

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/31/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335353	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/02/2024
NAME OF PROVIDER OR SUPPLIER Heritage Village Rehab and Skilled Nursing Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 4570 Route 60 Gerry, NY 14740	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43785 Based on interviews and record review conducted during an Extended Recertification survey completed on 8/2/24, the facility did not make prompt efforts to resolve grievances for two (Residents #25 and #45) of three residents reviewed. Specifically, there were no grievance forms filed and there was lack of follow through and resolution for missing property. The findings are: The New York State Department of Health packet titled Your Rights as a Nursing Home Resident in New York State dated 2022 documented Residents had the right to expect the facility to promptly investigate and try to resolve their concerns. The policy and procedure titled Grievances dated 2/28/2017 documented the facility will specifically notify the resident/representative of the right to file a complaint with the facility concerning misappropriation of resident property in the facility. Residents and representatives may file a complaint personally or in writing to the Grievance Officer. The Social Work Director has been designated as the Grievance Officer who will be responsible for receiving and tracking grievances through their conclusion, lead necessary investigations as appropriate, communicate with residents throughout the process to resolution and coordinate with other staff including the Administrator as may be indicated by specific allegations. Grievances can also be filed with the administrator, supervisors, department heads, or social work. All grievances will be reviewed and investigated, a response will be given within 5 business days. Written responses are available upon request. The facility will promote the grievance process throughout the organization by notifying residents of their rights related to grievances as well as educating all those affected by potential grievances or concerns on the facility grievance process. 1. Resident #25 had diagnoses which include diabetes mellitus type II, chronic obstructive pulmonary disease (lung disease), and major depressive disorder. The Minimum Data Set (a resident assessment tool) dated 5/22/24 documented the resident was cognitively intact. (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/29/24 at 10:23 AM, Resident #25 stated they had clothing go missing at the facility. They stated they had received two pairs of pants and a 6-pack of various color short sleeve T-shirts for Christmas in December 2023. They stated they had taken the T-shirts and pants to get tagged and the items were never returned to them. Resident #25 stated they had notified Registered Nurse #1 and Social Worker #1 of the missing items and had been told there was nothing they could do. The items were gifts received for Christmas. Review of the facility's Clothing to be Labeled list dated 12/24/23 revealed two pairs of bottoms (one green and one black) had been logged on 12/24/23. During an interview on 7/31/24 at 3:50 PM, Clerical Assistant #1 stated the process for clothing brought in for residents was to log the items on the Clothing to be Labeled sheet and then place them in a separate area behind the reception desk for housekeeping to pick the items up and label them, wash them, and return them to the resident. Clerical Assistant #1 stated they were the staff member who made the entry regarding two pairs of bottoms on the log for Resident #25. They stated they did not remember if there were T-shirts handed in along with the bottoms. During an interview on 7/31/24 at 4:08 PM, Social Worker #1 (designated by the facility as the Grievance Officer) stated they were aware of Resident #25's missing clothing items (pants/T-shirts) as they had been informed of the missing items by Registered Nurse #1, and they sent out an email regarding the missing items to facility staff, and another e-mail to Administrative Assistant #1 inquiring how to go about having a resident reimbursed for missing items. Social Worker #1 stated they did not follow up on these e-mails after sending them. Review of an e-mail dated 1/15/24 at 3:15 PM documented that Social Worker #1 had informed unit managers, clerical assistants, and department leaders of Resident #25's missing clothing items and requested they let Social Worker #1 know if any of the items were located. Review of an e-mail dated 3/20/24 at 2:06 PM from Social Services Worker #1 to Administrative Assistant #1 documented that Social Worker #1 inquired about how to reimburse Resident #25's family member for 2 pairs of sweatpants and 6 T-shirts they had purchased for Resident #25, as the items were missing. In the email Social Worker #1 also inquired about a missing beard trimmer and razor and requested reimbursement by Resident #45. Social Worker #1 was instructed by Administrative Assistant #1 to obtain the actual replacement cost of the missing items and notify the Administrator for approval of payment. During an interview on 7/31/24 at 4:08 PM, Social Worker #1 stated they did not have any further documentation of follow-up actions regarding missing personal property of Residents #25 and #45. During an interview on 7/31/24 at 4:26 PM, the Administrator stated that if personal property was to be reported missing, they would expect Social Worker #1 to file a grievance, follow the grievance process, and notify departments in the facility of the missing items. The Administrator stated the departments would conduct a search and hopefully, the items would be found. If items were not found, reimbursement by the facility would be based on whether the facility could substantiate that the resident, in fact, had the items at the facility prior to them missing. Then an online search for price comparison would assist with reimbursement amounts if there were no receipts available. When asked specifically about missing items for Residents #25 and #45, the Administrator stated they had not been made aware of missing items for these residents. (continued on next page)		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/1/24 at 10:44 AM, Social Worker #1 stated they had not been aware that missing property required a grievance to be filed and followed. They had only filed grievances if a family or resident requested to file a grievance. Social Worker #1 stated it was important to follow the grievance process for residents with missing property, because residents had a right to have their own property and have property replaced as appropriate, after a report and investigation did not help locate the property. Social Worker #1, who is the designated as the facility's grievance officer, stated no grievance was filed for resident #25's missing pants and T-shirts. 2. Resident #45 had diagnoses which include diabetes mellitus type II, osteomyelitis (bone infection) of vertebra and hypertension. The Minimum Data Set, dated dated dated [DATE] documented the resident was cognitively intact. During an interview on 7/29/24 at 9:39 AM, Resident #45 stated they had a razor and beard/ nose hair trimmer and when they moved rooms approximately 4 months ago it was lost. They stated they informed the nursing staff and the Social Work Department Director. Resident #45 stated that the Social Work Department Director had informed them they would look into it, and they haven't received any follow-up. Resident #45 stated the Social Work Department Director should have completed a grievance form. Review of the Resident #45's medical record revealed there was no evidence of a personal item list upon admission. Review of facility logging system for personal items of a form titled Clothing to be Labeled from 12/15/23 through present revealed there was no evidence of items logged in on admission. Resident #45 had clothing items logged on 2/24/24, 3/12/24, and 6/11/24. During an interview on 7/31/24 at 10:22 AM, Social Work Department Director stated they do not have any loss/ grievance forms for Resident #45 from admitted [DATE] through present. During an interview on 8/1/24 at 12:16 PM, the Social Work Department Director stated upon further review of Resident #45's concern of a missing razor and beard/ nose trimmer they recalled sending an email to Administrative Assistant #1 March 2023 concerning the lost razor and beard/ nose trimmer but had forgotten to follow up on the matter. The Social Work Department Director stated they should have completed a grievance form, informed the Administrator, and provided either a replacement or reimbursed the Resident for the items. They further stated they didn't follow their grievance process. In addition, the Social Work Department Director stated there should have been a personal property list completed upon admission to know what the resident had but does not know who is responsible or if there is a logging system for personal items upon admission. Review of an email dated March 20, 2024, at 2:17 PM from Administrative Assistant #1 to Social Work Department Director documented you need to get actual replacement costs for the items and then run it by the Administrator, if approved then it can be paid. Review of an email dated March 20, 2024, at 2:20 PM from Social Work Department Director to Administrative Assistant #1 documented Okay, Resident #45 stated both items totaled approximately \$60.00. (continued on next page)		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/1/24 at 12:32 PM the Administrator stated they were unaware Resident #45 was missing a razor and beard/ nose trimmer. The Administrator stated they would have expected the Social Work Department Director to complete a grievance form, investigate and search for the reported lost item, had the investigation concluded within 5 days and report provided to them for review if reimbursement should had occurred if Resident #45 brought one into the facility. In addition, the Administrator stated they were unable to locate Resident #45's personal item list from admission and the facility does not have a process to log resident's personal property items on admission and does not have a policy to safeguard resident's personal property. 