STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335340	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Cottages at Garden Grove, A Skilled Nrsg Comm	5460 Meltzer Court Cicero, NY 13039

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 46276 Based on observations, record review, and interviews during the recertification survey conducted 7/8/2024-7/16/2024, the facility failed to ensure all allegations of abuse, neglect, and mistreatment were thoroughly investigated or reported to the New York State Department of Health as required for 1 of 1 resident (Resident #77) reviewed. Specifically, Certified Nurse Aide #1 had a physical altercation with Resident #77 causing a skin tear (a wound caused when layers of skin separate or peel back) to the resident's arm and Certified Nurse Aide #1 was not immediately removed from direct resident care pending investigation. Additionally, the facility did not conduct a thorough investigation to rule out abuse and neglect and did not report the incident to the New York State Department of Health as required. Findings include: The facility policy, Dementia Care, dated 3/2024, documented upon admission all resident's cognitive status would be reviewed for an assessment of care needs; basic care approaches were to approach in a soft, low voice, re-direct whenever possible from a high stress environment, allow the resident to remain in a preferred location/environment if safe, and re-approach resident later if they expressed/chose to remain, recognizing that this was a preference/choice even in someone who had dementia. The facility policy, Abuse, reviewed by the facility 5/2024 documented all employees would be trained on appropriate interventions to deal with aggression and/or catastrophic reactions of residents; all staff were required to monitor staff for inappropriate behaviors including swearing, rough handing, or ignoring a resident's needs and report it to their supervisor and appropriate actions would be taken. The Nursing Supervisor was required to complete a Resident's Accident/Incident report if they became aware of any injury sustained by the Resident, and the Director of Nursing would investigate for any potential of abuse in accordance with New York State Department of Health's Investigative Guidelines for Allegations of Abuse/Neglect in Long-Term Care Facilities. Residents involved in allegations of abuse would be protected from harm during the investigation of reported abuse. If the Director of Nursing had reason to suspect the employee abused or mistreated a resident, options included: suspension of suspected employee until the investigation was complete; reassignment of suspected employee to another unit, change of assignment to prevent the involved employee contact with the involved resident; and termination. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335340	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2024
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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy, Resident Abuse Reporting, reviewed by the facility 5/2024, documented witnessed or suspected incidents of abuse were to be reported to the Department of Health when reasonable cause was established. The Supervisor would be responsible for notifying the Administrator/Director of Nursing of the witnessed or suspected incident of abuse. Upon receiving an allegation of abuse, the Nurse Manager/Designee would place the accused employee on immediate temporary suspension pending investigation and ensure that staff had correctly and accurately completed an incident report. Together, the Director of Nursing and Administrator would review the internal investigation to determine reasonable cause. The Nurse Manager/Designee would submit the Incident/Accident to the Department of Health within 24 hours and after reviewing with the Administrator and Director of Nursing. Resident #77 had diagnoses of restlessness and agitation and mild dementia with anxiety. The 5/20/2024 Minimum Data Set assessment documented the resident had severely impaired cognition, used a wheelchair, had highly impaired hearing, responded adequately to simple, direct communication, had behavioral symptoms not directed toward others 1-3 of 7 days, did not reject care, required moderate assistance for most activities of daily living, and did not have any skin tears. The 5/14/2024 admission assessment completed by Registered Nurse #17 documented Resident #77 was alert and oriented to person, place, time, and situation, made their own healthcare decisions, required extensive assistance with bed mobility and transfers and had multiple bruises on the right arm caused by multiple blood draws during hospitalization . The Comprehensive Care Plan documented: - on 5/14/2024 the resident had potential risk for impaired skin integrity related to limited mobility. Interventions were to inspect skin every shift for evidence of redness, excoriation, or breakdown; keep skin clean and dry; lubricate dry skin as needed, provide treatments as needed, and monitor lab work and report abnormalities as needed. - on 5/14/2024 the resident was at risk for falls due to impaired judgement and balance/coordination impairment. Interventions included keep in high visibility areas as applicable. - on 5/14/2024 the resident had a hearing deficit with interventions including staff should speak slowly, clearly, and loudly while facing the resident; approach the resident from the front and use gentle touch to get attention. - on 5/21/2024 the resident received buspirone (used to treat anxiety) related to diagnosis of agitation. Interventions included assess behavior pattern daily and assess effectiveness of medication. The buspirone was increased on 5/23/2024 due to agitation/anxiety in the evening. - on 5/22/2024 the resident had altered mood state as manifested by motor tension, autonomic hyperactivity, apprehensiveness, and hypervigilance. Interventions included encourage verbalizations of feelings, explore positive coping strategies, reduce environmental stimuli, and provide reassurance and emotional support. A 5/21/2024 Physician #6 order documented psychiatric consultation for behaviors. Document progress note every shift on the behaviors presented by the resident, any non-pharmacological interventions, and the result of the interventions. