassessed monthly, upon admission/readmission, 7 days from admission/readmission, change in level of care, and/or environment. The Wander Risk Assessment will be completed to determine the resident's risk for elopement. Exit seeking behavior may include but was not limited to opening doors to the outside, making statements referencing leaving the facility, seeking to find someone/something outside of the facility. The policy and procedure titled Wanderguard Alarm Procedure revised 4/2017 documented that to ensure the safety of wandering residents at risk of elopement, the facility had a Wanderguard System installed on all exiting doors to the outside. 3. Resident #11 had diagnoses of dementia, cerebral infarction (a type of stroke), and aphasia (absence or difficulty with speech). The Minimum Data Set, dated dated dated [DATE] documented Resident #11 was rarely understood, rarely understands and had severe cognitive impairment. The Minimum Data Set documented that Resident #11 required partial/moderate (helper does less than half the effort) assistance with transfers and ambulation and was dependent (helper does all of the effort) with wheelchair mobility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The comprehensive care plan with last revised on 1/16/25 documented Resident #11 had limited physical mobility related to weakness, utilized a manual wheelchair and required bilateral elevating footrests and a calf protector/footboard was to be in place. Review of the Kardex (a guide used by staff to provide care) dated 1/31/25 documented Resident #11 had a manual wheelchair with bilateral elevating footrests and calf protector/footboard. The Physical Therapy Treatment Encounter Notes from 7/18/24 through 7/23/24 documented Resident #11 had difficulty keeping their bilateral feet on elevating footrests which would increase the risk for skin integrity issues. The note also documented that when Resident #11 did not have footrests on their wheelchair their feet would not rest fully on the floor and would be at risk for bumping their feet into the wheelchair caster wheels. Nursing recommendations had been updated to include a calf protector/footboard when Resident #11 was to be in the wheelchair. Education had been provided to a certified nurse aide (unidentified) regarding the need to have bilateral elevating footrests and calf protector/ footboard in place. Observations made on 1/27/25 at 12:22 PM and 1/30/25 at 8:40 AM revealed that Resident #11 was sitting in their wheelchair and did not have bilateral foot pedals and calf protector/foot board in place as care planned. Observations made on 1/28/25 at 8:57 AM, Resident #11 was sitting in their wheelchair and did not have the calf protector/footboard in place as care planned. The resident's right foot was off the foot pedal and in between the foot pedals touching the floor. Continued observations on 1/29/25 at 10:58 AM, and 1/29/25 at 4:29 PM revealed that Resident #11 was sitting in their wheelchair and did not have the calf protector/footboard in place as care planned. Observation on 1/30/25 at 9:45 AM, Resident #11 was observed to be sitting in their wheelchair by the nurse's station and did not have bilateral foot pedals and calf protector/footboard in place. Certified Nurse Aide #14 reposition Resident #11 in wheelchair and transport Resident #11 to dining room (approximately 50 feet) with no foot pedals in place and was sliding forward in wheelchair. Resident #11 held their feet up extended outward approximately an inch off the floor during transport. During an interview on 1/30/25 at 9:52 AM, Certified Nurse Aide #14 stated that Resident #11 would frequently slide down in their wheelchair and that was why they had just repositioned them. Certified Nurse Aide #14 stated that Resident #11 did not have foot pedals or a calf board on and was unsure if they should have them in place. They stated Resident #11 was not on their assignment. During an interview on 1/30/25 at 10:00 AM, Certified Nurse Aide #20 stated they were assigned to Resident #11 and had provided care to them. Certified Nurse Aide #20 stated they had not checked Resident #11's care plan prior to providing care and did not see foot pedals or a calf protector/foot board in the resident's room. Certified Nurse Aide #20 stated they had not previously seen Resident #11 utilize foot pedals. Certified Nurse Aide #20 reviewed the transfer and ambulation section of Resident #11's care plan on the computer and stated they had not seen that Resident #11 was to have foot pedals or a calf protector/ footboard. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/30/25 at 10:26 AM, Licensed Practical Nurse #3 stated the residents care needs and safety devices would be documented on the care plan and Kardex (a guide used by staff to provide care). Both the nurses and certified nurse aides were responsible to ensure the care plan was followed. Licensed Practical Nurse #3 was observed to pull up Resident #11's Kardex on the computer and stated that Resident #11 was care planned to have bilateral foot pedals on their wheelchair and a calf protector/footboard was to be in place. They stated they were unaware that Resident #11 did not have both the foot pedals and calf protector/footboard on as care planned and it was important to prevent injury. During an interview on 1/30/25 at 10:39 AM, Licensed Practical Nurse Unit Manager #8 stated the cart nurses were responsible to make sure the certified nurse aides followed the care plan and all positioning devices were in place. The Licensed Practical Nurse Unit Manager #8 stated Resident #11 was to have bilateral foot pedals on due to edema. Resident #11 did not self-propel themselves and did not have the strength to hold up their legs while being transported and could be injured without the foot pedals. Licensed Practical Nurse Unit Manager #8 stated they were unaware that Resident #11 was care planned to have a calf protector/footboard. During an interview on 1/30/25 at 2:39 PM, the Director of Rehabilitation stated Resident #11's calf protector and footboard was added to their care plan in July 2024. They stated Resident #11 was having difficulty keeping their feet on their foot pedals and their feet were not touching the floor without the pedals. The Director of Rehabilitation stated the calf protector, and footboard was issued to prevent foot or leg injuries. They would expect nursing staff to follow the recommendations made for Resident #11 and that Resident #11 would be at risk for injury without having foot pedals or the calf protector/ footboard in place. During an interview on 1/31/25 at 12:40 PM, the Director of Nursing stated they expected the certified nurse aides to read the Kardex prior to providing resident care and ensure all safety devices including foot pedals and calf boards were in place as this would be important to prevent falls and injuries. 4. Resident #320 had diagnoses that included a fracture of the left femur, dementia and atrial fibrillation (an irregular heart rate that causes poor blood flow). The Minimum Data Set (a resident assessment tool) dated 3/7/24 documented Resident #320 had severe cognitive impairment, usually understands and was usually understood. The comprehensive care plan dated 3/29/24, documented Resident #320 had self-performance deficit related to limited mobility. Interventions included that Resident #320 may require a two-person approach due to combativeness. The care plan did not indicate that family could assist with transfers. The Kardex (guide used by staff to provide care) dated 4/1/24, documented that Resident #320 was dependent for wheelchair mobility; a maximal assist of one assist for toileting, bathing, dressing and hygiene; and a moderate assist of one for bed mobility and transfers. The Kardex documented that Resident #320 may require a two-person approach due to combativeness. The Kardex did not indicate that family could assist with transfers. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's undated Investigation Summary signed by the Director of Nursing, documented on 4/4/24 they were notified by a supervisor that Resident #320 has sustained a femur fracture to their left leg and the resident was sent to the emergency department. The summary documented that on 4/2/24 that the Director of Nursing was called to assess an area of bruising to Resident #320's left upper thigh and then again on 4/3/24. It was documented that on 4/3/24 there was swelling noted to Resident #320's left leg from the hip to knee with complaints of pain. X-rays from the pelvis to the foot were then ordered. Certified Nurse Aide #14 statement within the facilities investigation dated 4/5/24 at 8:30 AM, documented that Resident #320's family requested for the resident to be toileted, and the family member assisted with the transfer. Certified Nurse Aide #14 documented Resident #320 complained of pain but could not located it. They documented they left the resident in bed with their family member. Review of the Progress notes dated 4/5/24 at 12:14 PM, the Director of Nursing documented that they spoke with Resident #320's family member and asked them if they had a history of transferring the resident. The Director of Nursing documented the family replied yes, and they had not been trained/cleared by therapy for activities of daily living care. They documented that staff had told the family numerous occasions that they were to ask for help from the staff and the family member replied they sometimes did not want to wait. During an interview on 1/29/25 at 1:26 PM, Certified Nurse Aide #14 stated that Resident #320 was a maximal assist of two for transfers. They stated the resident was easy to transfer but at times would not let go of the handrail in the bathroom. They stated they did transfer Resident #320 with the assist of their family member to the toilet, off the toilet and then into bed. Certified Nurse Aide #14 stated during the transfer on to the toilet Resident #320 complained of pain to their hip. They stated the transfer went well and that the family was comfortab [TRUNCATED]