10 NYCRR 415.3(d)(1)(ii)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43785 Based on observation, interview, and record review conducted during an Extended Recertification Survey completed on 8/2/24 the facility did not ensure that all residents were free from neglect and mistreatment for five (Residents #15, #19, #20, #30, and #40) of ten residents reviewed. Specifically, the facility did not check, offer, and provide incontinence care to meet the needs of the residents. The findings are but not limited to: The policy and procedure titled Resident Abuse Prevention Reporting System revised on 1/29/24, documented that it is the facility's policy that residents have the right to be free from neglect and mistreatment, and it is the facility's mission to provide the highest quality, safest, and most compassionate care to all residents. The policy documented neglect was the deprivation of goods or services that are necessary to attain or maintain, physical, mental, and psychosocial well-being. Review Your Rights as a Nursing Home Resident in New York State dated 2022 documented as a resident in this facility, you have rights guaranteed to you by state and federal laws. Your rights strongly emphasize individual dignity and self-determination, promoting your independence and enhancing your quality of life. You have the right to be free be cared for in a manner that enhances your quality of life and receive adequate and appropriate care. Review of the nursing policy and procedure titled Care of Incontinent Resident with a revision date of 10/7/21 documented the objective is to keep the resident with problems of involuntary elimination, clean and dry in order to promote cleanliness, comfort, dignity and to prevent skin issues. Per Acting Director of Nursing this policy is the equivalent to the check and change system in place in the facility. 1. Resident #19 had diagnoses that included Alzheimer's disease, cognitive communication deficit and need for assistance with personal care. The Minimum Data Set (a resident assessment tool) dated 6/12/24 documented Resident #19 was severely cognitively impaired, was dependent on staff for all activities of daily living and was always incontinent of bowel and bladder. The comprehensive care plan dated 6/14/24, documented Resident #19 required total assist of two staff members with a mechanical lift for transfers; total assist of two staff members to/from bed for check and change for toileting. The care plan documented Resident #19 had urinary incontinence used incontinence briefs. The Certified Nursing Assistant Worksheet (guide used by staff to provide care) dated 7/31/24 documented Resident #19's required total assist of two staff members for a check and change for toileting. Resident #19 used incontinence briefs. (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 7/31/24 at 9:22 AM, Resident #19 was observed to be sleeping in their wheelchair at a table in the activity/dining room on the North Unit wearing pants and a shirt. At 10:00 AM, Resident #19 was observed in the same location and position. A continuous observation was started. Resident #19 remained in the room until 1:22 PM when Certified Nurse Aide #6 and #4 exited the room with the resident. During this time staff did not check, change or toilet the resident. Certified Nurse Aides #6 and #4 wheeled Resident #19 to their room and provided care. There was a strong urine odor noted when Resident #19 was lifted out their wheelchair with the mechanical lift. The resident's pants were visibly wet, and their incontinence brief was heavily saturated with urine and a small amount of stool. During an interview on 7/31/24 at 2:06 PM, Certified Nurse Aide #6 stated at 7:15 AM they provided Resident #19 with morning care and got them out of bed. They stated they did not provide any further care to Resident #19 until 1:22 PM. Certified Nurse Aide #6 stated per Resident #19's care plan they were a check and change for toileting which meant Resident #19 did not use the toilet. Certified Nurse Aide #6 stated Resident #19 should have been placed into bed, checked for incontinence, and if needed, had incontinence care provided. Certified Nurse Aide #6 stated they did not have enough time to check the resident after breakfast because they were still providing morning care to the other residents on their assignment and helping the other staff get residents out of bed. They stated it was important to provide incontinence care to maintain the resident's dignity, to keep them clean and prevent sores. In a further interview on 8/2/24 at 10:15 AM, Certified Nurse Aide #6 stated that definition of neglect would be not tending to a resident in a timely manner. They stated not being able to provide timely incontinent care would be neglect. During an interview on 7/31/24 at 2:31 PM, Licensed Practical Nurse #1 stated that check and change meant that an incontinent resident needed to be checked every two hours and changed if soiled. They stated Resident #19 should have been provided incontinence care every two hours because they could not verbalize when they needed to use the bathroom. Licensed Practical Nurse #1 stated Resident #19 had a recent history of pressure ulcers on their sacrum. During an interview on 8/1/24 at 2:30 PM, Licensed Practical Nurse #1 stated they would consider not providing residents with timely incontinence care a form a neglect because the facility was not able to meet the needs of the residents. During an interview on 7/31/24 at 6:40 PM, Registered Nurse #2 (Nursing Supervisor) stated on average there were two aides per unit, and they cannot complete all their duties with that ratio. Registered Nurse #2 stated that incontinence care did not get completed every 2-4 hours and should be. They stated the off-going aides give report to the oncoming aides as to which residents did not receive incontinence care so those residents would be a care priority. Registered Nurse #2 stated then that process rolls from shift to shift. Registered Nurse #2 stated the residents are safe, but they are getting an inadequate amount of nursing care. During an interview on 8/1/24 at 2:33 PM, Registered Nurse Unit Manager #1 stated they knew incontinence care was not being delivered timely but would not consider it neglect because the facility was attempting to do something about it. Registered Nurse #1 stated the reason certified nurse aides were doing walking rounds at change of shift was to identify which resident were not toileted appropriately and those residents needed top priority by the oncoming shift. During an interview on 8/2/24 at 8:58 AM, Certified Nurse Aide #4 stated it was neglectful to the residents if they were not provided with incontinence care at every two hours and as needed. (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. Resident #40 had diagnoses which included dementia, dysphagia (difficulty swallowing), and urinary incontinence. The Minimum Data Set, dated dated dated [DATE] documented Resident #40 was severely cognitively impaired and was dependent on staff for all aspects of care. Resident #40's comprehensive care plan dated 5/23/24 documented the resident had urinary incontinence and skin will break down due to incontinence. Resident #40 required a total assist of 2 persons for toileting and was on a check and change schedule. During a continuous observation on 7/31/24 from 10:20 AM to 2:22 PM Resident #40 was seated in their Geri-chair in the activity/dining room. The staff did not offer, check, change or provide the resident with toileting or incontinence care. During an observation on 7/31/24 at 3:43 PM Resident #40 was still seated in the same location in the activities/dining room. There were 7 other residents present in the room. Resident #40's pants in their groin area were visibly wet with urine. During an interview and observation on 7/31/24 at 3:44 PM Certified Nurse Aide #1 stated they were assigned Resident #40 that morning and was working until 6:00 PM because they were short staffed. They stated they reported off to the oncoming shift that Resident #40 had not been changed since 9:30 AM and would be a priority for them. During an observation of incontinence care completed by Certified Nurse Aide's #1 and #8. Resident #40's brief was heavily saturated with dark urine and there were indentations on the resident's buttocks from their incontinence brief. Certified Nurse Aide #1 stated the brief was saturated with urine and Resident #40 should have been changed sooner. We typically try to change residents every 2-4 hours, but they just don't have enough time to get everyone done. During an interview on 8/1/24 at 10:58 AM, Registered Nurse Unit Manager #1 stated Resident #40 should not have had soaked pants and when that occurs, they expected staff to prioritize and immediately remove them from any public area and change them. During an interview on 8/1/24 at 12:56 PM, Certified Nurse Aide #1 stated by Resident #40 not being changed in the 2-4-hour time frame on 7/31/24 was neglect. Not intentional neglect but it falls on the fact that there was not enough staff and enough time. They stated this could lead to falls, skin break down, and urinary tract infections. 