

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335281	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/20/2024
NAME OF PROVIDER OR SUPPLIER Absolut Ctr for Nursing & Rehab Aurora Park L L C		STREET ADDRESS, CITY, STATE, ZIP CODE 292 Main Street East Aurora, NY 14052	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36415</p> <p>Based on observation, interview and record review conducted during the Standard survey completed on 12/20/24, the facility did not ensure residents had the right to interact with members of the community and participate in community activities inside the facility for one (Resident #33) of two residents reviewed. Specifically, staff did not accommodate Resident #33's choice to attend the Resident Council Meeting on 12/17/24.</p> <p>The finding is:</p> <p>The policy and procedure titled Resident Rights and Responsibilities revised 4/2/24 documented the facility functions on the premise that the service it renders should demonstrate its belief in the dignity and worth of every individual. It is the objective of the facility to provide the Patient/Resident with optimal nursing and psychosocial care. Every effort is made by the staff to meet the Patient/Resident's individual needs and requirements.</p> <p>Resident #33 had diagnoses which included multiple sclerosis, paraplegia (paralysis of lower extremities) and anxiety. The Minimum Data Set (MDS, a resident assessment tool) dated 12/9/24 documented Resident #33 was cognitively intact. The Minimum Data Set, dated dated dated [DATE] documented it was very important for Resident #33 to participate in their favorite activities and with groups of people.</p> <p>The comprehensive care plan revised 9/18/24 documented Resident #33 would select daily activities of choice. The planned activities included Resident #33 enjoyed watching television, listening to music, playing bingo, attending resident council, and socializing with peers and staff.</p> <p>The Kardex (guide used by staff to provide care) with a print date of 12/18/24 documented Resident #33 required transport assistance to leisure time activities as needed.</p> <p>The December 2024 [NAME] 3 Activity Calendar revealed a Resident Council Meeting was scheduled at 10:30 AM on 12/17/24.</p> <p>During an observation on 12/17/24 at 10:30 AM the Resident Council Meeting took place in the [NAME] 3 dining room.</p> <p>(continued on next page)</p>

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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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and interview on 12/17/24 at 11:23 AM, Resident #33's call bell was activated and illuminated above their bedroom door. Resident #33 was lying in bed, and stated they were upset. They had their call light on for over an hour and no one had come to get them up and they had missed the Resident Council Meeting at 10:30 AM. Resident #33 stated they attended the Resident Council Meetings on a regular basis. They stated they told the Director of Activities that they had planned on attending the meeting this morning.</p> <p>Review of the Resident Council Meeting minutes from June 2024 through November 2024 revealed Resident #33 attended the Resident Council meetings regularly.</p> <p>During an interview on 12/18/24 at 9:33 AM, Certified Nurse Aide #6 stated Resident #33 actively participated and attended Resident Council meetings.</p> <p>During an interview on 12/18/24 at 9:34 AM, Registered Nurse #1 Unit Manager stated the Director of Activities should have informed Certified Nurse Aide #13 that Resident #33 wanted to attend the Resident Council Meeting on 12/17/24.</p> <p>During an interview on 12/18/24 at 9:50 AM, the Director of Activities stated Resident council meetings were held every third Tuesday of the month and were announced during the Daily Chronicle at 9:30 AM for a reminder. In addition, the Director of Activities invited Resident #33 to the Resident Council Meeting on 12/17/24 because they attended the meetings regularly. Resident #33 had told them that they were not feeling good and assumed that they did not want to attend. Resident #33 liked to be in the know of what's going on and that was their right and should not have assumed.</p> <p>During an interview on 12/18/24 at 10:50 AM, Certified Nurse Aide #14 stated they took over for Certified Nurse Aide #13 on 12/17/24 at 10:00 AM. Certified nurse aide #14 was sidetracked and couldn't provide care timely; there for Resident #33 missed the Resident Council Meeting. Certified Nurse Aide #14 stated attending the meeting was the resident's right and they should have prioritized their assignment and accommodated Resident #33's preference.</p> <p>During a telephone interview on 12/18/24 at 1:43 PM, Certified Nurse Aide #13 stated they provided care for Resident #33 at 9:00 AM on 12/17/24 and Resident #33 did not mention a thing about going to the Resident Council meeting.</p> <p>During an interview on 12/20/24 at 11:07 AM, the Director of Nursing stated the Director of Activities knows who wants to attend activities and should have let the nursing staff know. Attending the meeting was Resident #33's right and would have expected the staff to accommodate that right. I'm sure it was miscommunication.