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 7/2024 resident care instructions documented the resident used a walker and a wheelchair, required partial/moderate assistance with transfers, and had verbally abusive behaviors and negative statements. The instructions did not include interventions for behavioral symptoms. The 7/7/2024 at 8:19 PM Registered Nurse Supervisor #2's nursing progress note documented Resident #77 was reportedly being combative with Certified Nurse Aide #1 during the shift. The resident punched Certified Nurse Aide #1 several times and Certified Nurse Aide #1 grabbed Resident #77's arm when the resident swung at them a fourth time, resulting in a 2.5-inch skin tear to the resident's left arm. The skin tear was covered with Suresite (a transparent film dressing). The family was notified, and a message was sent to the social worker and the Director of Nursing. There was no documented evidence an investigation was initiated to rule out abuse and neglect or that Registered Nurse Supervisor #2 immediately removed Certified Nurse Aide #1 from providing resident care. The 7/7/2024 Certified Nurse Aide Documentation Record documented the resident refused to bath or eat during the evening shift (3:00 PM-11:00 PM) and was signed by Certified Nurse Aide #1. There were no behaviors documented. A 7/7/2024 Physician #6 order documented cleanse left forearm skin tear with normal saline. Pat dry and apply Suresite dressing every 3 days. Monitor for signs and symptoms of infection and report to registered nurse. During an observation and interview on 7/8/2024 at 5:28 PM, Resident #77 was observed with a bandage and bruising to their left arm. Resident #77 stated Certified Nurse Aide #1 grabbed and cut their arm. The resident was able to answer screening questions appropriately. The facility Accident/Incident Report signed by Registered Nurse Supervisor # 2 on 7/11/2024 (four days after the incident) documented on 7/7/2024 at 7:21 PM an incident occurred in the living room of the resident's cottage. The resident was aggressive and had reportedly hit the certified nurse aide (unidentified). After multiple strikes the resident attempted to hit the certified nurse aide again. In an attempt to protect themself, the certified nurse aide grabbed the resident's arm which resulted in a skin tear due to the resident's fragile skin. The resident had an order for a psychiatric evaluation already in place due to agitation and anxiety and was seen 7/11 with recommendations for management of anxiety and symptoms. The offense was not reportable. The section First Accused Perpetrator had N/A written through it. The conclusion documented the investigation did not support the allegation of abuse, mistreatment, neglect. The report was signed by the Administrator and the Director of Nursing on 7/11/2024. There was no documented evidence how the facility concluded abuse or mistreatment did not occur or that Certified Nurse Aide #1 was suspended pending investigative outcome. Certified Nurse Aide #1's timecard documented the following hours worked: - on 7/7/2024 6:56 AM- 9:13 PM - on 7/8/2024 6:57 AM-10:33 PM (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- on 7/10/2024 7:04 AM- 9:04 PM - on 7/11/2024 7:04 AM-3:03 PM - on 7/12/2024 7:03 AM (survey exited prior to the end of Certified Nurse Aide #1's shift). During an interview on 7/11/2024 at 12:02 PM, Resident #77 stated Certified Nurse Aide #1 wheeled them to the dining room area (unsure of the date) and locked their wheelchair wheels so they could not move. They attempted to move in their chair and Certified Nurse Aide #1 repeatedly grabbed their wheelchair and stopped them from returning to their room. Certified Nurse Aide #1 grabbed their arm and when the resident pulled away, their arm was cut. During an interview on 7/11/2024 at 11:57 AM, Certified Nurse Aide #1 stated they worked on 7/7/2024 during the evening shift from 3:00 PM-9:00 PM. Licensed Practical Nurse #3 and they put the resident in their wheelchair and brought them to the common area. The resident later wanted to go back to their room, was combative, and struck them (Certified Nurse Aide #1). They grabbed the resident's arm to stop them from hitting and the resident sustained a skin tear. They thought it was appropriate to grab the resident's arm due to the resident's combative behaviors. They and Licensed Practical Nurse #3 reported the incident to Registered Nurse Supervisor #2 that evening. During a telephone interview on 7/11/2024 at 12:49 PM, Licensed Practical Nurse #3 stated they worked on 7/7/2024. They were administering medications in the resident's cottage. At approximately 6:00 PM- 6:30 PM, they were advised by Registered Nurse Supervisor #2 had arrived due to Resident #77 hitting Certified Nurse Aide #1 but had no knowledge of the incident only that the resident had a skin tear and they cleaned it and covered it with gauze. During a telephone interview on 7/11/2024 at 2:26 PM, Registered Nurse Supervisor #2 stated they worked on 7/7/2024 and were alerted Resident #77 had a skin tear to their left arm. They stated when they arrived, Certified Nurse Aide #1 informed them the resident had been combative and they grabbed the resident's arm to stop them from hitting them. Registered Nurse Supervisor did not think it was abuse and the only prevention implemented was the certified nurse aide was prevented from doing further care. Registered Nurse Supervisor #2 stated they were unaware if a full investigation was completed. During an interview on 7/11/2024 at 2:30 PM, the Director of Nursing stated the facility had not started a full investigation of the incident that occurred on 7/7/2024 because the New York State Department of Health entered the facility for the recertification survey on 7/8/2024. They stated Resident #77 was combative, their family was notified, and the resident had been seen by Social Services and progress notes would be added. On 7/11/2024 at 3:59 PM, the Director of Nursing submitted an Investigative Report to the New York State Department of Health, 4 days after the incident occurred. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow-up interview on 7/12/2024 at 9:23 AM, the Director of Nursing stated they were not made aware of the incident with Resident #77 and Certified Nurse Aide #1 until they completed rounds on the morning of 7/8/2024. They stated Registered Nurse Supervisor #2 had completed an incident report and abuse was not suspected. They asked Certified Nurse Aide #1 and Registered Nurse Supervisor #2 about the incident and concluded there was no abuse and did not notify anyone else. They stated they would investigate now that they were aware. During an interview on 7/12/2024 at 9:41 AM, the Administrator stated they were not aware of an incident between Certified Nurse Aide #1 and Resident #77 until the New York State Department of Health requested a full investigative report. They stated they were responsible for investigating to rule out abuse but had accepted the Director of Nursing's statement that abuse was unfounded. The Administrator stated they knew what incidents needed to be reported to the New York State Department of Health but did not do so as they thought abuse was ruled out; if abuse was ruled out, they did not send the accused home. During an interview on 7/12/2024 at 10:14 AM, Physician #6 stated they were familiar with Resident #77 who had diagnoses of dementia and anxiety and had seen them on 7/10/2024. They were not advised of any incidents between Certified Nurse Aide #1 and Resident #77 and was not aware the resident had a skin tear. They thought it was appropriate for Certified Nurse Aide #1 to grab Resident #77's arm if it were done in self-defense. 