3. Resident #20 had diagnoses which included dementia, anxiety disorder, and cognitive communication deficit. The Minimum Data Set, dated dated dated [DATE] documented Resident #20 was severely cognitively impaired, does not exhibit behaviors of rejection of care and was always incontinent of urine and occasionally incontinent of bowels. Resident #20's comprehensive care plan dated 2/27/24 documented the resident required extensive assistance of one with rolling walker/ grab bar for transfers to and from toilet. Staff to assist with all tasks. Additionally, it documented the resident was at increased risk for urinary incontinence. Interventions included the resident used incontinence products and the resident's incontinence would be managed. Resident #20's Certified Nursing Assistant Worksheet dated 7/31/24 documented the resident required extensive assistance of one with rolling walker/ grab bar for transfer to and from toilet. Staff to assist with all tasks and the resident used incontinence products. (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a continual observation on 7/31/24 at 12:03 PM to 2:33 PM Resident #20 was sitting in their wheelchair at a table in the dining room. During an interview on 7/31/24 at 2:15 PM, Certified Nurse Aide #6 stated they heard Certified Nurse Aide #7 tell Certified Nurse Aide #5 they were unable to provide incontinent care to Resident #20 because they didn't have time. During an interview on 7/31/24 at 2:18 PM, Certified Nurse Aide #5 stated they were informed by Certified Nurse Aide #7 that they were unable to provide incontinence care to Resident #20 because they didn't have time. They stated they assumed Resident #20 last received incontinence care around breakfast time (8 AM). They stated that Resident #20's care plan does not specify how often incontinence care was to be provided but it was expected that Resident #20 was to be offered toileting or incontinence care every 2 hours. During an observation and interview on 7/31/24 at 2:33 PM, Certified Nurse Aide #5 provided toileting and incontinence care to Resident #20. Resident #20's brief was odorous and heavily saturated with urine from the front waistline to back waistline of the entire brief. Certified Nurse Aide #5 stated the brief was saturated with urine and the resident should have been provided with incontinence care every 2 hours and can't ask to be toileted. During an interview on 7/31/24 at 2:43 PM, Registered Nurse #1 Unit Manager stated they expected incontinent residents to be toileted every 2 - 4 hours. During an interview on 8/1/24 at 8:08 AM, Licensed Practical Nurse #4 (Infection Preventionist /Nurse facilitator) stated they would expect the staff to check and provide incontinence care at least every 4 hours to promote skin integrity, resident dignity and prevent urinary tract infections. They stated if incontinence care was not completed at least every 4 hours it was considered neglect. During an interview on 8/1/24 at 8:55 AM, Certified Nurse Aide #7 stated they toileted Resident #20 at 7:30 AM on 7/31/24 and were unable to provide toileting or incontinence care the remainder of that day. They stated they had reported to the oncoming aide Certified Nurse Aide #5 that Resident #20 needed to be provided with toileting and incontinence care. They stated Resident #20 was always incontinent and should have been provided incontinence care every 2 to 3 hours and wasn't. During an interview on 8/1/24 at 9:48 AM, the Administrator reviewed the facility policy Care of Incontinent Resident and stated the policy does not provide direction how often an incontinent resident requires care therefore they don't know how often staff should provide incontinence care. During an interview on 8/2/24 at 11:07 AM, Acting Director of Nursing #1 stated incontinence care should be done twice a shift and as needed. Certified Nurse Aides should check for signs like the resident being antsy or if there was an odor. It was important for skin, comfort, and dignity. Acting Director of Nursing #1 stated the residents that were left in their soiled briefs for extended amounts of time (6-8 hours), based on policy and the definition of neglect, they would have to agree that the situation meets the definition of neglect. During an interview on 8/2/24 at 12:09 PM, the Administrator reviewed of the facilities policy and definition of neglect and stated they do not feel the facility was being neglectful by not providing timely incontinence care. (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a telephone interview on 8/2/24 at 10:26 AM, the Medical Director stated that appropriate toileting time frame for an incontinent resident would be every two to four hours. They stated that there would be concerns for skin breakdown with a resident was not being toileted or changed for 6 or more hours. 10NYCRR 415.4(b)(1)(i)		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43785 Based on observation, interview, and record review conducted during an Extended Recertification Survey completed on 8/2/24, the facility did not ensure that each resident who was unable to carry out Activities of Daily Living received the necessary services to maintain nutrition and grooming for two (Resident #29 and #63) of four residents reviewed. Specifically, staff did not offer or provided assist with removing facial hair (#63) and staff did not provide staff assistance as planned for meals (#29). The findings are: Review of the nursing policy and procedure titled Activities of Daily Living dated 1/14/15 documented activities of daily living are those activities which must be accomplished each day in order for the resident to care for his own needs and participate in the society of others. The nursing staff will assist the resident with any of the activities that he/she is unable to perform by him/herself. Review of the nursing policy and procedure title Shower dated 10/7/14 documented provide hygiene care including hair washing and/or shaving if necessary. 1. Resident #29 had diagnoses which included Parkinson's (progressive brain disorder that causes damage to parts of the brain over many years), chronic kidney disease, and dysphagia (difficulty swallowing). The Minimum Data Set (a resident assessment tool) dated 6/26/24 documented Resident #29 was cognitively intact, was understood and usually understands. The Minimum Data Set further documented the resident required a partial moderate assist for eating. The Comprehensive Care Plan documented that Resident #29 had impaired functional status with activities of daily living. An intervention dated 6/27/24 documented the resident required a limited assist of 1 person for eating and was on all aspiration (choking) precautions. The Certified Nursing Assistant Worksheet (guide used by staff to provide care) dated 6/27/24 documented Resident #29 was a limited assist of 1 person for eating and was on all aspiration precautions. Resident #29's meal tickets dated 7/29/24 through 8/1/24 documented limited assist at the bottom of the meal ticket in all capital letters in red and the resident required level 5 diet (minced meat) and regular liquids. The Nursing Progress note dated 7/29/24 at 9:41 AM documented Resident #29 had complaints of trouble swallowing water. The Nursing Progress noted dated 7/29/24 at 1:15 PM documented a new order was placed per the nurse practitioner (NP): Swallow Therapy evaluation and treatment as indicated- trouble swallowing water. The Interdisciplinary Noted on 7/30/24 at 3:26 PM writer by the Speech Pathologist documented a swallow evaluation was completed on this date due to difficulty swallowing water. No further intervention warranted at this time. Continue with current diet recommendations. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Heritage Village Rehab and Skilled Nursing Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 4570 Route 60 Gerry, NY 14740	