</p> <p>During an interview on 12/20/24 at 10:57 AM, the Administrator stated they would have expected Resident #33 to attend the meeting based on their preference.</p> <p>10 NYCRR 415.5 (b) (1,3)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36415</p> <p>Based on interview and record review conducted during a Complaint investigation (#NY00347404) during a Standard survey completed on 12/20/2024, it was determined the facility did not protect residents from sexual abuse for two (Resident #165 and Resident #151) of seven residents reviewed. Specifically, residents who lacked ability to consent were observed undressed and in bed together.</p> <p>The policy and procedure titled Abuse Prohibition dated 02/2023 documented that residents have a right to be free from abuse including sexual abuse.</p> <p>The policy and procedure titled Abuse Prohibition Staff Responsible for Coordinating and Implementing dated 11/19/2021 documented that the Administrator is responsible for preventing abuse of the residents.</p> <p>The findings are:</p> <p>1. Resident #165 was admitted to the facility with diagnoses of Alzheimer's disease and dementia. The Minimum Data Set (a resident assessment tool) dated 5/30/24 documented Resident #165 was severely cognitively impaired and had wandering behaviors.</p> <p>The comprehensive care plan dated 5/24/24 documented Resident #165 had wandering behaviors and displayed promiscuous behaviors at times. Resident #165 was alert and oriented to person only and could ambulate independently in their room and in the hall.</p> <p>The Patient Resident's Rights and Responsibilities dated 5/29/24 documented that Resident #165 was unable to give consent due to cognitive capacity.</p> <p>The Determination of Capacity dated 5/31/24 documented Resident #165 lacked the capacity to make health care decision and the reason for this lack of capacity was due to Alzheimer's disease.</p> <p>The Mini Mental State Examination dated 6/4/24 documented Resident #165 scored a 13 out of 30 which indicates that Resident #165 severely cognitively impaired.</p> <p>Review of a progress note written on 6/3/2024 at 4:35 PM by the Director of Social Work documented that capacity determination was signed by provider and the concurring provider stated that Resident #165 does not have capacity to make their own medical decisions.</p> <p>Resident #151 was admitted to the facility with diagnoses of dementia and Parkinson's disease. Review of the Minimum Data Set, dated dated dated [DATE] documented Resident #151 was moderately cognitively impaired and had wandering behaviors.</p> <p>The comprehensive care plan dated 5/21/2024 documented Resident #151 had an alteration in decision making skills related to dementia. The comprehensive care plan documented the resident encourages others behavioral tendencies at times. Additionally, it documented a potential for alteration in mood and behavior patterns related to dementia and adjustment difficulties.</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the patients' rights and responsibilities dated 5/21/2024 documented Resident #151 does not have capacity to give consent.</p> <p>Review of the determination of capacity dated 5/23/2024 documented that Resident #151 lacks the capacity to make health care decisions. It documented that the lack of capacity was due to dementia.</p> <p>An incident report dated 7/6/2024 at 4:45 PM completed by Licensed Practical Nurse Supervisor #2 documented while doing their medication pass, Licensed Practical Nurse #4 walked into Resident #151's room and found Resident #151 sitting on their bed with Resident #165 without clothes on. Resident #151 stated at this time, that it had been [AGE] years since I had sex, and they (Resident #165) were willing. The incident report documented that Resident #165 was dressed and escorted from the room. It documented that both residents were assessed for injuries, and none were found.</p> <p>Review of an investigation statement dated 7/6/2024 documented that Licensed Practical Nurse #4 walked into Resident #151's room to pass medications and found Resident #151 and Resident #165 unclothed in Resident 151's bed. The statement documented that Licensed Practical Nurse #4 instructed Resident #165 and Resident #151 to get dressed. Licensed Practical Nurse #4 then notified Licensed Practical Nurse Supervisor #3 and other staff.</p> <p>An investigation report dated 7/11/2024 documented that Resident #165 was last seen by staff at 3:15 PM on 7/6/2024. Resident #165 was found close to the genital area of Resident #151 by Licensed Practical Nurse #4 on 7/6/2024 at 4:45 PM. The investigation documented the residents were noted to be unclothed in Resident #151's room. Resident #165 was dressed by staff and re-directed out of the room. Resident #151 stated they did not have sex with Resident #165 but Resident #165 did perform oral sex on them. The conclusion of the investigation documented the residents' cognitive status, they were unable to give consent for sexual activities and this was reported to the New York State Department of Health.</p> <p>Review of a progress note from the Psychiatric Nurse Practitioner dated 7/16/2024 documented that Resident #165 was seen for sexual inappropriateness. The progress noted documented that Resident #165 had poor insight, poor memory, and poor judgement due to dementia.