10NYCRR 415.4(b)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 50561 Based on observations, record review, and interviews during the recertification and abbreviated (NY00340968, NY00316430, and NY00302422) surveys conducted 7/8/2024-7/16/2024, the facility did not ensure residents were given the appropriate treatment and services to maintain or improve their ability to carry out the activities of daily living for 1 of 4 residents (Resident #61) reviewed. Specifically, Resident #61 leaned far to the right in their wheelchair and was not assisted with repositioning. Findings include: The 9/2014 facility policy Repositioning, documented elders would receive the required assistance for repositioning based on their assessment from the interdisciplinary team and that repositioning in bed/chair was assured for those elders who needed assistance. Resident #61 was admitted to the facility with diagnoses including unspecified dementia, multiple sclerosis (a central nervous system disease), generalized muscle weakness, and unspecified pain. The 5/17/2024 Minimum Data Set assessment documented the resident had severely impaired daily decision making skills, was rarely understood, had one fall, required moderate assistance with sitting to lying and transfers, and used a manual wheelchair. The 3/22/2023 Occupational Therapist #44 discharge summary documented the resident was able to maintain static (sitting still) sitting with contact guard assistance. Therapy provided to address standing tolerance and sitting balance. Recommendations included to perform activities of daily living in seated position as much as possible. The 1/29/2024 Physical Therapist #45 discharge summary documented the resident required stand by assistance to maintain static (with no movement) and dynamic (with movement) sitting. The comprehensive care plan revised 2/20/2024 documented the resident was at risk for falls due to balance impairment. Interventions included reposition in chair as needed. The comprehensive care plan revised 5/15/2024 documented the resident required set up or clean up assistance with eating. The care instructions dated 7/9/2024 documented, Dycem (non-slip material) in wheelchair at all times. Do not leave in wheelchair unsupervised. The resident was observed: -On 7/8/2024 at 5:35 PM, sitting in their wheelchair leaning far to their right side, using their right arm to eat and drink. Their food fell off their fork and the milk spilled to the floor when they tried to bring the utensil and cup to their mouth. -On 7/9/2024 at 9:56 AM, sitting in their wheelchair leaning far to their right. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 7/10/2024 at 10:44 AM, sitting in their wheelchair leaning far to the right with their right underarm in direct contact with wheelchair arm rest. -On 7/10/2024 at 12:30 PM, sitting in their wheelchair leaning far to the right. Certified Nurse Aide #12 used the waist band of the resident's pants to straighten the resident. -On 7/10/2024 at 12:53 PM, sitting in their wheelchair leaning far to the right side, using their right arm to eat salad. Lettuce dropped off their fork onto the floor. -On 7/15/2024 at 12:56 PM, sitting in their wheelchair eating lunch, leaning to the far right. They were able to straighten their posture briefly, but immediately went back to a right leaning posture. During an interview on 7/16/2024 at 9:14 AM, Certified Nurse Aide #12 stated if they noticed a resident was leaning in a chair, they should realign the resident and report it to the nurse who could trigger a physical therapy evaluation. Resident #61 required the assistance of one for positioning and tended to lean to the side. During mealtimes they sometimes leaned with their food and the food dropped onto the floor. Therapy worked with the resident, but they did not believe anything was changed to help with positioning. During an interview on 7/16/24 at 9:37 AM, Licensed Practical Nurse #16 stated if there was a positioning concern with a resident, they would do whatever they could to make sure the resident was properly aligned. If they saw a resident was leaning in their chair and it was not ordinary behavior, they would call the Nurse Manager to assess. If the leaning affected the resident's ability to eat, they should straighten them and help them eat. Resident #61 sometimes needed help when sitting in their chair due to leaning and sitting to the side of the chair. They did not see the resident at mealtimes due to covering another cottage during mealtimes but did not think the resident required any assistance with eating. During an interview on 7/16/2024 at 11:15 AM, the Assistant Director of Nursing stated if staff saw a positioning issue with a resident, such as sliding or leaning in a chair, they should reposition the resident. If it was an ongoing issue, they expected a physical therapy evaluation to be triggered. They expected the same if the leaning occurred during mealtime. They were not sure what Resident #61's assistance level for positioning or eating was. They had not seen the resident lately, but the last time they did, the resident was self-propelling in their wheelchair and did not notice any abnormalities. Proper positioning was important for swallowing, comfort, safety, and for prevention of wounds. During an interview on 7/16/24 at 11:47 AM, Occupational Therapist #15 stated on admission residents were assessed for appropriate wheelchairs, cushions, and need for adaptive equipment such as lateral supports. If they noticed a change in a resident or received an alert from a Nurse Manager, they would reassess the resident. If a resident leaned in their wheelchair, they would reassess the wheelchair or the need for lateral supports to correct leaning. Resident #61 leaned to the right, but they had never worked with them. They thought lateral supports would agitate the resident due to their history of behaviors. Blankets might work if placed in the wheelchair for positioning because they could be removed by the resident, whereas the lateral supports could not. They did not believe lateral supports had been tried with the resident. Proper positioning was important to prevent skin breakdown as leaning could agitate the resident's underarm. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10NYCRR 415.12(a)(3)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 48675 Based on observation, record review, and interviews during the recertification and abbreviated (NY00302422, NY00316430, NY00340968) surveys conducted 7/8/2024-7/16/2024, the facility did not ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 of 7 residents (Resident #100) reviewed. Specifically, Resident #100 was not assisted with removing unwanted facial hair and had unclean and untrimmed fingernails. Findings include: The facility policy, Standard of Care: Personal Hygiene/Grooming/Dressing/Eating- ADL Function/Rehab Potential, revised 9/2014 documented every elder should be encouraged and assisted as necessary to maintain personal hygiene for optimal physical and psychological well-being. Daily morning care would consist of shaving and fingernails would be cleaned and checked for trimming on showers days. Resident #100 had diagnoses including dementia and anxiety. The 5/20/2024 Minimum Data Set assessment documented the resident had severely impaired cognition, required partial/moderate assistance with personal hygiene, substantial/maximal assistance with showering/bathing, and did not refuse care. The comprehensive care plan initiated 2/6/2024 documented the resident had a self-care deficit related to dementia. Interventions included nail care and shaving assistance per customary routine preferences, showers on Wednesday and Saturday evening, and the resident required substantial/maximal assistance with bathing and general personal hygiene. The 7/2024 Certified Nurse Aide Resident Care Record documented the resident received a shower during the evening shift on 7/6/2024 and 7/10/2024 and received assistance with personal hygiene from 7/8/2024-7/14/2024 on both day and evening shifts. Resident #100 was observed at the following times: - On 7/8/2024 at 6:20 PM, seated in their wheelchair with thick black hair covering their upper lip, long gray/white hair under their chin, and their fingernails were long and unkept with brown debris underneath the fingernails. The resident stated they did not want facial hair. - On 7/9/2024 at 2:59 PM, seated in their wheelchair with thick black hair covering their upper lip, long gray/white hair under their chin, and their fingernails were long and unkept with brown debris underneath most of them. - On 7/10/2024 at 12:30 PM, seated in their wheelchair with thick black hair covering their upper lip, long gray/white hair under their chin, and their fingernails were long and unkept with brown debris underneath most of them. -On 7/15/2924 at 11:10 AM, seated in their wheelchair with thick black hair covering their upper lip and long gray/white hair under their chin. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/15/2024 at 1:52 PM, Certified Nurse Aide #34 stated they looked at a resident's care instructions to see how to properly care for the resident. Personal hygiene was completed every day and consisted of bathing, dressing, oral care, nail care, and shaving. They stated they documented all care provided and if a resident refused, they would document the refusal and notify the nurse so they could reapproach the resident. They were familiar with Resident #100, they did not refuse care, and they assisted with their care on the morning of 7/15/2024. They did notice Resident #100's facial hair earlier but did not have time to remove it. They planned on shaving the resident later that day. They stated long, unwanted facial hair and dirty fingernails were not dignified. During an interview on 7/15/2024 at 2:24 PM, Certified Nurse Aide #37 stated personal hygiene consisted of dressing, bathing, shaving, and nail care. They were familiar with Resident #100, assisted with their care earlier that day, and the resident did not refuse care. They did notice Resident #100's facial hair, but they were already up and, in their wheelchair, so they did not shave them. They planned on cutting Resident#100's fingernails. It was important to complete all personal hygiene including shaving and nail care daily so the resident would feel good and not cut themselves. During an interview on 7/16/2024 at 9:53 AM, Licensed Practical Nurse #29 stated staff looked at a resident's care plan or care instructions to tell how to properly care for the resident. Personal hygiene was completed each shift and consisted of washing a resident's face and body, nail care, hair care, shaving, and oral care. Nail care was also done on shower days. If a resident refused care, the certified nurse aides should document the refusal and notify the nurse. They had not been notified of any refusals by Resident #100. They stated it was important for the certified nurse aides to offer shaving and cutting fingernails to maintain Resident #100's dignity. During an interview on 7/16/2024 at 11:15 AM, the Assistant Director of Nursing stated personal hygiene consisted of bathing, oral care, shaving, nail care, and should be completed daily for each resident and as needed. If a resident refused any kind of care, the certified nurse aide should document the refusal and notify the nurse. If personal hygiene was signed off as completed, that meant it was done. They stated it was important to shave and provide nail care to Resident #100 to maintain their dignity. 10NYCRR 415.12(a)(3)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 46276 Based on observation, interview, and record review during the recertification and abbreviated (NY00316340 and NY00336542) surveys conducted 7/8/2024-7/16/2024, the facility did not ensure residents were provided an ongoing program to support their choice of activities, designed to meet their interests and support their physical, mental, and psychosocial well-being for 1 of 5 residents (Resident #120) reviewed. Specifically, Resident #120 was not offered meaningful activities that included their interests and preferences. Findings include: The undated facility policy, Recreation Philosophy and Practice, documented the Recreation Department honored freedom of choice for their household members, and enabled elders/persons to either actively or passively participate in leisure experiences to enhance quality of life via groups or one to one endeavors targeted to provide experiences for success. The facility Admission Agreement dated 5/2024 documented covered services included an activities program and would provide a varied schedule of activities to meet resident physical, psychological, spiritual, and individual needs. Resident #120 had diagnoses of peripheral vascular disease (poor circulation), diabetes, and chronic kidney disease. The 1/29/2024 Admission Minimum Data Set assessment documented the resident's cognition was moderately impaired, they felt down, or depressed, and daily preferences included listening to classical music, attending religious services, and going outside for fresh air when weather permitted. The comprehensive care plan initiated 2/7/2024 documented a focus of therapeutic recreation. Interventions included to ensure the resident had an activities calendar in their room, invite to programs of interest such as music, exercising, watching sports of interest, reading, spiritual time, reminiscing, and spending time outdoors when the weather permitted. The July 2024 activity schedule for Cottage #87 was posted on a white board in the common area and was placed on top of the fireplace hearth. The board sat in the corner of the hearth and wall and was approximately 6 feet from the floor and not highly visible. Activity times were listed as AM and PM and included: - On 7/8/2024 AM church, PM good news. - On 7/9/2024 AM cow craft, PM milk/cookies. - On 7/10/2024 AM exercise, PM manicures. - On 7/11/2024 AM exercise, PM musical. - On 7/12/2024 AM BINGO, PM snacks/chats. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: The Cottages at Garden Grove, A Skilled Nrsg Comm		STREET ADDRESS, CITY, STATE, ZIP CODE: 5460 Meltzer Court Cicero, NY 13039	