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a continuous observation on 7/31/24 from 10:22 AM to 2:22 PM Resident #29 was seated in the recliner in their room. At 11:57 AM Resident #29 was served their lunch tray and staff exited the room and closed the door behind them. At 12:06 PM Resident #29 was observed in their recliner in their room attempting to eat their lunch. During an interview at this time Resident #29 stated they were having difficulty getting food onto the fork. Resident #29 stated staff never come into the room to help them eat unless they ask for assistance. At 12:45 PM a Unit Helper #1 knocked on the resident's room and asked if they were finished with their meal, took the tray, and exited the room. No staff helped or checked on the resident while they were eating their meal. The resident consumed 50 percent of their meal. During a continuous observation and interview on 8/1/24 from 8:12 AM to 8:49 AM Resident #29 was in recliner in their room. Residents breakfast tray was delivered at 8:18 AM. At 8:19 AM. The certified nurse aide exited the room and continued passing meal trays. At 8:46 AM, Certified Nurse Aide #7 entered Resident #29's room to collect their breakfast tray. At this time Certified Nurse Aide #7 looked at the meal ticket and stated Resident #29 was a limited assist. Certified Nurse Aide #7 stated when a resident was a limited assist for eating it means they need help, and the staff should be always there to assist them. At 8:49 AM Certified Nurse Aide #7 pulled up Resident #29's care plan on the kiosk and stated the resident was on aspiration precautions. When residents were on aspiration precautions it meant they may need a nurse present to watch them, so they don't choke and potentially die. Certified Nurse Aide #7 stated Resident #29 should have had someone in the room to assist them during meals because they could have choked, and no one would have been there to help them eat. The resident consumed 50 percent of their meal. During an interview on 8/1/24 at 10:32 AM, the Speech Pathologist stated all aspiration precautions meant the resident must be supervised while eating. The Speech Pathologist stated Resident #29 was on all aspiration precautions because they pocket their food (to hold food in the mouth for an extended amount of time without swallowing) and drinks and could be at risk of aspirating which could lead to pneumonia or death. During an interview on 8/1/24 at 10:44 AM, Certified Occupational Therapy Aide #1 stated Resident #29 was a limited assist for eating. Limited assist means supervision touching assist, meaning they can be checked in on during self-feeding. Certified Occupational Therapy Assistant stated they would expect staff to at least check in after the start of the meal and to make sure everything was okay, make sure they aren't having any difficulty with feeding or swallowing. Certified Occupational Therapy Assistant stated if a resident was supposed to be assisted with meals but was not, this could result in poor intake and weight loss. To their knowledge, Resident #29 has not had any weight loss or choking episodes. During an interview on 8/1/24 at 10:58 AM, Registered Nurse Unit Manager stated if a resident was a limited assist for meals they should be supervised. Registered Nurse Unit Manager stated Resident #29 was on an altered diet and at increased risk of aspirations. During an interview on 8/2/24 at 11:12 AM, the Acting Director of Nursing stated a limited assist for feeding would be touching supervision. This meant that supervising for some of the meal. Staff do not have to sit with them for the entirety of the meal, but someone should be visualizing them from time to time. The Acting Director of Nursing stated Resident #29 had a diagnosis of Parkinson's so they may need assistance because they cannot reach, may have increased spillage, trouble swallowing, have a grip strength issue or needed prompts to increase their intake. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #63 had diagnoses which included dementia, hypertension (high blood pressure), and cognitive communication deficit (a condition that makes it difficult to communicate). The Minimum Data Set, dated dated [DATE] documented Resident #63 was sometimes understood, sometimes understands and was severely cognitively impaired. Additionally, the Minimum Data Set documented that Resident #63 was dependent on staff for personal hygiene including combing hair, shaving, applying makeup, washing/drying face, and hands. The comprehensive care plan dated 7/11/24 documented Resident #63 had impaired functional status for: bed mobility, transfers, walking, toileting, locomotion, eating, grooming, personal hygiene, and bathing. Interventions included dependent on staff for personal hygiene/grooming. The Certified Nursing Assistant Worksheet dated 7/11/24 documented Resident #63 was dependent on staff for personal hygiene and grooming. Review of the nursing progress notes dated 7/9-7/31/24, revealed there was no evidence of Resident #63 refusing care. During an observation on 7/29/24 at 10:43 AM, Resident #63 had numerous 0.25-inch-long white hairs covering their chin. During an observation on 7/31/24 at 6:55 AM, Certified Nurse Aide #10 and Certified Nurse Aide #16 provided morning care to Resident #63. After Certified Nurse Aide #10 and Certified Nurse Aide #16 transferred Resident #63 to their chair, Certified Nurse Aide #16 left the room while Certified Nurse Aide #10 combed Resident #63's hair. Certified Nurse Aide #10 did not offer or attempt to remove Resident #63's facial hair, before the completion of morning care. During observations and interviews on 7/31/24 at 7:28 AM, Certified Nurse Aide #10 stated facial hair was removed on shower days and as needed. Licensed Practical Nurse #4 entered the room to assist with the foot pedals of the wheelchair. Certified Nurse Aide #10 looked at Resident #63's chin, felt their facial hair, and then stated, this is presentable. Licensed Practical Nurse #4 then looked at Resident #63's chin and stated they needed their facial hair to be removed. Certified Nurse Aide #10 stated they would go get razors. During an interview on 7/31/24 at 7:30 AM, Licensed Practical Nurse #4 stated Resident #63 had facial hair that needed to be removed. They stated it was important to remove the facial hair because it was a dignity concern for Resident #63. During an interview on 7/31/24 at 7:33 AM, Certified Nurse Aide #16 stated they had noticed Resident #63 had facial hair and removal of the facial hair should have been completed during morning care. Certified Nurse Aide #16 stated Resident #63 was unable to make their needs known and was dependent on staff for all their needs. During an interview on 8/1/24 at 11:07 AM, Registered Nurse #1 stated they would expect personal hygiene, including facial removal, to be completed during morning care, especially for Resident #63. Registered Nurse #1 stated it was not ok for the certified nurse aide not to provide facial hair removal for Resident #63 because it was a dignity concern. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/2/24 at 11:06 AM, Acting Director of Nursing #1 stated it was expected that the certified nurse aides provided appropriate grooming for the residents including removal of facial hair. Acting Director of Nursing #1 stated facial hair was considered a dignity issue and staff members needed to remember what Resident #63 would have wanted prior to admitting to the skilled nursing facility. They stated even when Resident #63 was on Covid precautions, it was still an expectation to provide all morning care including facial hair removal. 10NYCRR 415.12(a)(3)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 43785 Based on observation, interview and record review conducted during the Extended Recertification Survey completed on 8/2/24 for two (North Unit and East Unit) of two resident care units the facility did not ensure sufficient nursing staff to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically, the facility did not have adequate nursing staff based on the facility's established minimum number of staff for each shift. Additionally, there was a lack of sufficient nursing staff to provide timely care to meet the needs of the residents. This involves residents #15, 19, 20, 29, 30, 40, 45, 51, & 64. The findings are: Refer to F600 Neglect- scope and severity = F During the entrance conference on 7/29/24 at 9:40 AM, the Administrator stated the current facility census was 71 residents. The policy and procedure titled Emergency Staffing Strategies, revised 1/6/24, documented when facility staffing is at a critical level impeding on resident care, the following actions will be taken: Administrator and Director of Nursing will be notified, all current on duty staff we be asked to remain duty until it's resolved, incentives would be offered to enlist any available staff, staff agencies would be contacted, and staff from other Heritage facilities would be requested. a. The Facility Assessment, dated 6/30/24, documented the facility's bed capacity was 120 beds and the average daily census at the time of the assessment was 75. The facility assessment documented the minimum number of staff required to meet the needs of the residents in a 24-hour period. For the current census, they required 8 Licensed Practical Nurses, 15 Certified Nurse Aides, and 1 Registered Nurse to safely care for their residents. The Minimum Nursing Staff breakdown provided by Scheduler #1, on 7/30/24 at 9:04 AM, documented the day shift (6:00 AM to 2:00 PM) minimum staffing was 3 nurses and 6 Certified Nurse Aides, evening shift (2:00 PM to 10:00 PM) minimum staffing was 3 nurses and 6 Certified Nurse Aides, and night shift (10:00 PM to 6:00 PM) minimum staffing was 2 nurses and 3 Certified Nurse Aides. The document did not list the requirement of a Registered Nurse. The daily staffing sheets, reviewed from 6/29/24 to 8/1/24, documented the facility did not meet their minimum number of staff on the following dates: 6/29/24 6:00 AM to 2:00 PM down 1 Certified Nurse Aide 7/5/24 6:00 AM to 2:00 PM down 1 Certified Nurse Aide 7/6/24 6:00 AM to 2:00 PM down 1 Certified Nurse Aide 10:00 PM to 6:00 AM down 1 Certified Nurse Aide and no (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Registered Nurse 7/7/24 6:00 AM to 2:00 PM down 0.5 Certified Nurse Aide 7/8/24 6:00 AM to 2:00 PM down 2 Certified Nurse Aides 2:00 PM to 10:00 PM down 2 Certified Nurse Aides 7/9/24 2:00 PM to 10:00 PM down 1 Certified Nurse Aide 7/11/24 6:00 AM to 2:00 PM down 1 Certified Nurse Aide 7/13/24 6:00 AM to 2:00 PM down 1 Certified Nurse Aide 2:00 PM to 10:00 PM down 1 Certified Nurse