</p> <p>During an interview on 12/18/2024 at 1:22 PM, Certified Nurse Aide #1 stated that staff were looking for Resident #165 prior to the incident, but they did not witness anything between Resident #165 and Resident #151.</p> <p>During an interview on 12/19/24 at 9:27 AM, Social Worker #1 stated Resident #151 does not have the capacity to consent. They stated residents with dementia cannot consent to anything.</p> <p>During an interview on 12/19/24 at 9:36 AM, the Director of Social Work stated that non-consenting adults having sex would be considered abuse. They stated that Resident #151 does not have capacity to consent.</p> <p>During an interview on 12/19/2024 at 10:33 AM, the Assistant Director of Nursing stated because there was no psychosocial harm between Resident #165 and Resident #151, there was no abuse. They stated that Resident #165's going into other residents' rooms was a new behavior and that's why Resident #165 was put on one-to-one supervision to prevent Resident #165 from repeating this wandering behavior.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/19/2024 at 1:11 PM, Resident #151's responsibility party stated visited Resident #151 right after the incident occurred. They stated that Resident #151 told them that Resident #165 had performed oral sex on them. The Responsible Party stated they spoke to Resident #151 about informed consent and that other residents might not be able to consent to sex.</p> <p>During an interview on 12/19/2024 at 1:21 PM, Licensed Practical Nurse #4 stated they stand by what was in their statement. They stated that if two residents do not have the ability to consent to sex, then it was considered abuse.</p> <p>During an interview on 12/19/2024 at 3:58 PM, Resident #165's responsible party stated they were not aware that Resident #165 was unclothed and in bed with Resident #151. The facility informed them that Resident #165 was fully clothed, and that Resident #151 only had their pants down. They stated the facility informed them they couldn't find Resident #165 for over an hour and that the security cameras were not working on the memory unit.</p> <p>During an interview on 12/19/2024 at 4:33 PM, the Medical Director stated that if residents cannot consent to sex, then it was considered abuse. They stated that they do not believe Resident #165 could consent.</p> <p>During an interview on 12/20/2024 at 9:26 AM, the Psychiatric Nurse Practitioner stated that Resident #165 does not have the capacity to consent. Two residents who don't have the capacity to consent; can't consent to sex so they would consider this abuse.</p> <p>During an interview on 12/20/2024 at 12:08 PM with local law enforcement, they stated that they were called to the facility concerning an incident between two residents. They stated that the facility told them the contact was consensual and they did not initiate an investigation because of what the facility told them.</p> <p>During an interview on 12/20/2024 at 12:23 PM, Licensed Practical Nurse Supervisor #3 stated that Resident #165 does not have the ability to say yes or no. Resident #165 was put on one to one supervision after the incident because they did not want Resident #165 to wander in and out of other residents' rooms to protect them and other residents from possible abuse. They stated they had contacted the local police department because they thought it may have been abuse.</p> <p>During an interview on 12/20/2024 at 1:21 PM, the Director of Nursing stated that what happened between Resident #151 and Resident #165 was not abuse because nothing was witnessed. The Director of Nursing stated that a reasonable amount of time to do a Registered Nurse assessment for an incident between two residents was 12 to 24 hours after the incident.</p> <p>During an interview on 12/20/2024 at 1:36 PM, Licensed Practical Nurse #2 stated that confused residents do not have the ability to consent. They stated that two residents unclothed in a room together would be considered abuse and should be reported right away to the Director of Nursing or Administrator.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/20/2024 at 1:44 PM, Registered Nurse Supervisor #2 stated they started their shift at 7:00 PM on 7/6/2024. They had assessed Resident #151 a little after 7:00 PM when they started their rounds, and they did not find any injuries on the resident at that time. Registered Nurse Supervisor #2 stated they did not assess Resident #165 right away because the resident was sleeping. They stated they assessed Resident #165 around 1:00 AM when Resident #165 was receiving a medication and they did not observe any marks or injuries at that time. Registered Nurse Supervisor #2 stated at the time of the incident, there didn't seem to be a sense of urgency, so they assumed there was no abuse involved.</p> <p>During an interview on 12/20/24 at 2:06 PM Licensed Practical Nurse Inservice Coordinator #1 stated, if two residents who lacked capacity to consent were found naked in bed together it would be considered abuse.