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F 0730 Level of Harm - Potential for minimal harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 43802 Based on record review and interview conducted during the Standard survey completed on 1/31/25, the facility did not ensure Certified Nurse Aide performance reviews were completed once every 12 months per year for three (Certified Nurse Aides #7, #8, #9) of five reviewed. Specifically, there was no evidence Certified Nurse Aide #7, #8, and #9 who had worked for the facility more than 12 months had performance reviews completed at least once every 12 months. Additionally, the facility did not have a process/system in place to conduct annual performance evaluations for certified nurse aides. The finding is: Review of Certified Nurse Aide #7 employee file revealed they were hired on 11/24/17 and there was no evidence that an annual performance review had been completed. Review of Certified Nurse Aide #8 employee file revealed they were hired on 7/19/23 and there was no evidence that an annual performance review had been completed. Review of Certified Nurse Aide #9 employee file revealed they were hired on 11/6/20 and there was no evidence that an annual performance review had been completed. During an interview on 1/31/25 at 12:26 PM, the Director of Nursing stated the facility did not conduct any annual performance reviews for Certified Nurse Aides and that there was no process in place to track when performance reviews needed to be completed. They stated a new union contract was being negotiated and would try to have annual reviews added to the contract. The Director of Nursing stated it was a priority to establish a process to conduct annual performance and competency reviews for the Certified Nurse Aides, they stated it was important to ensure residents were receiving the best care. During a telephone interview on 1/31/25 at 2:00 PM, Certified Nurse Aide #8 stated they had worked at the facility full time for almost 2.5 years. They stated they never had a performance review or evaluation completed. During an interview on 1/31/25 at 2:05 PM, the Administrator stated there was no current process in place for annual performance reviews and that historically performance evaluations had not been completed by the facility. The Administrator stated it would be important to evaluate certified nurse aides to ensure they were competent with skills. The facility was unable to provide a policy and procedure for employee annual performance evaluations. 10NYCRR 415.26 (d)(7)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. 43802 Based on observation and interviews conducted during the Standard survey completed on 1/31/25, the facility did not ensure the nursing staff information was posted on a daily basis and contained the required information. Specifically, the facility did not post daily the current resident census and the total number, and the actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift in a prominent place readily accessible to residents and visitors for 4 of 5 days reviewed. The undated policy and procedure titled BIPA Staff Posting documented the nursing supervisor or designee will post the facilities staffing at the beginning of their shift. The 3:00 PM -11:00 PM and 11:00 AM -7:00 AM nursing supervisor/designee will update this information for their shift. The number and categories of nursing staff, as well as the total number of hours worked by licensed and unlicensed nursing staff directly responsible for resident care and include the facility name, current date and resident census. Posting information must be displayed in a clear and readable format and be posted in a prominent place readily accessible to residents and visitors. The finding is: During observations made on 1/27/25 at 10:44 AM and 1/27/25 at 11:58 AM, the Daily Staffing was posted on the bulletin board located down the front entrance hallway and was dated 1/24/25. Continued observation on 1/27/25 at 12:43 PM revealed the Daily Staffing form posted was dated 1/27/25 and had included the current census number of 117 and total number and actual hours worked for direct care staff. During an observation on 1/28/25 at 10:10 AM, the Daily Staffing was posted on the bulletin board located down the front entrance hallway was dated 1/27/25. Continued observation on 1/28/25 at 4:15 PM revealed there was no Daily Staffing form posted on the bulletin board. Intermittent observations made on 1/29/25 at 8:53 AM, 1/29/25 at 1:38 PM, 1/30/25 at 7:19 AM, 1/30/25 at 11:12 AM, 1/30/25 at 4:15 PM, and 1/31/25 at 8:32 AM revealed there was no posting of the Daily Staffing form on the bulletin board down the front entrance hallway or at the front reception desk. During an interview on 1/31/25 at 11:45 AM, Human Resource Manager #1 stated that they were responsible to complete and post the Daily Staffing form. They stated the daily staffing was posted on the bulletin board outside their office located in the