Aide 7/14/24 6:00 AM to 2:00 PM down 1 Certified Nurse Aide 7/15/24 6:00 AM to 2:00 PM down 1 Certified Nurse Aide 2:00 PM to 10:00 PM down 1 Certified Nurse Aide 7/16/24 6:00 AM to 2:00 PM down 2.5 Certified Nurse Aides 2:00 PM to 10:00 PM down 1.5 Certified Nurse Aides 7/17/24 6:00 AM to 2:00 PM down 3.5 Certified Nurse Aides 10:00 PM to 6:00 AM down 1 Licensed Practical Nurse, Director of Nursing as staff 7/18/24 6:00 AM to 2:00 PM down 3.5 Certified Nurse Aides, down 1 Licensed Practical Nurse & 1 Licensed Practical Nurse worked as Certified Nurse Aide 2:00 PM to 10:00 PM down 1 Certified Nurse Aide 10:00 PM to 6:00 AM down 1 Licensed Practical Nurse, Director of Nursing as staff 7/19/24 6:00 AM to 2:00 PM down 3 Certified Nurse Aides, no Registered Nurse 7/20/24 6:00 AM to 2:00 PM down 1.5 Certified Nurse Aides 7/21/24 6:00 AM to 2:00 PM down 3.5 Certified Nurse Aides, no Registered Nurse 7/22/24 6:00 AM to 2:00 PM down 2 Certified Nurse Aides 2:00 PM to 10:00 PM down 1 Certified Nurse Aide 7/23/24 6:00 AM to 2:00 PM down 3 Certified Nurse Aides (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2:00 PM to 10:00 PM down 1.5 Certified Nurse Aides 7/25/24 2:00 PM to 10:00 PM down 1 Certified Nurse Aide 7/26/24 6:00 AM to 2:00 PM down 1.5 Certified Nurse Aides 2:00 PM to 10:00 PM down .5 Certified Nurse Aide 7/27/24 6:00 AM to 2:00 PM down .5 Certified Nurse Aide 7/28/24 6:00 AM to 2:00 PM down 2 Certified Nurse Aides 10:00 PM to 6:00 AM down 1 Licensed Practical Nurse & Director of Nursing as staff 7/29/24 6:00 AM to 2:00 PM down 1 Certified Nurse Aide 2:00 PM to 10:00 PM down 1 Certified Nurse Aide 8/1/24 6:00 AM to 2:00 PM down 3.5 Certified Nurse Aides During an interview on 8/1/24 at 11:34 AM, Scheduler #1 stated they knew staffing was bad. Scheduler #1 reviewed the staffing sheets and stated the facility did not meet their minimum staffing numbers. They stated they used the Minimum Nursing Staff numbers as a guide when they made the schedule. When there was not enough staff they would offer incentives, including double hourly pay, plus overtime, and they requested staff from agencies and the float pool. Scheduler #1 stated there were 5 agencies contracted, but only 1 was currently supplying staff to the facility. Scheduler #1 stated the Director of Nursing, and the Administrator were both aware they were not meeting their minimum staffing numbers. b. Review of the Resident Council minutes on 7/29/24 revealed staffing concerns were discussed in April 2024. May 2024 minutes residents complained of not getting their showers. The facility response was to add new staff agencies to their staff pool. In June 2024 they discussed the new agency staff during the meeting, but the residents' responses were not documented. During an interview on 7/30/24 at 11:36 AM, the Ombudsman stated the residents had concerns with staffing at the facility. They stated the Administrator was aware of the residents' concerns. During an interview at the Resident Council meeting on 7/30/24 at 1:41 PM, Resident #45 stated there was one time when they sat on the toilet for two hours before staff answered the call bell and assisted them off the toilet. During an interview on 7/30/24 at 1:41 PM, Certified Nurse Aide #12 stated they frequently worked with just one nurse aide on the North Unit. Certified Nurse Aide #12 stated they did not have time to provide incontinence care every two hours as they should or have time to give residents their showers. (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 7/30/24 at 3:11 PM, Resident #51 and Resident #64 were observed to be sitting in the North Unit common area wearing hospital gowns. The residents were not able to be interviewed. During an interview on 7/30/24 at 3:26 PM, Certified Nurse Aide #3 stated they put Resident #51 and #64 in hospital gowns after they provided incontinence care. They stated that they had two other residents on the bed pan and needed to change Resident #51 and #64 quickly out of their clothes because they were wet with urine. Certified Nurse Aide #3 stated that it was common practice for the outgoing aide not to have enough time in their shift to provide incontinence care. During an interview on 7/31/24 at 6:01 AM, Certified Nurse Aide #2 stated they had worked as the only aide on night shift at times (census 37). Certified Nurse Aide #2 stated they were able to get through 2 rounds on night shift but were unable to complete a 3rd round. They stated the first round of the night took longer, about 3-4 hours, to clean up everything from the evening shift. During an interview on 7/31/24 at 7:04 AM, Certified Nurse Aide #4 stated they were frequently short staffed and worked with only 2 aides on the day shift. They stated when there were 2 Aides, they were unable to provide incontinence care to all the residents, especially after lunch because they assisted residents with their meal and their shift ended at 2:00 PM. They stated they have had family members complain to them that there was not enough staff. Certified Nurse Aide #4 stated when there was only 1 aide on the North Unit (census 34) it was not possible to follow the care plans for all the residents. During an interview on 7/31/24 at 7:32 AM, Certified Nurse Aide #6 stated they have worked with 2 aides on the day shift in the last 7 days and it was not possible to provide care to all the residents that require incontinence care according to their plan. During an interview on 7/31/24 at 7:34 AM, Licensed Practical Nurse #1 stated the facility was short staffed almost every day, and it was reported to them almost daily, that the aides were unable to complete all their work before they leave at 2:00 PM. They had reported the concerns to Registered Nurse Unit Manager #1 on multiple occasions. Licensed Practical Nurse #1 stated the Director of Nursing was aware incontinence care was not being completed timely, but the staff were informed they must complete their charting before they leave the facility making staff choose charting over care. During an interview on 7/31/24 at 8:24 AM, Registered Nurse Unit Manger #1 stated they were the Manager for both the East and North Units, and the Supervisor for the day shift. Frequently there were 2 aides on the day shift and were aware the aides were voicing concerns that they were unable to provide care timely and follow the resident's care plans. Registered Nurse Unit Manager #1 stated corporate had a staff meeting which they attended May 8th, 2024; and stated many of the nurse aides voiced they were unable to provide care according to care plans because of the short staffing. (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 7/31/24 at 9:22 AM, Resident #19 was sleeping in their wheelchair at a table in the activity/dining room on the North Unit. At 10:00 AM, Resident #19 was in the same location and position. A continuous observation was started, and Resident #19 was not removed from the room until 1:22 PM when Certified Nurse Aides #6 and #4 exited the room with the resident. Certified Nurse Aides #6 and #4 wheeled Resident #19 to their room to provide incontinence care. During the care observation, a strong urine odor was noted while Resident #19 was being lifted out of their wheelchair with the mechanical lift. The resident's pants were visibly wet, their brief was saturated with urine and a small amount stool. During an interview on 7/31/24 at 2:06 PM, Certified Nurse Aide #6 stated at 7:15 AM they provided Resident #19 with morning care and got them out of bed. They stated they did not check Resident #19 after breakfast for incontinence because they were still providing morning care to the other residents on their assignment and helping other staff get residents out of bed. They stated when they provided care after lunch, the resident had a strong odor of urine, and their pants were wet. During an interview and observation on 7/31/24 at 11:14 AM, Resident #29 stated they were told at 9:00 AM the aide would be in to do their morning care and get them dressed. The aide did not return until after 11:00 AM. Resident #29 stated they would like to be dressed before they ate their breakfast. During a continuous observation on 7/31/24 from 10:20 AM to 2:22 PM Resident #40 was seated in their Geri chair (a reclining chair with wheels) in the activity/dining room on the East Unit. At 3:43 PM, Resident #40 was still in the same location and the resident's pants were visibly wet in their groin area. During an observation on 7/31/24 at 2:00 PM Certified Nurse Aide #1 was heard giving report to the oncoming shift. They stated at least 4 residents on that hall (East Unit) had not been changed since before breakfast. During a continuous observation on 7/31/24 from 10:20 AM to 2:15 PM Resident #15 was in the activity/dining room on the East Unit. Resident #15 was not checked for incontinence or provided with incontinence care. During an interview and observation on 7/31/24 at 3:44 PM, Certified Nurse Aide #1 stated they were assigned Resident #40 that morning and were working until 6:00 PM because they were short staffed. They reported off to the next shift that Resident #40 was a priority because they had not been changed since 9:30 AM. During an interview on 8/1/24 at 12:56 PM, Certified Nurse Aide #1 stated they were not able to properly care for all the residents on their assignment because of the lack of staffing. Certified Nurse Aide #1 stated they received calls and texts from facility messaging system daily asking to pick up shifts. They stated they were tired and burned