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 7/15/2024 AM church, PM strolls. - On 7/16/2024 AM exercise, PM gardening. The July 2024 activity attendance record for Resident #120 did not document attendance for music, spiritual services, or going outdoors per the resident's preferences. There were no documented activity progress notes for Resident #120. During an observation and interview on 7/8/2024 at 1:48 PM, Resident #120 was sitting in their room on their bed. There were no personal effects in their room. A July 2024 activity calendar was hanging on a bulletin board to the right of the door and was not visible from the main part of the room. The resident stated they loved classical music but did not have means to listen to it. They enjoyed socializing with other people of the same sex, but they were the only cognitive one of their sex in their building. They loved to spend time outdoors. They were only invited to attend BINGO which they did not like. During an observation on 7/10/2024 at 12:31 PM, the resident was sitting at a dining room table with a cognitively impaired resident. There was no interaction between the residents. During an observation and follow-up interview on 7/15/2024 at 10:47 AM, Resident #120 was observed self-propelling in their wheelchair near the exit door of the Cottage and asked to go outdoors or sit on the porch. Certified Nurse Aide # 25 told the resident they could not go outside. Resident #120 propelled themself over to the dining room window and sat and looked outside. The resident became tearful and stated they had rules to follow so what could they do? They stated they were a practicing Roman Catholic and had only spoken to a priest one time but would love to attend church. They felt lonely, and they wanted to socialize with other residents of the same sex. During an interview on 7/15/2024 at 11:35 AM, Recreation Specialist #2 stated they were responsible for activity programs for three Cottages, including Resident #120's. Resident #120 liked music, going outdoors, and socializing. They tried to incorporate those preferences into their programs but often did not have enough time. They had played a 50-minute church service on the television in Resident #120's cottage so they could run over to a different cottage and finish up those resident activities. Resident #120 was not invited to the church service. There were no social groups, but they tried to bring residents to other buildings to socialize. Outside vendors did not come to provide activities due to the facility requirement of background checks and paperwork that took too long to process. They had not brought Resident #120 to any other buildings for socialization. They stated the resident had not been outside lately and did not have any classical music in their room to listen to. During an interview on 7/16/2024 at 8:48 AM, the Director of Therapeutic Recreation stated they had a full caseload and was responsible for activity programs in Cottages #31, #51 and #61. They stated the facility had not had any outside vendors come to the facility since COVID-19. They had a priest come only when needed and did not have any Catholic mass services. They did not have social groups except for Resident Council and a cooking group. They had not had outdoor activities such as cookouts in a long time. They were not set up for those types of events. Residents were not allowed to go outside if the temperature was 85 degrees Fahrenheit or higher for safety reasons. 10NYCRR 415.5(f)(1)

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 46276 Based on observation, record review, and interview during the recertification and abbreviated (NY00316430) surveys conducted 7/8/2024-7/16/2024, the facility did not ensure residents with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote wound healing, prevent infection, and prevent new ulcers from developing for 2 of 6 residents (Residents #125 and #7) reviewed. Specifically, Resident #125 did not have an alternating pressure overlay (a specialty mattress overlay that provides air flow to relieve pressure) in place as ordered, and Resident #7's wound treatments were not completed as ordered. Findings include: The facility policy, Skin Care, dated 3/2014 documented residents with pressure ulcers would receive the necessary treatment and services to promote healing, prevent infection, and prevent new pressure ulcers from developing. The Nurse Manager would assess all residents with any staged pressure ulcers weekly, collect data, and document on the skin tracking worksheet. Depending on the statistics, continuing education would be given on prevention and treatments. The facility policy, Alternating Pressure Mattress Overlay, revised 3/2022 documented an order would be obtained from the provider. The licensed practical nurses would check the function and comfort mode of the mattress every shift, sign off on the Treatment Administration Record, and report any unresolved issues to the Nurse Manager or Supervisor. 1) Resident #7 had diagnoses including an unstageable pressure ulcer (full thickness tissue loss in which the base of the ulcer is covered by dead tissue) of the right heel, protein-calorie malnutrition, and local infections of the skin and subcutaneous (below the surface) tissue. The 5/15/2024 Minimum Data Set assessment documented the resident had severely impaired cognition, did not reject, had one Stage 3 pressure ulcer (full thickness tissue loss), had a pressure reducing device for their bed, and received pressure injury care. The 5/15/2024 at 8:52 AM physician treatment order documented Medi Honey paste (a medical grade honey product used for wound healing) apply 1 applicator by topical route once daily. Wash right heel pressure ulcer with soap and water, pat dry, apply skin prep (skin protectant) around the wound, apply Medi Honey to the wound base, and cover with adhesive foam dressing. Change daily and as needed. The Comprehensive Care Plan initiated 6/24/2022 documented the resident had skin breakdown related to pressure on their right heel. Interventions included to assess characteristics of wound during treatment care and document weekly; elevate heels off bed with pillow