front entrance hallway and they would adjust the staffing form throughout the day to reflect the actual staff in the building. Human Resource Manager #1 stated the Nursing Supervisor was responsible to complete, update and post the Daily Staff form on the weekends. Human Resource Manager #1 stated that they had completed the Daily Staffing forms from 1/27/25 - 1/31/25. They posted the 1/27/25 form in the afternoon but did not have a chance to get the forms posted the rest of the week and should have. They stated it was important to have the Daily Staffing form posted so that families would know how many staff members were providing care to the residents. (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 1/31/25 at 12:32 PM, the Director of Nursing stated Human Resource Manager #1 was responsible to complete and post the Daily Staffing form. They stated they would complete and post the Daily Staffing in the absence of Human Resource Manager #1 and that the Nursing Supervisor would complete the form on the weekend. The Director of Nursing stated the Daily Staffing form was to be posted on the bulletin board in the front entrance hallway, so that it would be accessible to visitors, families and residents. They stated would expect the Daily staffing form to be completed and posted. It was important for visitors and families to know the actual staffing of the building. The Director of Nursing stated they were unaware that the Daily Staffing form had not been posted from 1/28/25 - 1/31/25. 10NYCRR 415.13

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43802 Based on observation, interview, and record review conducted during a Standard Survey completed on 1/31/25, the facility did not provide separately locked, permanently affixed compartments for the storage of controlled drugs for two (2) (Garden View and [NAME] View North) of three (3) medication rooms observed. Specifically, in both medication rooms, controlled drugs were stored in a locked metal box, inside a locked small refrigerator that was not permanently affixed to the wall or countertop. Additionally, the Garden View medication refrigerator housed a locked metal box, containing emergency narcotics, that was not permanently affixed to the refrigerator. This involved Residents #6, 8, 40, and 82. The findings are: The policy and procedure titled Controlled Medication Storage and Count, dated 1/2023, documented a controlled substance requiring refrigeration will be kept double locked in the med room refrigerator within the metal locked box. During an interview and observation of the Garden View medication room on 1/30/25 at 8:41 AM, a locked medication refrigerator was sitting on the counter, it was not secured to the counter or the wall. Licensed Practical Nurse #6 stated the keys to the medication refrigerator were kept by the Nursing Supervisor. Each medication nurse carried the keys to their unit narcotic box, but the medication refrigerator contained medications from all the Villages (Garden View, Orchard, Canal). Licensed Practical Nurse #6 stated the medication refrigerator had never been permanently affixed to the counter or wall. During an interview and observation of the Garden View medication room on 1/30/25 at 2:41 PM, Licensed Practical Nurse #5 (covering Supervisor), opened the locked medication refrigerator. The refrigerator contained 2 locked metal boxes. One locked box was permanently affixed to the shelf, and the second locked box was not permanently affixed. Licensed Practical Nurse #5 stated they did not have a key to the second metal box, because it was for emergency use only. The key to that box was locked inside the automated medication dispensing system and required pharmacy approval for access. They stated the refrigerator had never been permanently affixed and they did not know that it should be. The affixed metal box was opened by Licensed Practical Nurse #5 and contained: -one unopened, 10 milliliter vial of Lorazepam (a controlled substance and anti-anxiety/anti-seizure medication) and one unopened 30 milliliter bottle of Lorazepam for Resident #40 -three unopened, 1 milliliter vials of Lorazepam for Resident #6 -four unopened, 2.5 milliliter vials of Lorazepam for Resident #82 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/30/25 at 3:00 PM, Licensed Practical Nurse #2 stated the medications inside the second locked metal box were for emergency use. The key was only accessible by calling the pharmacy, getting an access code, and having two staff members type their credentials into the automated dispensing system. They stated the pharmacy monitored the contents of the emergency box. Licensed Practical Nurse #2 stated, not having the metal box secured to the inside of the refrigerator and by the refrigerator not being permanently affixed, made it a higher risk for diversion. During an interview and observation of the [NAME] View North medication room on 1/31/25 at 8:37 AM, the locked medication refrigerator contained: for Resident #8, one 10 milliliter vial of Lorazepam. The