out from working so many 12 to 16-hour shifts. Certified Nurse Aide #1 added sometimes there were other duties like showers that do not get completed. During an interview on 7/31/24 at 2:18 PM, Certified Nurse Aide #5 stated they received report from Certified Nurse Aide #7 that they were unable to provide incontinence care to Resident #20 this afternoon because they were short staffed and ran out of time. They stated, that almost daily, some residents didn't receive incontinence care according to their care plan. (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 7/31/24 at 2:33 PM Certified Nurse Aide #5 took Resident #20 to their room and provided incontinence care. The resident's incontinence brief was saturated with urine. During a continuous observation on 7/31/24 from 10:30 AM until 2:30 PM, Resident #30 was seated in their Geri chair (a reclining chair with wheels) in the activity/dining room on the North Unit. Resident #30 was fidgety, placed legs over arms of Geri chair and at times attempting to stand. Resident #30 was not checked or provided incontinence care during this time. During an interview on 7/31/24 at 6:45 PM, Certified Nurse Aide #5 stated they provided incontinence care to Resident #30 at 4:45 PM. They stated that the off going aide did not report to them that Resident #30 was a priority and when they provided care, the resident's brief was saturated with urine. Certified Nurse Aide #5 stated they only complete a toileting round at the beginning of the shift and then when they put the resident to bed for the night because of low staffing numbers. During an interview on 7/31/24 at 6:21 PM, Certified Nurse Aide #11 stated they normally work with one or two other aides on the evening shift and cannot get their work completed. Sometimes it took them until 7:45 PM to finish assisting residents with their dinner and they would have to leave some residents for night shift to put to bed. During an interview on 7/31/24 at 6:40 PM, Registered Nurse #2, Nursing Supervisor stated there had been a shortage of nursing staff in the building. On average there were two aides per unit, and they could not complete their duties and meet the residents needs with that ratio of aides to residents. Registered Nurse #2 stated when there was only one or two aides per unit there was not enough minutes in a shift to complete toileting every 2-4 hours per resident. Registered Nurse #2 stated the residents were safe, but they were getting an inadequate amount of nursing care due to the low staffing numbers. During an observation on 8/1/24 at 8:20 AM, revealed the North Unit was in the process of assisting the residents with their breakfast. At 8:37 AM Resident #30 was wheeled into the activity/dining on North Unit and their breakfast tray placed in front of them. Resident #30 reached for a slice of toast and began eating it before they were placed in proper position and their tray completely set up. During an interview on 8/1/24 at 8:32 AM, Licensed Practical Nurse #1 stated that they arrived to work at 2:00 AM and they were working (at the time of the interview) as a nurse and an aide due on the North Unit. They stated that breakfast trays were usually delivered between 7:30 AM - 7:45 AM and Resident #30 was eating breakfast almost an hour late. During an interview on 8/1/24 at 8:55 AM, Certified Nurse Aide #7 stated they provided incontinence care once on 7/31/24 at 7:30 AM and was unable to offer toileting or provide incontinence care the remainder of the day because of short staffing. They stated they had not informed the nurses that day regarding the inability to complete care and follow care plans because it was an ongoing issue. The nurses, the Director of Nursing and Administrator all knew this was a daily issue and we were told to do the best we can. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335353	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/02/2024
NAME OF PROVIDER OR SUPPLIER Heritage Village Rehab and Skilled Nursing Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 4570 Route 60 Gerry, NY 14740	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 8/1/24 at 10:29 AM, Licensed Practical Nurse/ Nurse Facilitator #4 stated with the low staffing numbers, they did not feel staff could provide good care for the residents. Licensed Practical Nurse #4 stated the Director of Nursing, the Administrator and Corporate were all aware that staff were unable to provide good care for the residents, and follow their care plans, with the current staff levels. During an interview on 8/1/24 at 10:44 AM, Registered Nurse #1 Unit Manager stated they expected staff to provide incontinence care timely and for staff to try their best. It was expected the on-coming shift make those residents who were not provided incontinence care a priority. During an interview on 8/2/24 at 11:07 AM, the Acting Director of Nursing, stated they were aware the facility was not meeting their minimum staffing numbers and they did not feel that staff could get their work done, including incontinence care, and serving meals. They stated the Administrator and Corporate were aware they were not meeting their minimum staffing numbers. They stated there were meetings with administration and corporate, where staff voiced their concerns about not being able to provide care to the residents. During an interview on 8/2/24 at 12:09 PM, the Administrator stated the Facility Assessment did reflect accurate minimum staffing numbers. They stated they were aware they were not meeting their minimum staffing. The Administrator stated that staff had come to them and told them they could not get their work done because of low staffing. During an interview on 8/2/24 at 1:49 PM, the Corporate Director of Skilled Nursing Facilities Administration stated they were aware the facility was not meeting their minimum nurse staffing numbers. They felt the staff could get their work done with the numbers they had, but that was not their goal. They did attend the corporate/staff meetings but did not recall staff specifically saying they could not get their work done. 10 NYCRR 415.13 (a)(1)(i)		

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 43785 Based on interview and record review, conducted during the Extended Recertification Survey completed on 8/2/24, the facility did not ensure there were services of a Registered Nurse for at least 8 consecutive hours, 7 days a week except when waived. Specifically, the facility did not have 8 consecutive hours of Registered Nurse coverage on 7/6/24, 7/19/24 and 7/21/24 as required and did not have a waiver. The finding is: 1. The Facility Assessment, dated 6/30/24, documented the facility's bed capacity was 120 beds and the average daily census at the time of the assessment was 75. The facility assessment documented the minimum number of staff required to meet the needs of the residents in a 24-hour period. For the current census, they required 8 Licensed Practical Nurses, 15 Certified Nurse Aides, and 1 Registered Nurse to safely care for their residents. The policy and procedure titled Emergency Staffing Strategies, revised 1/6/24, documented when facility staffing is at a critical level impeding on resident care, the following actions will be taken: Administrator and Director of Nursing will be notified, all current on duty staff we be asked to remain duty until it's resolved, incentives would be offered to enlist any available staff, staff agencies would be contacted, and staff from other Heritage facilities would be requested. The daily staffing sheets, reviewed from 6/29/24 through 8/1/24, documented they did not have a Registered Nurse for 8 consecutive hours, in the facility, on the following dates: 7/6/24, 7/19/24 and 7/21/24. During an interview on 8/1/24 at 11:34 AM, Scheduler #1 stated they were aware they were supposed to have a Registered Nurse in the facility for 8 hours a day, every day. They stated they thought there was coverage on 7/6/24 because there were 2 Registered Nurses on for 4 hours each, however, they were both on the same 4 hours so there was not 8 hours of coverage. On 7/19/24 the Director of Nursing was supposed to be the Registered Nurse covering, but they were unavailable. Scheduler #1 stated the Director of Nursing, and the Administrator were both made aware that there was no Registered Nurse coverage on those dates 7/19/24 and 7/21/24. Scheduler #1 stated they told them to keep trying to find coverage, but there was no coverage available. During an interview on 8/2/24 at 11:07 AM, the Acting Director of Nursing stated stated they were aware the facility had days where there was no Registered Nurse in the building. They stated if they were told there was no Registered Nurse coverage they would notify the Administrator and try to help find coverage. They themselves have been assigned to be the Registered Nurse for the facility, act as supervisor or even take a medication cart. The Acting Director of Nursing stated they thought the Administrator could contact corporate and ask for a float Registered Nurse from another building. (continued on next page)		

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/2/24 at 12:09 PM, the Administrator stated they were aware there were days the facility did not have a Registered Nurse for the required 8 consecutive hours. They stated when they were notified there was no Registered Nurse available, they notified Corporate and attempted to find coverage. The Administrator stated Corporate was unable to provide a Registered Nurse for those days. They stated it was important to have a Registered Nurse in the facility to conduct resident assessments and to provide care that a Licensed Practical Nurse could not perform. They understood that it was essentially the Administrators responsibility to ensure safe nursing coverage in the facility. 10 NYCRR 415.13 (b)(1)		