supplied by therapy; turn and position every 2-3 hours as needed; foot cradle on end of bed, alternating air mattress set to middle firmness and use pressure relieving devices in bed or chair as indicated. The July 2024 resident care instructions documented use pressure relief mattress, elevate heels off the bed with therapy supplied pillow; use extra caution when ambulating, dressing and repositioning due to new blood thinner order; turn and position every 2 to 3 hours and as needed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 6/4/2024-6/18/2024 Nurse Practitioner #35 progress notes documented the resident had a Stage 3 pressure ulcer measuring 1.5 centimeters by 0.5 centimeters by 0.1 centimeters on 6/4/2024 and measured 1.2 centimeters by 0.8 centimeters by 0.1 centimeters on 6/18/2024 and was improving. A 7/2/2024 at 10:13 AM Assistant Director of Nursing #21 progress note documented the resident had a healing Stage 3 pressure ulcer to the right heel measuring 1.9 centimeters x 1.5 centimeters and containing 100% pale pink tissue. No signs or symptoms of infection were noted. There was a moderate amount of serosanguinous (mixture of serum and blood) drainage on the old dressing. The 7/2024 Treatment Administration Record documented to wash right heel pressure ulcer with soap and water, pat dry. Apply skin prep around wound and allow to air dry. Apply Medi Honey 100% topical paste, apply 1 applicator to wound base. Cover with gauze, cover with abdominal pad (absorbent dressing), and wrap with elastic gauze every day during the 3:00 PM- 11:00 PM shift and as needed. The Treatment Administration Record documented Licensed Practical Nurse #36 did not complete the treatment to their right heel on 7/8/2024, 7/9/2024, and 7/10/2024 due to not having supplies. During an interview on 7/15/2024 at 9:32 AM, Licensed Practical Nurse #20 stated the resident's treatment to their right heel was scheduled for the 3:00 PM-11:00 PM shift. If supplies were not available, nurses should notify their supervisor. During a treatment observation and follow-up interview on 7/15/2024 at 2:32 PM, Licensed Practical Nurse #20 applied Medi Honey topical paste to the wound and covered the right heel with an abdominal gauze pad and Kerlix bandage. The wound appeared to be a clean Stage 3 ulcer with some maceration (moisture damage) around the perimeter. The 7/15/2024 at 4:04 PM Assistant Director of Nursing #21 progress note documented a late entry from the 7:00 AM-3:00 PM shift. The resident's wound care supplies were noted to be unavailable per the licensed practical nurse documentation and after consult with the wound care nurse the treatment was changed. During an interview on 7/16/2024 at 9:16 AM, Assistant Director of Nursing #21 stated they were responsible for ordering wound care supplies. They stated the nurses would write down what was needed, and they would order them. Supplies were delivered every Wednesday. They stated the resident's lack of wound care supplies triggered on the 24-hour report and they became aware on 7/15/2024 the treatment was not completed for 3 days. They stated it was unacceptable for the resident's treatment not to be completed by Licensed Practical Nurse #36 due to a lack of supplies; the Registered Nurse Supervisor should have been notified and the resident's pressure ulcer could have gotten worse or infected. During an interview on 7/16/2024 at 9:59 AM, Infection Preventionist #46 stated also functioned as the wound care nurse for the facility. They stated Resident #7 had a stage 3 pressure ulcer to their right heel and arterial ulcers to the surface of their toes. They stated they were not aware the resident's treatments were not completed until 7/15/2024 when the Assistant Director of Nursing approached them and asked for an alternate treatment. The Infection Preventionist stated it was unacceptable for the resident to not have their wound care for 3 days and could lead to infection of the wound or it could worsen. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Voicemail messages were left with Licensed Practical Nurse #36 and no return calls were received. 2) Resident #125 had diagnoses including dementia, Stage 2 (partial thickness skin loss). pressure ulcers of the right and left heels. The 6/21/2024 Minimum Data Set assessment documented the resident had severely impaired cognition, did not exhibit behaviors, did not reject care, required partial/moderate assistance for bed mobility and transfers, was at risk for developing pressure ulcers, had two Stage 2 pressure ulcers that were not present on admission, and received pressure ulcer care. The comprehensive care plan initiated on 5/20/2024 documented the resident had impaired skin integrity related to a Stage 2 pressure ulcer on their right and left heel. The interventions included alternating pressure overlay on the bed, apply treatments as ordered, assess skin every shift, elevate heels off the bed, and turn and position every two hours while in bed. The 6/26/2024 physician order documented alternating pressure overlay on the bed, set to middle firmness, and check inflation every shift. Resident #125 was observed at the following times: - On 7/8/2024 at 1:26 PM, sitting in their wheelchair with a regular mattress on their bed. The alternating pressure overlay was rolled up on the floor next to the dresser and the pump was lying on top of the dresser. - On 7/9/2024 at 9:58 AM, sitting in their wheelchair with a regular mattress on their bed. The alternating pressure overlay was rolled up on the floor next to the dresser and the pump was lying on top of the dresser. - On 7/10/2024 at 6:23 AM, lying on their back in bed, on a regular mattress. The alternating pressure overlay was rolled up on the floor next to the dresser and the pump was lying on top of the dresser. - On 7/11/2024 at 7:16 AM, lying on their back in bed, on a regular mattress. The alternating pressure overlay was rolled up on the floor next to the dresser and the pump was lying on top of the dresser. The July 2024 treatment administration record documented alternating pressure overlay checks every shift. Check functioning/inflation and set to middle firmness. The alternating pressure overlay was documented as checked: - On 7/8/2024 by Licensed Practical Nurse #28 from 7:00 AM- 3:00 PM; by Licensed Practical Nurse #30 from 3:00 PM- 11:00 PM; by Licensed Practical Nurse #32 from 11:00 PM- 7:00 AM. - On 7/9/2024 by Licensed Practical Nurse #29 from 7:00 AM- 3:00 PM; by Licensed Practical Nurse #30 from 3:00 PM- 11:00 PM; by Licensed Practical Nurse #32 from 11:00 PM- 7:00 AM. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 7/10/2024 by Licensed Practical Nurse #28 from 7:00 AM- 3:00 PM; by Licensed Practical Nurse #28; by Licensed Practical Nurse #30 from 3:00 PM- 11:00 PM; by Licensed Practical Nurse #32 from 11:00 PM- 7:00 AM. - On 7/11/2024 by Licensed Practical Nurse #29 from 7:00 AM- 3:00 PM; by Licensed Practical Nurse #31 from 3:00 PM- 11:00 PM; by Licensed Practical Nurse #33 from 11:00 PM- 7:00 AM. During an interview on 7/15/2024 at 1:59 PM, Certified Nurse Aide #34 stated they thought Resident #125 had pressure ulcers on their heels and was supposed to be on an alternating pressure overlay, be turned and positioned frequently, and have their heels elevated while in bed. These tasks were listed on Resident #125's care instructions. The nurses were responsible for the mattress settings, and ensured it was in place and functioning. They stated they did not notice if the mattress was in place, and they would notify a nurse if there were any issues. They stated it was important for the alternating pressure overlay to be in place and working to prevent Resident #125's pressure ulcers from getting worse. During an interview on 7/16/2024 at 9:41 AM, Licensed Practical Nurse #29 stated all direct care staff were responsible for checking to ensure alternating pressure overlays were in place and functioning. The nurses had to sign off every shift that the overlay was functioning correctly, and the settings were correct. They did not recall the last time they checked Resident #125's alternating pressure overlay, but if they signed it off in the treatment administration record it meant they observed it working. They stated it was important to check the alternating pressure overlay as ordered because if it was not in place or working properly it could put Resident #125 at risk for further skin breakdown on their heels. During an interview on 7/16/2024 at 11:07 PM, the Assistant Director of Nursing #21 stated staff looked at a resident's care plan to tell them how to properly care for the resident. All alternating pressure overlays needed a physician order, and the order would include the correct setting. The licensed practical nurses had to sign off every shift that it was working properly and set correctly. They expected the alternating pressure overlay to be in place if the licensed practical nurses were signing off on it and would expect the staff to notify a manager or provider if it was not in place. They stated they had heard from staff it was on the floor all week and not being used. Any nurse could have placed it on the bed and turned it on because there was an order for it. They stated it was important to ensure Resident #125's alternating pressure overlay was in place and working to prevent further skin breakdown. 10NYCRR 415.12(c)(1)(2) 48675

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 33421 48675 Based on observation and interview during the recertification and abbreviated (NY00316430 and NY00336542) surveys conducted 7/8/2024-7/16/2024, the facility did not ensure each resident received food and drink that was palatable, flavorful, and at an appetizing temperature for 2 of 2 meals reviewed (the 7/10/2024 lunch meal in Cottage 60 and the 7/15/2024 lunch meal in Cottage 31). Specifically, food was not served at palatable and appetizing temperatures during the lunch meals on 7/10/2024 and 7/15/2024 and Residents #40 and #105 stated the food did not taste good. Findings include: The facility policy, Food Handling Guidelines, revised 1/2024 documented: - Foods should be held hot for service at a temperature of 135 degrees or higher. - Foods should be covered during hot holding whenever possible to minimize the effects of evaporative cooling on the surface. - Foods should be held cold for service at a temperature of 41 degrees or less. During an interview on 7/8/2024 at 2:35 PM, Resident #40 stated they did not care for the food. The hot food was not hot, and the cold food was not cold. During an interview on 7/8/2024 at 2:17 PM, Resident #105 stated the hot food was not hot, and the cold food was not cold by the time it was served to them. During a lunch meal observation on 7/10/2024 at 12:14 PM in Cottage 60, Resident #40 was served their lunch meal tray. A replacement tray was ordered, and Resident #40's original meal tray was tested . The cheeseburger was measured at 130 degrees Fahrenheit, the milk was 58 degrees Fahrenheit, the apple juice was 69 degrees Fahrenheit, and the water was 53 degrees Fahrenheit. During an interview on 7/10/2024 at 12:38 PM, Dietary [NAME] #22 stated food was precooked, reheated in the oven before it was served, and the oven top was kept on low while the meal was being plated. They stated the certified nurse aides could pre-pour residents' drinks but would usually pour them while they were plating each resident's food. All food had temperatures taken before it was served and the hot food was supposed to be 165 degrees Fahrenheit and above, and any cold drinks or food were supposed to be under 40 degrees Fahrenheit. During a lunch meal observation on 7/15/2024 at 12:12 PM in Cottage 31, Resident #105 was served their lunch meal tray. A replacement tray was ordered, and Resident #40's original meal tray was tested . The carrot salad was 52 degrees Fahrenheit, and the apple juice was 53 degrees Fahrenheit. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/15/2024 at 12:21 PM, Certified Nurse Aide #34 stated they were unsure when the refrigerator was last stocked. They had just opened a new apple juice when lunch was being served. Cold food items should have been served between 34-36 degrees Fahrenheit and hot food items close to 180 degrees Fahrenheit. They stated the apple juice container did not feel warm, so they thought it was fine to serve it to the residents. During an interview on 7/16/2024 at 9:11 AM, Food Service Director #23 stated they completed test trays sporadically throughout the month and would test a meal tray from each cottage. Cold food items were to be served below 40 degrees and hot food at 140 degrees or above. They sent the results to the Administrator, Director of Nursing, food service staff, and the Nurse Managers. Temperatures of 52.5, 58, and 69 degrees Fahrenheit were not acceptable for apple juice, carrot salad, and milk. Cold drinks should always be served cold, staff should pour resident drinks at the time of service, and if they pre-poured drinks they should be covered and placed back into the refrigerator until served. During an interview on 7/16/2024 at 9:18 AM, Registered Dietitian #24 stated they completed test trays twice a week. Hot food was supposed to be served at 140 degrees or above and cold food items were supposed to be below 40 degrees. The Nurse Managers would review the results with the nursing staff because they were responsible for serving the meals to the residents. 10NYCRR 415.14(d)(1)(2) 49448