vial was located inside an unlocked stainless-steel box affixed to a shelf inside the refrigerator which was sitting on top of a foot-stool on the floor and was not permanently affixed. Licensed Practical Nurse #7 stated the refrigerator was not affixed to anything and was sitting on a stool. Licensed Practical Nurse #7 attempted to lock the stainless-steel box inside the refrigerator but could not and said the key wasn't working. They stated they counted the Lorazepam that morning and the key wasn't working then either. They were not sure how long the key didn't work. During an interview on 1/31/25 at 8:47 AM, Licensed Practical Nurse Unit Manager #8 stated they were the medication nurse on the [NAME] View North unit on Monday (1/27/25) and the key to the stainless-steel lock box worked, they just had to work with it and wiggle it. They stated the lock box in the refrigerator should have been locked when there was a controlled medication inside. They weren't sure how long the refrigerator had not been permanently affixed and they would call the pharmacy to fix the lock. During an interview on 1/31/25 at 10:58 AM, Pharmacy Manager #1 stated they expected the facility to keep their controlled drugs secured in a double locked container. They stated they did not know the refrigerator was not permanently affixed to the counter or that the emergency narcotics box was not affixed to refrigerator. They stated that pharmacy staff monitor and count the contents of the emergency box weekly, and they had not had any diversion. Pharmacy Manager #1 stated the box contained Lorazepam for emergency use. They stated, not having the box secured to the inside of the refrigerator and by the refrigerator not being permanently affixed, made it a higher risk for diversion. During an interview on 1/31/25 at 12:59 PM, the Director of Nursing stated they were aware that the medication room refrigerators were not permanently affixed and contained controlled drugs. The Director of Nursing stated they have had their pharmacy come in every six months and this was never an identified issue. If they were not permanently affixed, it could be a risk for diversions. 10NYCCRR 415.18 (e)(2)

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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. 43802 Based on observation, interview, and record review conducted during a Standard survey completed 1/31/25, 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 unlabeled or outdated in the refrigerators; stained, worn ceiling tiles, lack of [NAME] #2 wearing a beard guard in food preparation areas. Additionally, during the puree observation texture modified bread mix was not prepared and used in accordance with the manufacturer's directions. The findings are: The policy and procedure titled Food Storage Refrigerator and Freezer dated 8/2017 documented to ensure foods are stored properly to minimize spoilage and contamination and ensure taste and quality of food. All food items must be labeled and dated. The policy and procedure titled Cleaning of Food Storage Areas documented to ensure maintenance and cleanliness to storage areas. All kitchen areas shall be kept clean and free litter and rubbish. All counters, shelves and equipment shall be kept clean and maintained in good repair. The facility policy and procedure titled Hair Coverings dated 3/2017 documented it is the policy of the facility to prevent hair from contaminating food or beverage. Food code recommends that food handles wear beard nets or other hair restraints when appropriate. However, the rule is not specific about the length or the beard that requires a net. It is the responsibility of the management staff in the food service department to monitor and enforce the policy. During an observation on 1/27/2025 at 9:32 AM of the main kitchen revealed the following: -reach in refrigerator ajacent to the stove had an open undated packages of sliced corn beef and turkey. -walk-in cooler had a tray of five (5) premade sandwiches in clear plastic baggies dated 1/24/25 and four (4) prepared 4-ounce cups of canned fruit dated 4-ounce cups of canned fruit dated 1/24/25. -3-tier metal cart across from the dish machine had approximately 29 plastic coffee mugs stored ready for use that were right side up uncovered, the cart had a large amount of brown liquid on the second and third tier. -ceiling tiles had brown and yellow discolored spots and stains throughout the kitchen, being more prevalent over the dish machine. -floor beneath the coffee station across from the tray line was soiled with large area of dried brown liquid. (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 at the time of the observation 1/27/2025 at 9:32 AM the Food Service Director #1 stated all open foods should be dated and labeled if they are not, they should be discarded. The floor under the coffee station should be cleaned. The coffee mugs should be stored upside down or a tray covering them. The nourishments in the walk-in refrigerator should be discarded because they