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. 43785 Based on observation interview and record review, conducted during the Extended Recertification Survey completed on 8/2/24, the facility did not ensure the nursing staff information was posted on a daily basis and contained the required information. Specifically, the facility did not complete the forms to include the resident census, and actual hours of nursing staff worked by licensed and unlicensed nursing staff directly responsible for resident care, including Registered Nurses, Licensed Practical Nurses and Certified Nurse Aides. The finding is: The policy and procedure titled BIPA Staffing Provision (BIPA- Benefit Improvement and Protection Act) dated 8/22/2018 documented prior to the beginning of all shifts, the nursing supervisor will prepare and post the BIPA staffing that includes the following: Facility name, current date, the total number and the actual hours worked by Registered Nurses, Licensed Practical Nurses or Licensed Vocational Nurses, Certified Nurse Aides directly responsible for resident care per shift and the facility census. The staffing must be posted at the beginning of each shift, information posted must be uptodate and current. During an observation on 7/29/24 at 3:01 PM the Report of Nursing Staff Directly Responsible for Resident Care posted at the front desk, was dated 7/29/24, the space for census was blank and the column labeled actual hours worked, was blank. During observations on 7/30/24 at 10:00 AM and 3:20 PM the Report of Nursing Staff Directly Responsible for Resident Care posted at the front desk was dated 7/29/24, the space for census was blank and the column labeled actual hours worked was blank. Review of the Report of Nursing Staff Directly Responsible for Resident Care, from 6/30/24 through 7/30/24, revealed that none of the reports documented the resident census. The reports dated 7/22/24 through 7/29/24 did not document the actual hours worked. During an interview on 8/1/24 at 11:34 AM, Scheduler #1 stated they were responsible for filling out the Report of Nursing Staff Directly Responsible for Resident Care, they stated they did not know that they should update the form when there were staff call offs, so the form was accurately displaying the number of staff in the facility. They did not know the purpose of the daily posted staffing sheets, and they were never given formal training on how to fill them out. Scheduler #1 stated the documents from 7/22/24 through 7/29/24 were completed by the Director of Nursing, because they were on vacation. Scheduler #1 stated they completed the forms on Fridays for the weekend days. During an interview on 8/2/24 at 11:07 AM, the Acting Director of Nursing stated the daily posted staffing sheets were supposed to be updated every shift to reflect actual staff in the building, so residents and family could see how much staff they had. They didn't know who was recently filling them out, but it used to be the supervisor's responsibility. 10 NYCRR 415.13		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 43785 Based on interview and record review conducted during the Extended Recertification Survey completed on 8/2/24, the facility did not ensure that the pharmacist reported irregularities to the attending physician, the facility's Medical Director and the Director of Nursing (DON) were acted upon. The attending physician must document in the medical record that the identified irregularity has been reviewed and what action should be taken. Specifically, the facility did clarify the providers orders to continue or discontinue a medication based on the pharmacy consultant's recommendation. The finding is: The policy and procedure titled Unnecessary Drugs dated 8/6/15 documented that during the monthly medication regimen review, the pharmacist evaluates resident-related information for dose, duration, continued need, and the emergence of adverse consequences for all medication. When evaluating the resident's progress, the practitioner reviews the total plan of care, orders, the resident's response to medication and determines whether to continue, modify, or stop a medication. The policy and procedure documented that the pharmacist must report any irregularities to the attending physician, and the director of nursing and these reports must be acted upon. The practitioner will document an acceptable clinical indication for use of medication. Resident #19 had diagnoses that included Alzheimer's disease, delirium, and cognitive communication deficit. The Minimum Data Set (a resident assessment tool) dated 6/12/24 documented that Resident #19 was severely cognitive impaired. The Minimum Data Set documented Resident #19 was taking an antidepressant and antipsychotic medications. Review of the Comprehensive Care Plan with dated 6/14/24, documented Resident #19 was receiving psychotropic therapy relate to the diagnosis of dementia. Their target behaviors were weepiness. Medications included Zyprexa (olanzapine), Lexapro (escitalopram) and Trazadone (an antidepressant medication). Interventions included medication reductions as indicated, pharmacy consultant review as need, and psychology consults as indicated. The Physician's Orders dated 8/2/24 documented Resident #19 had a current order for escitalopram 5 milligrams once a daily with a start date of 12/28/24; Trazadone 50 milligram twice a day with a start date of 4/25/24; and olanzapine 5 milligrams daily with a start date of 10/18/23. Review of the Consultant Note for April 15, 2024, revealed the Pharmacy Consultant documented that Resident #19 was due for a gradual dose reduction (GDR) review for Trazadone and olanzapine. The Pharmacy Consultant documented to consider decreasing Trazadone 50 milligrams twice a day and to consider decreasing olanzapine to 2.5 milligrams daily. Nurse Practitioner #1 signed and dated the recommendation on 4/25/24 with a notation to decrease Trazadone to 50 milligrams twice daily. Nurse Practitioner #1 did not document a rationale to agree or disagree with the recommendation to consider a decrease of the olanzapine. (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Consultant Note for June 13, 2024, the Pharmacy Consultant documented that Resident #19 was due for a gradual dose reduction review for escitalopram. The Pharmacy Consultant documented to consider discontinuing the escitalopram. Physician Assistant #1 signed and dated the recommendation on 6/24/24 with a notation decline GDR (gradual dose reduction). Nurse Practitioner #1 signed and dated the recommendation on 6/25/24 to discontinue the escitalopram. During an interview on 8/2/24 at 8:57 AM, Licensed Practical Nurse #1 stated they were not involved in the pharmacy consultant recommendation process but if a new order was handed to them, they would transcribe the new order. After review of the pharmacy consultant recommendation dated 6/13/24 for Resident #19, they stated that Physician Assistant #1 wrote decline GRD dated 6/24/24 and was unsure what that meant. Licensed Practical Nurse #1 stated Nurse Practitioner #1 also documented on the 6/13/24 pharmacy consultant recommendation on 6/25/24 to discontinue Resident #19 escitalopram. After review of Resident #19's medical provider orders, Licensed Practical Nurse #1 stated the resident remained on escitalopram and it should have been discontinued. Licensed Practical Nurse #1 stated the pharmacy consultant recommendation from 6/13/24 was not handed to them and that was the first time they reviewed the recommendation. During a telephone interview on 8/2/24 at 9:09 AM, after review of the pharmacy consultant recommendation for Resident #19 on 6/13/24 Physician Assistant #1 stated on 6/24/24 they documented on the consultant form they declined the recommendation to discontinue the escitalopram. They stated then on 6/25/24 Nurse Practitioner #1 documented to discontinue Resident #19's escitalopram. Physician Assistant #1 stated they would have expected the nursing staff to follow the most recent documented order and Resident #19 escitalopram should have been discontinued. During a telephone interview on 8/2/24 at 9:15 AM, Nurse Practitioner #1 stated pharmacy consultant recommendations were placed into the book for review. They stated after they agree/disagree with the recommendation they will hand the consult to the nurse to transcribe any new orders. After review of the 4/15/24 pharmacy consultant recommendation, they stated they agreed to a gradual dose reduction for Resident #19's Trazadone. Nurse Practitioner #1 stated they disagreed to reducing Resident #19 olanzapine and did not write a note or give a rationale as to why they did not agree. Nurse Practitioner #1 added they did not feel they needed to write a justification note as to why they disagreed with the recommendation to decrease Resident #19's olanzapine. After review of the 6/13/24 pharmacy consultant recommendation, Nurse Practitioner #1 stated on 6/24/24 Physician Assistant #1 recommended not to discontinue Resident #19's escitalopram and on 6/25/24 they recommended to discontinue the escitalopram. Nurse Practitioner #1 stated they were unsure why the consult was still in their book for review if Physician