</p> <p>10 NYCRR 415.4(b)(1)(i)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36415</p> <p>Based on observation, interview, and record review conducted during the Standard survey completed on [DATE], the facility did not store, prepare, distribute, and serve food in accordance with professional standards for food service safety. Specifically, five ([NAME] 3, [NAME] 2, Willink A, Willink C, Willink Legacy Cove) of five unit Nourishment Room refrigerators contained undated, unlabeled, and out of date food and drink items and a staff member's personal food was stored with residents' food.</p> <p>The findings are:</p> <p>The policy and procedure titled Food Receiving and Storage, revised ,d+[DATE], documented potentially hazardous foods stored in the refrigerator will be labeled and dated and discarded after three days once opened. All non-potentially hazardous foods stored in the refrigerator will be labeled and dated and discarded after five days once opened.</p> <p>The policy and procedure titled Food(s) Brought in from Outside the Facility, revised ,d+[DATE], documented perishable foods brought in must be labeled with resident's name and dated and consumed promptly. The facility is responsible for storing food brought in by family or visitors in a way that is separate from or easily distinguishable from facility food. All foods are labeled/ dated and discarded after three days.</p> <p>1a. Observation in the [NAME] 3 Nourishment Room on [DATE] at 9:10 AM revealed the following items were stored in the refrigerator:</p> <ul style="list-style-type: none"> -One 8.8-ounce glass jar of raw wildflower honey, opened, not labeled with the date opened, and no manufacturer expiration date. -One poured applesauce cup with a facility sticker that stated, use by Saturday ,d+[DATE]. -One poured pudding cup with a facility sticker that stated, use by Saturday ,d+[DATE]. -One opened 32-ounce thickened lemon water, not labeled with the date opened, manufacturer instructions stated discard if not used with in four days of opening. -One opened 46-ounce thickened dairy beverage, not labeled with the date opened, manufacturer instructions stated after opening, may be kept for up to seven days under refrigeration. -Two opened 46-ounce thickened apple juices, not labeled with the date opened, manufacturer instructions stated discard if not used within ten days of opening. -One individual bottle of water, one individual bottle of iced tea, one individual bottle of blue electrolyte drink, all opened, not labeled with a resident name or date opened. <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview at the time of the observation, Registered Nurse Unit Manager #1 stated Dietary staff maintained the refrigerators in the Nourishment Rooms, but Nursing staff was responsible for dating the items when they were opened.</p> <p>1b. Observation in the [NAME] 2 Nourishment Room on [DATE] at 10:15 AM revealed the following items were stored in the refrigerator:</p> <ul style="list-style-type: none"> -One commercially prepared individual container of ready to eat oats, manufacturer best by' date [DATE]. -Two opened 32-ounce nectar and honey consistency beverages, not labeled with the date opened, manufacturer instructions discard if not used within four days of opening. <p>During an interview at the time of the observation, the Director of Environmental Services stated the ready to eat oats needed to be discarded because its manufacturers best by date had passed.</p> <p>1c. Observation in the Willink A Nourishment Room on [DATE] at 11:15 AM revealed the following items were stored in the refrigerator:</p> <ul style="list-style-type: none"> -One plastic storage container of cut vegetables labeled with a resident's name, but no date. -One tray of food labeled with a resident's name, but no date. -Two unopened commercially prepared individual turkey meals labeled with a resident's name; manufacturer instructions stated keep frozen. -Two unopened commercially prepared individual scrambled egg cups, labeled with a resident's name, manufacturer 'best by' date 24Nov24. <p>Additional observation revealed a sign was posted on the Willink A Nourishment Room refrigerator that read, All items in this refrigerator must be dated and labeled.</p> <p>During an interview at the time of the observation, Certified Nurse Aide #2 stated resident foods needed to be dated. They stated the resident that the individual turkey meals and scrambled egg cups belonged to was no longer at the facility. At this time, Certified Nurse Aide #2 voluntarily discarded the turkey meals and stated manufacturer's instructions to keep frozen were not followed. Certified Nurse Aide #2 also voluntarily discarded the scrambled egg cups and stated they should not be eaten because they were past the manufacturer's 'best by' date.</p> <p>1d. Observation in the Willink Legacy Cove Nourishment Room on [DATE] at 12:00 PM revealed the following items were stored in the refrigerator:</p> <ul style="list-style-type: none"> -A plastic container of chicken and pasta, labeled with a name, but no date. -A purple plastic container with pasta and crackers in a black bag, no name or date appeared on the black bag or the items inside the black bag. -A pitcher of lemonade with a facility sticker that stated, Use by Sunday ,d+[DATE]. <p>(continued on next page)</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>36415</p> <p>Based on observation, interview, and record review conducted during the Standard survey completed on 12/20/24, the facility did not maintain an infection prevention program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infection for one (Resident #10) of three residents reviewed. Specifically, staff placed linens soiled with urine and fecal matter and soiled incontinence briefs directly on the floor and on the resident's bed headboard and footboard while providing care.