were three days old. During an observation on 1/29/2025 at 11:35 AM, [NAME] #2 had a surgical mask on with approximately 1/2 inch long facial hair that was exposed under their chin and both cheeks [NAME] #2 was on tray line and in and out of kitchen area with food service and preparation occurring. During the pureed food observation and interview on 1/30/25 at 10:33 AM with [NAME] #1 stated there were approximately 32 residents requiring a pureed diet texture and they would be pureeing hot dogs. [NAME] #1 added 6 to 8 cooked hot dogs to the food processer added a small amount of water and blended till smooth and repeated the same process twice, pouring the pureed hot dogs into a square metal pan. A discussion took place during the observation with [NAME] #1 and the Food Service Director #1. [NAME] #1 was instructed by the Food Service Director to use bread or the Texture Modified Bread Mix to substitute the hot dog bun. [NAME] #1 obtained a box of Texture Modified Bread Mix from under the prep station and placed an eight-ounce disposable cup in the contents of the box. [NAME] #1 added 6-8 cooked hot dogs to the food processer added a small amount of water and processed the hot dogs for approximately 30 seconds. [NAME] #1 then proceeded to take the eight-ounce cup and filled the cup approximately half full with the modified bread mixture without reviewing the manufactures preparation directions and added it to the pureed hot dogs in the food processer, blended the mixture and hotdogs together and added it to the square metal pan of hot dogs previously processed. [NAME] completed the same process three times adding the pureed hotdogs and bread mixture to the same metal pan. Review of the Texture Modified Bread Mix manufactures mixing directions documented the following for 18 slices of bread: -combined in a bowl 2 cups of bread mix 2/3 cup vegetable oil and stir with a fork till breadcrumbs are well coated. - add three cups of hot water -mix well with a fork or whisk, pour mixture into a nonstick pan sprayed with nonstick cooking spray, cover with plastic wrap and let stand at room temperature for at least 30 minutes. -slice and serve There was no recipe available for the preparation of hotdogs with buns puree. During an interview on 1/30/25 at 10:56 AM, [NAME] #1 stated they have used the Texture Modified Bread Mix in the past but not the way the Food Service Director #1 told them too. They would normally mix the bread mixture with water and serve it separately. They were unsure what the manufactures directions called for. [NAME] #1 after tasting a sample of the pureed hot dogs stated, it tastes like a hot dog. The Surveyor tasted the hot dog/bun puree, and it was gritty. (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 1/30/25 at 10:57 AM, Dietary Aide #1 after trying a sample of the pureed hot dogs stated they did not like it, said it looked gross, tasted it made a face and walked away. During an observation on 1/30/25 at 2:57 PM [NAME] #2 was observed in the food preparation area across from the stove, prepping sandwiches. Their beard guard was around their neck below their chin. During an interview on 1/30/25 at 3:03 PM, [NAME] #2 stated they should be wearing a beard guard when in the kitchen or they would wear a surgical mask. They were unsure if a surgical mask would be considered a beard guard and would have to check with the Food Service Director. [NAME] #2 was observed during the interview to have their beard guard covering only their chin area leaving their mustache and cheek areas exposed and this was in a food prep area. During an interview on 1/31/25 at 11:12 AM the Food Service Director #1 stated staff who have facial hair should wear a beard guard, at all times when in the kitchen. They stated beard guards were available and were unsure if a surgical mask was an acceptable substitute. Food Service Director #1 stated they have used the Textured Modified Bread Mix in the past but was unsure what the directions called for when preparing the product and would have to clarify how it should be used. They were also unsure what could be done about the kitchen ceiling tiles. During an interview on 1/31/25 at 11:59 AM, the Registered Dietitian stated the directions should be followed in preparing the Texture Modified Bread Mix and it should not be added from the box directly into food. All open food should be labeled and dated, if not then it should be thrown away. The Registered Dietitian stated staff who have facial hair should always wear a beard guard when they were in the kitchen. 