Assistant #1 had already review the recommendation. Nurse Practitioner #1 stated when they signed the recommendation on 6/25/24 they want the escitalopram to be discontinued but would have expected the nursing staff to contact a provider for clarification. During a telephone interview on 8/2/24 at 9:42 AM, the Pharmacy Consultant stated they did not receive the pharmacy consultant recommendation for Resident #19 that a medical provider addressed from 4/15/24 and 6/13/24. They stated the past few months it was hit or miss if they received any of their recommendation addressed from the providers of any resident from the facility. The Pharmacy Consultant stated they would expect there to be documentation from the medical provider as to why they declined a gradual dose reduction/discontinuation for Resident #19 on the 4/15/24 recommendation. The Pharmacy Consultant stated they were unaware of the conflicting orders on Resident #19's 6/13/24 recommendation to discontinue the escitalopram. They stated they would have expected the staff to call the medical providers for clarification to be able to act upon those recommendations accordingly. (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/2/24 at 11:57 AM, the Acting Director of Nursing stated that they were unsure of the pharmacy consultant recommendation process. After review of the pharmacy consultant recommendation for Resident #19 on 6/13/24 they stated that Physical Assistant #1 and Nurse Practitioner #1 had documented conflicting orders and was unsure which order to follow. They stated they would expect the nursing staff to follow up with a medical provider for clarification. In a further interview at 1:30 PM, the Acting Director of Nursing stated they were unable to located documented evidence that a clarification was completed, and Resident #19 remained on escitalopram. During a telephone interview on 8/2/24 at 12:34 PM, Register Nurse Unit Manager #1 stated that pharmacy consultant recommendations were printed from the electronic medical record and place into the provider acute log books for the provider to review. They stated the provider would either agree/disagree and write an order if need be. Register Nurse #1 stated the order then would be given to themselves or a floor nurse for transcription of the new order. Register Nurse #1 stated that if the medical provider disagreed with the recommendation, then the provider should be writing an explanation as to why. Register Nurse #1 stated they were unaware of the miscommunication on the 6/13/24 consultant recommendation and the nursing staff should have contacted a medical provider for clarification. 10 NYCRR 415.18 (c)(2)		

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 43785 Based on observation, interview and record review conducted during the Extended Recertification survey completed on 8/2/24, the facility did not ensure a Quality Assurance and Performance Improvement program (QAPI) developed, implemented, monitored, maintained effective systems, and used feedback to develop an appropriate plan of action to correct identified deficiencies. Specifically, the facility administration was aware of the continued non-compliance with sufficient nursing staff and the concerns brought forth by staff, resident council, and advocates. The facility QAPI plan was ineffective and was not maintained to a correct a quality deficiency identified on the previous recertification survey to ensure there was sufficient nursing staff to meet the needs of each resident. The finding is: Review of the facility document titled QAPI Plan (Quality Assurance Performance Improvement) dated 2024 documented the organization is to take a proactive approach to continually improve the way we care for and engage with the residents, caregivers, and other partners. The Plan documented that aspect of service and care are measured against established performance goals and the key monitors are measured and trended on a quarterly basis. The plan documented that the if a performance goal is not being met the facility will conduct a root cause and analysis and develops a performance improvement projection utilizing plan, do, study, act cycles to meet the goal by an established date. The plan documented that a facility goal would be to review and enhance the quality of care of its residents in the following area (unity in action): activities, hairdressers, resident meals, and staffing modifications to help resident care. The plan also documented that a facility goal would be to develop a stable workforce by decreasing the annual turnover at or below 33% for all departments. Refer to F725 Sufficient Nursing Staff scope and severity F Refer to F600 Free from abuse and neglect scope and severity F Refer to F727 Registered 8 hours/7 days/week scope and severity E Review of Recertification Survey Statement of Deficiencies (form 2567) issued by the New York State Department of Health with an exit date of 8/12/22 revealed the facility was cited at F-725 for the lack of sufficient nurse staffing to meet the care needs of the residents. The facilities corrective action plan included adequate staff will be provided to ensure residents will be served and fed in an appropriate amount of time. Call bell wait times will be adequate, showers/baths will be provided. Trend analysis data will be reviewed by QAPI trends or issues will be discussed and recommendations for improvement will be made as needed. Review of the facility's Continuous Quality Improvement Quarterly Report agenda dated July 25, 2023; October 31,2023; and February 6, 2024, documented that turnover statistic were review at the meeting. Review of the Facility Continuous Quality Improvement Quarterly Report agenda date April 23,2024 documented that turnover statistics and current nursing coverage was reviewed at the meeting. (continued on next page)		

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Resident Council minutes on 7/29/24 revealed staffing concerns were discussed in April 2024. May 2024 minutes residents complained of not getting their showers. The facility response was to add new staff agencies to their staff pool. In June 2024 they discussed the new agency staff during the meeting, but the residents' responses were not documented. During an interview on 7/30/24 at 11:36 AM, the Ombudsman stated the residents had concerns with staffing at the facility. They stated the Administrator was aware of the residents' concerns. During an interview on 8/2/24 at 11:07 AM, the Acting Director of Nursing, stated they were aware the facility was not meeting their minimum staffing numbers and they did not feel that staff could get their work done, including incontinence care, and serving meals. They stated the Administrator and Corporate were aware they were not meeting their minimum staffing numbers. The Acting Director of Nursing also stated they were aware the facility had days where there was no Registered Nurse in the building for the required 8 consecutive hours. During an interview on 8/1/24 at 11:34 AM, Scheduler #1 stated the facility did not meet their minimum staffing numbers on several days. Scheduler #1 stated there were 5 agencies contracted, but currently only 1 was able to be used. Scheduler #1 stated the Director of Nursing, and the Administrator were both aware they were not meeting their minimum staffing numbers. During an interview on 8/2/24 at 12:09 PM, the Administrator stated they were aware that there were days the facility did not have a Registered Nurse for the required 8 consecutive hours. They stated when they were notified that there was no Registered Nurse available, they notified Corporate and attempted to find coverage. They understood that it was essentially the Administrators responsibility to ensure safe nursing coverage in the facility. The Administrator stated they were aware they were not meeting their minimum staffing. The Administrator stated that staff had come to them and told them they could not get their work done because of low staffing. During an interview on 8/2/24 at 1:07 PM, with the Acting Director of Nursing present, the Administrator stated that Quality Assurance Committee meets quarterly for a formal meeting and involves the interdisciplinary team members, the Medical Director, and a board member. The Administrator stated they were aware the facility had a cited deficiency for insufficient nursing staffing on the last recertification survey that involved the inability of staff to perform adequate care needs for the residents. The Administrator stated that had discussed as an interdisciplinary team about the need for more nurse staffing and developed interventions. The Administrator stated that they had communicated with cooperate administration about the lack of staff retention and were given more access to staffing agencies and staff incentives. The Administrator stated that the quality improvement plan was effective because it was brought out awareness that more nursing staff was needed. The Administrator stated they strive to meet the facilities minimal staffing numbers but due to call offs it is too hard to react on a short-term basis. The Administrator added the facility could always use more staff. During an interview on 8/2/24 at 1:49 PM, the Corporate Director of Skilled Nursing Facilities Administration stated they were aware the facility was not meeting their minimum nurse staffing numbers. They felt the staff could get their work done with the numbers they had, but that was not their goal. 10 NYCRR 415.27 (c)(2)(3)(v)		