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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. 50561 Based on observation, record review, and interview during the recertification and abbreviated (NY00336542) surveys conducted 7/8/2024-7/16/2024, the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 of 2 staff (Licensed Practical Nurse #7 and Certified Nurse Aide #8) reviewed. Specifically, Licensed Practical Nurse #7 did not perform hand hygiene or change their gloves during wound care, and Licensed Practical Nurse #7 and Certified Nurse Aide #8 did not perform hand hygiene or wear gowns when providing incontinence and wound care to Resident #106 who was on enhanced barrier precautions. Findings include: The facility policy, Hand Washing, revised 5/27/2022, documented all personnel were required to perform hand hygiene after contact with wound dressings and if moving from a contaminated body site to a clean body site. The facility policy, Enhanced Barrier Precautions, dated 5/2024, documented the facility would implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms by employing targeted gown and glove use during high contact resident care activities such as wound and hygiene care. Resident #106 was admitted to the facility with diagnoses including a Stage 4 pressure ulcer (full thickness tissue loss with exposed bone, tendon, or muscle pressure) of the left buttock. The 6/7/2024 Minimum Data Set assessment documented the resident had severely impaired cognition, was dependent with most activities of daily living, was incontinent of bowel and bladder, and had a pressure ulcer. The comprehensive care plan initiated on 1/25/2024 and revised on 3/5/2024 documented the resident had a Stage 4 pressure ulcer. Interventions included perform weekly wound rounds, apply local treatments as ordered, and to monitor for signs and symptoms of infection. The comprehensive care plan initiated on 7/8/2024, documented the resident was on enhanced barrier precautions related to an active infection. Interventions included maintain universal precautions at all times and infection control practices through proper handwashing. The facility's education record documented Licensed Practical Nurse #7 completed hand hygiene training on 10/28/2023, enhanced barrier training on 4/22/2024, and infection prevention and control training on 4/23/2024. The training record for Certified Nurse Aide #8 documented they completed hand hygiene training on 12/12/2023. There was no documented evidence of enhanced barrier precaution training or infection prevention and control training. The following observations were made: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 7/9/2024 at 9:09 AM, an enhanced barrier precautions sign and a bin with isolation gowns was outside of Resident #106's room. The sign indicated gowns and gloves were needed for high contact activities including personal hygiene and wound care. - On 7/11/2024 at 10:30 AM, the Resident #106 was in bed. Licensed Practical Nurse #7 entered the resident's room, washed their hands, applied clean gloves, started to remove the resident's brief, found the resident was incontinent of stool, removed their gloves, and exited the room to get assistance without performing hand hygiene. Licensed Practical Nurse #7 returned with Certified Nurse Aide #8. They applied clean gloves and provided incontinence care. Licensed Practical Nurse #7 placed soiled linen directly on the floor then changed their gloves without performing hand hygiene, removed the old dressing from the wound, prepared new packing gauze with saline, and packed the wound using a cotton swab and their hand without cleansing the wound. They did not change their gloves after the soiled dressing was removed or before the new dressing was applied. Certified Nurse Aide #8 removed their gloves and left the room without performing hand hygiene. Licensed Practical Nurse #7 and Certified Nurse Aide #8 did not wear a gown while performing care. During an interview on 7/15/2024 at 1:34 PM, Certified Nurse Aide #8 stated if a resident was on precautions there would be a sign outside the room that directed what type of personal protective equipment was needed in the room. All personal protective equipment should be in a bin outside the door. Resident #106 was on precautions due to an open wound on their bottom and had a sign and a bin outside of their room. The sign said gown and gloves were required if they were dealing directly with the wound, which they did not. They thought they had precaution and hand washing training this past June and that it was important that precautions were followed to prevent the spread of infection and resident illness. During an interview on 7/15/2024 at 1:53 PM, Licensed Practical Nurse #7 stated residents on precautions had a sign and a bin with personal protective equipment outside their door. They should wash their hands before and after entering the room of any resident on precautions. They were unsure what enhanced barrier precautions were. They stated after they removed the old dressing, they should have changed their gloves to prevent contamination and the soiled supplies should not have been placed on the floor. They stated 7/15/2024 was the first day Resident #106 was on precautions and the first day there was a sign outside their door. They thought their last infection control training was last winter. They stated it was important to maintain proper precautions including hand hygiene to prevent the spread of infection and to cleanse Resident #106's wound to keep it from becoming infected. During an interview on 7/15/2024 at 2:18 PM, Registered Unit Nurse Manager #14 stated they put precaution signs and bins outside resident rooms and expected staff to follow what was on the signage. A wound treatment order should include cleansing instructions and gloves should be changed after removing an old dressing to prevent counter contamination. Soiled supplies should have been placed in the garbage not on the floor. Resident #106 had been on enhanced barrier precautions for about a month and had a sign and bin outside their room. They stated an order that included cleansing was important to promote healing and prevent infection, and following precautions was important for the same reasons. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335340	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2024
NAME OF PROVIDER OR SUPPLIER The Cottages at Garden Grove, A Skilled Nrsg Comm		STREET ADDRESS, CITY, STATE, ZIP CODE 5460 Meltzer Court Cicero, NY 13039	

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/16/2024 at 9:59 AM, Infection Preventionist #46 stated all staff received yearly infection control training. Resident #106 had a Stage 4 pressure ulcer that required treatments. Their 6/28/2024 wound treatment order was not complete and did not include cleansing the wound. The treatment order was updated on 7/15/2024 and had instructions on cleansing the wound. They stated it was unacceptable for the nurse to not remove their gloves appropriately when performing wound care on Resident #106 and it could have led to an infection in the wound, or the wound could worsen. 10 NYCRR 415.19(a)(b)