10 NYCRR 415.14(h)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43802 Based on observation, interview, and record review conducted during the Standard survey completed on 1/31/25 the facility did not maintain an infection prevention and control program designed to provide a safe, sanitary, and a comfortable environment, to help prevent the development and transmission of communicable diseases and infection for two (Resident #42 and Resident #89) of five residents reviewed for Enhanced Barrier Precautions. Specifically, Enhanced Barrier Precautions were not initiated for Resident #42 who had a sacral pressure ulcer and staff did not wear appropriate personal protective equipment (PPE) during pressure ulcer care. Additionally, staff did not wear appropriate personal protective equipment (PPE) while they emptied a urinary catheter bag (a urine collection bag) for Resident #89 who had an indwelling foley catheter (tube inserted into the bladder to drain urine) and was on Enhanced Barrier Precautions. The findings are: The policy and procedure titled Enhanced Barrier Precautions dated 12/2024 documented that Enhanced Barrier Precautions (EBP) were an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involved gown and glove use during high-contact resident care activities. High contact resident activities include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, urinary catheter care and wound care: any opening requiring a dressing. Enhanced Barrier Precautions should be used for the duration of a resident's stay in the facility or until the resolution of the wound of discontinuation of the indwelling medical device that placed them at higher risk. 1. Resident #42 had diagnoses that included sacral pressure ulcer stage 3 (area above the tail bone with full thickness tissue loss, with no bone, tendon or muscle exposed), spinal stenosis (narrowing of one or more areas in your spine), and acute kidney failure. The Minimum Data Set (an assessment tool) dated 1/13/25 documented Resident #42 was cognitively intact and had one stage 3 pressure ulcer that was not present upon admission. The comprehensive care plan revised on 1/31/25, documented Resident #42 had a sacral pressure ulcer related to immobility and urinary incontinence. Interventions included to administer treatments as ordered and to follow policies and protocols for the prevention/treatment of skin breakdown. The comprehensive care plan documented that Enhanced Barrier Precautions were resolved on 12/12/24 and had not been re-implemented on until 1/31/25. Review of the facility's Enhanced Barrier Precaution line list provided by the Assistant Director of Nursing and dated 1/29/25 revealed that Resident #42 was not on Enhanced Barrier Precautions. Review of Resident #42's medication administration record from 1/1/25 to 1/31/25 revealed that there was no physician order in place for Enhanced Barrier Precautions until 1/31/25. Additionally, the medication administration record documented that Resident #42 had been treated with antibiotics for a sacral wound infection from 1/7/25 to 1/17/25. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #42 physician orders which included all active, completed and discontinued orders revealed that Enhanced Barrier Precautions for Resident #42 had been discontinued on 12/27/24 and had not been re-ordered until 1/31/25. Review of skin and wound note dated 1/15/25, the Wound Consultant documented that Resident #42 had a stage 3 sacral pressure ulcer. The wound status was documented as stable, peri wound was macerated, with a moderate amount of serous drainage (clear/yellow drainage) was noted. During intermittent observations on 1/27/25 at 11:05 AM, 1/28/25 at 9:12 AM, 1/29/25 at 9:00 AM and 1/30/25 at 8:48 AM, Resident #42 was sitting in wheelchair in their room. There was no Enhanced Barrier Precaution signage posted on Resident #42's door, and there was no personal protective equipment located outside or inside of Resident #42's room. One closed lid garbage can was noted in Resident #42's room and labeled isolation trash only. During an observation and interview on 1/20/25 at 8:48 AM, Licensed Practical Nurse #4 completed wound care to Resident #42's sacral wound. Resident #42 was able to stand up while Licensed Practical Nurse #4 completed their wound care. The pressure ulcer was noted to have yellow/brown drainage. Licensed Practical Nurse #4 stated the pressure ulcer was a stage 3 and had tunneling present (opening underneath the surface of the skin). Licensed Practical Nurse #4 described the pressure ulcer as being opened with small amount of brown drainage. They cleansed the wound with Dakins (antiseptic for wound care) solution, applied collagen powder (promotes new tissue formation), calcium alginate (absorbent fibrous material used for wound management) and covered the pressure ulcer with a dressing. Licensed Practical Nurse #4 utilized gloves for personal protective equipment and did not wear a gown during the observation. Licensed Practical Nurse #4 stated that Resident #42 was not on Enhanced Barrier Precautions, they stated that they believed if the wound was cultured and came back clear Enhanced Barrier Precautions would not be needed. They stated the Assistant Director of Nursing determined who was placed on enhanced barrier precautions. During an interview on 1/31/25 at 9:04 AM, Licensed Practical Nurse Unit Manager #8 stated any resident with a draining wound would be placed on Enhanced Barrier Precautions. They stated that