</p> <p>The finding is:</p> <p>The policy and procedure titled Incontinent Care revised 3/2022 documented to remove brief, clothing and bed linen and place on a soiled barrier. Wash perineum, anus, buttocks, abdomen, hips, and thighs. Rinse if using soap. Pat dry with a towel. Remove gloves, wash hands, apply new gloves and apply a thin layer of protective skin barrier per care plan. Apply one glove before leaving room to place linen in hamper.</p> <p>The policy and procedure titled Infection Prevention and Control General Statement revised 11/2024 documented the primary purpose of this facility's infection prevention and control program is to establish guidelines to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Establish guidelines to follow in implementing Standard and Transmission Precautions for handling of blood, body fluids, secretions, excretions, mucous membranes, and non-intact skin.</p> <p>Resident #10 was admitted with diagnoses of depression, anxiety, and paranoid schizophrenia. The Minimum Data Set (a resident assessment tool) dated 10/23/24 documented Resident #10 was usually understood, usually understands and was cognitively intact. Additionally, Resident #10 required partial/moderate assistance from staff for personal hygiene.</p> <p>The comprehensive care plan dated 7/29/24 documented Resident #10 had a self-care performance deficit related to Parkinson's Disease and was incontinent of bowel and bladder. The resident required maximal assist for bathing and incontinent care.</p> <p>The Visual/Bedside Kardex Report (a guide for staff to provide care) dated 12/19/24 documented incontinent care was to be provided every 2-3 hours and the resident required maximum assist of two people.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation of morning care on 12/19/24 at 8:13 AM, Certified Nurse Aide #4 and Certified Nurse Aide #5 performed hand hygiene and donned gloves. Certified Nurse Aide #4 wet a washcloth at the sink in the room and then began to cleanse Resident #10's face. Certified Nurse Aide #4 placed the washcloth that was used on Resident #10's face on top of the headboard of the bed. Certified Nurse Aide #5 placed a barrier for soiled items at the foot of the bed and stated to Certified Nurse Aide #4 that the dirty barrier was placed at the foot of the bed. Certified Nurse Aide #4 cleansed Resident #10's chest and then placed the used washcloth directly on the footboard of the bed, away from the soiled barrier. Certified Nurse Aide #4 provided urinary incontinent care with another washcloth and then placed that washcloth on the footboard of the bed, away from the soiled barrier. Prior to rolling Resident #10 on their side and removing the urine soiled brief, Certified Nurse Aide #4 stated to Certified Nurse Aide #5 that Resident #10 was usually incontinent of urine whenever they were rolled and then placed a rolled clean towel between Resident #10's legs. They rolled Resident #10 onto their right side and Certified Nurse Aide #4 removed the urine soiled brief and placed it directly on the floor. They used the washcloth to cleanse the buttocks and anus. There was a small amount of brown debris on the washcloth after Certified Nurse Aide #4 cleansed the anus. Certified Nurse Aide #4 dropped the washcloth to the floor near the brief that was on the floor. Certified Nurse Aide #4 cleansed the anus again with another washcloth, there was a small amount of brown debris on the washcloth and Certified Nurse Aide #4 placed the washcloth directly on the floor. The Certified Nurse Aides rolled Resident #10 onto their left side after placing a clean brief under them. The Certified Nurse Aides rolled Resident #10 onto their back and Certified Nurse Aide #4 removed the towel from between Resident #10's legs and placed it on the bed alongside Resident #10's left hip. Certified Nurse Aide #5 asked if the towel was wet and Certified Nurse Aide #4 held it up and stated Yes, [Resident #10] peed on it. The towel was visibly wet. Without changing their gloves and performing hand hygiene Certified Nurse Aide #4 then took the towel that was next to the resident's hip, the washcloths and the brief from the floor, walked over to the door and placed their hand on the door handle. Certified Nurse Aide #5 stated to Certified Nurse Aide #4 to stop what they were doing and to place the soiled items in a bag before leaving. Certified Nurse Aide #4 then placed all items directly on the floor. Certified Nurse Aide #5 stated to Certified Nurse Aide #4 to place items on the dirty barrier and wash their hands. Certified Nurse Aide #4 picked the soiled items off the floor, placed them on the dirty barrier, removed their gloves, washed their hands, and then left the room. They returned with bags and placed the soiled items into the bags.</p> <p>During an interview on 12/19/24 at 8:54 AM, Certified Nurse Aide #5 stated Certified Nurse Aide #4 should have used a dirty barrier for the washcloths and brief because without the barrier they were contaminating the surfaces in the room.</p> <p>During an observation and interview on 12/19/24 at 8:56 AM, Certified Nurse Aide #4 stated that the floor was the correct place to put the soiled brief and washcloths because there was fecal matter on the washcloths. They stated if they would have placed the soiled brief and washcloths on the barrier that was on the bed then they would have contaminated the bed. They stated that placing the used washcloths and towel on the headboard, footboard and alongside Resident #10 contaminated those areas of the bed.</p> <p>During an interview on 12/19/24 at 8:58 AM, Registered Nurse Unit Manager #3 stated Certified Nurse Aide #4 should have used the barrier that was placed by Certified Nurse Aide #5 from the start of care. They should not have placed the soiled washcloths, towel, or brief on the headboard, on the footboard, along the side of Resident #10, or on the floor because that was an infection control risk.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/19/24 at 9:43 AM the Registered Nurse Assistant Director of Nursing Infection Preventionist stated Certified Nurse Aide #4 needed to be re-educated regarding the use of dirty barriers. They stated it was expected that certified nurse aides used proper hand hygiene including glove changes and used dirty barriers and bags to handle soiled linen during morning care and routine incontinent care. They stated the nurses, unit managers, and in-service coordinators were responsible to make sure the certified nurse aides were educated on infection control.</p> <p>During an interview on 12/20/24 at 10:49 AM, the Director of Nursing stated they expected Certified Nurse Aide #4 to follow the correct procedure during care and follow infection control guidelines because it was for the protection of the resident. They stated it was everyone's responsibility to follow infection control guidelines including certified nurse aides, licensed practical nurses, unit managers, the director of nursing and in-service coordinators. They stated ultimately, the Director of Nursing was responsible for the nursing staff on the units.</p> <p>10 NYCRR 415.19(a)(1)(c)</p>

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36415</p> <p>Based on observation, interview, and record review conducted during the Standard survey completed on 12/20/24, the facility did not ensure each resident was offered the pneumococcal and influenza immunizations and received education regarding the benefits and potential side effects of the immunizations for two (Residents #171 and #10) of six residents reviewed. Specifically, Resident #171 was not given the influenza vaccine after their responsible party consented to the vaccination nor were they offered and educated about the pneumococcal vaccination. Additionally, Resident #10 was not given the pneumococcal vaccination after their responsible party consented to the vaccination.</p> <p>The findings are:</p> <p>The policy and procedure titled Policy on Influenza Immunization revised 10/2020, documented the facility assures that all residents receive a flu vaccination, unless medically contraindicated, or the resident makes an informed choice of refusal. The resident is immunized once the influenza vaccine consent form has been signed.</p> <p>The policy and procedure titled Pneumococcal Vaccination Program Residents revised 10/2024 documented the facility assures that all residents receive a pneumococcal pneumonia vaccine, unless medically contraindicated, or the resident makes an informed choice of refusal. An immunization history will be obtained upon admission and the physician will be consulted regarding an order for vaccination. The vaccine will be offered to all residents and administered with consent, unless medically contraindicated or the resident has previously received the vaccination. All residents/responsible parties will be educated on the risks and benefits of the pneumococcal vaccine using the current CDC/ACIP (Centers for Disease Control/Advisory Committee on Immunization Practices) Guidelines as the basis for the education. If a resident/responsible party refuses the vaccine, a declination form is obtained by the nurse and filed in the medical record.</p> <p>1. Resident #171 was admitted with diagnoses of pneumonia, necrotizing encephalopathy (a severe brain disease that can occur after a viral infection), and dementia. The Minimum Data Set (a resident assessment tool) dated 10/31/24 documented Resident #171 was sometimes understood, sometimes understands and was severely cognitively impaired. The Minimum Data Set documented the influenza vaccine was not received in the facility and the pneumococcal vaccination was not up to date and not offered.</p> <p>Review of the nursing progress notes dated 9/1/24 - 12/19/24 lacked documented evidence that Resident #171, or their responsible party were offered, declined, or were provided education regarding the pneumococcal immunization.</p> <p>Review of Resident #171's electronic medical record on 12/19/24 lacked documented evidence of the pneumococcal immunization consent/declination form.