Enhanced Barrier Precautions would be important to protect staff and residents from the spread of infections. Licensed Practical Nurse Unit Manager #8 stated that Resident #42 was not on Enhanced Barrier Precautions because their wound did not have drainage. During an interview on 1/31/25 at 10:45 AM, the Assistant Director of Nursing stated they would review and update the list of residents on Enhanced Barrier Precautions during morning report and conduct audits on the precaution signage, caddy, care plan and orders for Enhanced Barrier Precautions. The Assistant Director of Nursing stated any resident who had open wounds would be placed on Enhanced Barrier Precautions. They stated that if the wound was granulated and had scant to no drainage, they would remove the resident from Enhanced Barrier Precautions. The Assistant Director of Nursing stated that Resident #42 had been removed from Enhanced Barrier Precautions, their wound had improved and had no drainage. They stated that if Resident #42's wound started to drain again that they would be at risk for infection and should be placed back on Enhanced Barrier Precautions. The Assistant Director of Nursing stated that they were not aware Resident #42's wound had drainage. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335212	A. Building B. Wing	01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villages of Orleans Health and Rehab Center	14012 Route 31 Albion, NY 14411

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/31/25 at 12:46 PM, the Director of Nursing/Infection Preventionist stated they reviewed the resident list of Enhanced Barrier Precautions daily at morning report. They stated that they would expect that any resident with an open draining wound would be placed on Enhanced Barrier Precautions. They stated it was important to protect the residents and prevent the spread of infection from staff to resident. The Director of Nursing /Infection Preventionist stated that Resident #42 had an open wound, they would be at risk for infection and should have been on Enhanced Barrier Precautions. 2. Resident #89 had diagnoses that included a history of urinary tract infections and low back pain. The Minimum Data Set, dated dated dated [DATE] documented Resident #89 was cognitively intact and had a foley catheter. The comprehensive care plan dated 12/12/24 documented Resident #89 was on Enhanced Barrier Precautions for use of an indwelling catheter and that a gown and gloves were to be worn for high contact resident care related to their foley catheter. Resident #89's current Kardex (guide used by staff to provide care) documented to maintain Enhanced Barrier Precautions - use of gown and gloves - during high-contact resident care activities related to their foley catheter. During an observation on 1/27/25 at 1:21 PM, Licensed Practical Nurse #4 entered Resident #89's room to empty Resident #89's foley catheter bag of urine. Resident #89 had an order for Enhanced Barrier Precautions, which was posted at the door of their room along with a supply cart with personal protective equipment. Licensed Practical Nurse #4 stated this was going to be quick and told the surveyor they could remain in the room. Licensed Practical Nurse #4 was wearing gloves only, proceeded to empty the urine collection bag at the resident's bedside into a urinal, measured the urine, and then emptied the urinal into the toilet in the resident's room. Licensed Practical Nurse #4 did not wear an isolation gown while caring for the resident's foley. Review of the Enhanced Barrier Precautions sign on Resident #89's door documented gloves and gown were required for high contact resident care activities for device care or use of a urinary catheter. During an interview on 1/29/25 at 8:59 AM, Licensed Practical Nurse #4 stated they should have worn a gown along with the gloves when they emptied Resident #89's foley urine bag on 1/27/25. The reason for the gown was to protect residents from anything the nurse may carry and to protect the nurse and other residents from any possible source of infection the urine may carry. During an interview on 1/29/25 at 8:49 AM, Assistant Director of Nursing stated the personal protective equipment they expected staff to wear when a resident is on Enhanced Barrier Precautions was a gown and gloves, to empty a foley urine bag. This was important, in case there was any splashing and to protect the staff person and residents from contracting any possible infection. During an interview on 1/29/25 at 9:05 AM, Director of Nursing/ Infection Preventionist stated the personal protective equipment they expected a staff to wear when emptying a foley urine bag was a gown and gloves. This was important because urine could be a source of infection, and they would not want the staff person to carry any possible infection from one resident to another. (continued on next page)

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	335212	A. Building B. Wing	01/31/2025

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