</p> <p>Review of the Influenza (Seasonal and H1N1) Vaccine Consent/Declination Form dated 9/26/24, completed by Licensed Practical Nurse Unit Manager #8, documented verbal consent was obtained from Resident #171's responsible party.</p> <p>(continued on next page)</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the nursing progress note dated 9/26/24 at 4:06 PM, Licensed Practical Nurse Unit Manager #8 documented they had spoken with the resident's responsible party regarding the resident receiving the influenza vaccine. Education was provided and the resident's responsible party gave consent for the resident to receive the vaccine. There was no documented evidence Licensed Practical Nurse Unit Manager #8 provided education or offered the pneumococcal vaccination.</p> <p>Review of the Medication Administration Records dated 9/1/24-9/30/24, 10/1/24-10/31/24, and 11/1/24-11/30/24 lacked documented evidence the influenza vaccination was given.</p> <p>Review of the Immunization Report dated 12/19/24 documented Resident #171 was not eligible for the influenza vaccination.</p> <p>Review of the Order Listing Report dated 12/19/24 lacked documented evidence of an order for the influenza vaccine.</p> <p>During an interview on 12/19/24 at 11:01 AM, Hospice Doctor #1 stated patients who were on the hospice program received the influenza vaccination based on their functional status and overall goals of care. They stated there were families and patients who requested the vaccine in order to avoid the burden of symptoms of the flu and they were welcomed to receive vaccinations. The only time they may have advised against vaccinations, as a Hospice Doctor, was when death was imminent. They stated Resident #171 had a prognosis of months, meaning death was not imminent. They stated, according to the medical record, there was no egg allergy that would make Resident #171 ineligible for the vaccination and the only other reason that would make Resident #171 ineligible was a history of an adverse reaction. However, they stated, if Resident #171's responsible party consented to the vaccination, then they would have assumed there was never an adverse reaction to the vaccination in the past. They stated, in their experience, there were many hospice patients throughout the area and many of them received the influenza vaccination, unless their death was expected within the next two weeks.</p> <p>During an interview on 12/19/24 at 11:07 AM, Resident #171's responsible party stated they consented to the influenza vaccination, but they were unaware if Resident #171 received it. Resident #171 received the vaccination in the past and never had any adverse reactions to it. They stated they remembered asking a staff member about the pneumococcal vaccination because they thought it would be a good idea since Resident #171 was admitted to the facility with pneumonia, but nobody had followed up with them. They stated they wanted Resident #171 to receive both vaccinations.</p> <p>During an interview on 12/19/24 at 11:19 AM, Licensed Practical Nurse Unit Manager #7 reviewed the electronic medical record, and stated they did not see any consent or declination for the pneumococcal vaccine. They stated it may have been documented in the nursing progress notes if it was offered. They stated the influenza consent form was in the electronic medical record and dated 9/26/24. Licensed Practical Nurse Unit Manager #7 stated the immunization documentation in the electronic medical record stated Resident #171 was not eligible to receive the influenza vaccination. They stated Resident #171 was a Hospice resident and a vaccination could be painful and that may have been why they were not eligible to receive the vaccination. They stated Resident #171 became a Hospice resident on 10/18/24 and they were not on the Hospice program at the time of the consent form.</p> <p>(continued on next page)</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/19/24 at 11:34 AM, Licensed Practical Nurse Unit Manager #8 stated there was not a pneumococcal consent/declination form in Resident #171's electronic medical record and if it was offered, the consent/declination form would have been completed and scanned into the electronic medical record. Resident #171 had a consent/declination form completed for the influenza vaccination and it was their responsible party who had consented to the vaccination. They stated in the electronic medical record, Resident #171 was ineligible for the influenza vaccination. Licensed Practical Nurse Unit Manager #8 stated that Resident #171 may have been on antibiotics at some point and that was why they were ineligible. Resident #171 was ordered to have antibiotics from 10/10/24-10/17/24. They stated they should have received the influenza vaccination at some point after 10/20/24. They stated the Unit Managers were responsible to ensure the residents on their units had consent/declination forms completed for vaccinations and that they received the vaccination if there was consent received. They stated Resident #171 should have received the vaccinations because the vaccinations could lessen the symptoms of influenza and pneumonia. The residents in the facility had the right to be offered a consent or declination to vaccinations.</p> <p>During a telephone interview on 12/19/24 at 4:30 PM, the Medical Director stated Resident #171 had severe dementia and their responsible party made medical decisions for them. They stated Resident #171 was not ineligible to receive the influenza vaccine and they should have received it. The Medical Director stated the pneumococcal vaccination should have been discussed with the responsible party and offered to the resident.</p> <p>2. Resident #10 was admitted with diagnoses adult failure to thrive (a decline in physical and mental functioning), depression, and anxiety. The Minimum Data Set, dated dated dated [DATE] documented Resident #10 was usually understood, usually understands and was cognitively intact.</p> <p>Review of the Absolut Care Determination of Capacity dated 7/19/24 documented Resident #10 lacked the capacity to make health care decisions due to a diagnosis of dementia.</p> <p>Review of the Resident Consent/Declination of Immunizations and Health Screening form dated 11/21/24 documented Resident #10's responsible party consented to the influenza vaccine and the pneumococcal vaccine.</p> <p>Review of the nursing progress notes dated 11/1/24 through 12/19/24 lacked documented evidence that the pneumococcal vaccine was ordered, refused, or given.</p> <p>Review of the Medication Administration Record dated 11/1/24-11/30/24 lacked documented evidence the pneumococcal vaccination was given.</p> <p>Review of the Medication Administration Record dated 12/1/24-12/31/24 documented the pneumococcal vaccine was ordered for a one time administration from 12/19/24-12/21/24, but was not signed by a nurse as given or refused.</p> <p>Review of the Immunization Report printed on 12/19/24 documented the Prevnar-20 (pneumococcal vaccine) was refused.</p> <p>(continued on next page)</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/19/24 at 11:46 AM Registered Nurse Unit Manager #3 stated Resident #10 has not received the pneumococcal vaccine because it has not been given yet and there was no order for it. Registered Nurse Unit Manager #3 stated they spoke with Resident #10 in May 2024, and they refused because they had already received the vaccine but did not know when. Nurse Practitioner #1 completed the consent form with Resident #10's responsible party on 11/21/24 and they may have requested having the pneumococcal vaccine spaced apart from the influenza vaccine. They stated both the medical providers and unit managers were responsible to put orders into the electronic medical record; nurses and unit managers were responsible to ensure vaccines were given.</p> <p>During an observation and interview on 12/19/24 at 11:59 AM, Nurse Practitioner #1 stated they remembered discussing the risks and benefits of vaccinations with Resident #10's Responsible Party and they had consented to both the influenza and pneumococcal vaccination. They stated they preferred to space vaccinations out by two weeks instead of giving them all at once. They stated, Resident #10 should have had an order to receive the pneumococcal vaccine on 12/6/24, two weeks after they received the influenza vaccine on 11/22/24. They stated there was nothing in Resident #10's chart contraindicating them from receiving the pneumococcal vaccine. They stated there should have been an order in the electronic medical record because there needed to be an order for it to be given. They stated they preferred the Unit Managers put the orders in because they were not comfortable putting the orders into the electronic medical record. Resident #10 should have received the pneumococcal vaccine because older adults could become very ill and respiratory illnesses spread a lot faster in the communal setting. Registered Nurse Unit Manager #3 was observed requesting an order for the pneumococcal vaccine for Resident #10 from Nurse Practitioner #1. Nurse Practitioner #1 gave a verbal order for the pneumococcal vaccine for Resident #10, and it was entered into the electronic medical record by Registered Nurse Unit Manager #3.</p> <p>During an interview on 12/20/24 at 9:11 AM, the Registered Nurse Assistant Director of Nursing/Infection Preventionist stated Resident #171 should have received the influenza vaccination and should have been offered the pneumococcal vaccination. They stated both vaccinations were important because in the geriatric population the vaccinations could protect them from respiratory symptoms and illness. They stated because Nurse Practitioner #1 usually waited a couple weeks between vaccinations, they felt Resident #10 received their pneumococcal vaccination timely. The physicians were responsible for giving the order for vaccinations, but at the end of the day the Unit Managers were responsible to make sure the consent/declination form was completed, and if there was consent for the vaccination, they were responsible to make sure the vaccination was administered.</p> <p>During an interview on 12/20/24 at 10:49 AM, the Director of Nursing stated they expected the influenza and pneumococcal vaccinations to be offered to the residents or the responsible parties. They expected the unit managers or nurses on the unit to obtain the orders for the vaccination and to administer the vaccinations.</p> <p>10 NYCRR 415.19(a)(1)</p>		