STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335357	A. Building B. Wing	03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Pines Healthcare & Rehab Centers Olean Campus	2245 West State Street Olean, NY 14760

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 36415 Based on observation, interview, and record review conducted during the Standard survey completed on 3/7/25, the facility did not ensure residents were free from physical restraints imposed for purposes of discipline or convenience that were not required to treat the resident's medical symptoms, used for the least amount of time and document ongoing re-evaluation of the need for restraints for one (1) (Resident #19) of two (2) residents reviewed for physical restraints. Specifically, Resident #19 did not have a physician's order for the use of a wheelchair trunk restraint and there was no evidence quarterly assessment/evaluation was completed for its use. Additionally, there was no documented evidence the trunk restraint was released every two hours. The finding is: The policy and procedure titled Physical Restraints dated 4/16 documented each physical restraint in use was to be assessed and monitored as a medical necessity using the interdisciplinary approach. Physical restraints are items used to restrict, restrain or prevent movement of a person. Examples may include but not limited to chairs with a latching bar and/or securing strap. The multidisciplinary team will assess the use of the restraints on at least a quarterly basis and to be reviewed at the resident's interdisciplinary quarterly care plan meeting. Options for removal or reduction of restraint were to be considered at that time, documentation of risks, benefits and plan were to be placed in the medical record. A physician order was required for any device considered a restraint and the physician order was to be reviewed and renewed at least every 60 days. Alternatives to restraints must be tried and the effect documented routinely. Nursing staff were to attend to a restrained resident at a minimum of every two hours; restraint was to be released or removed at least every two hours. Resident #19 had diagnoses which included Parkinson's disease, repeated falls, and encephalopathy (disease of both brain and spinal cord). The Minimum Data Set (MDS- a resident assessment tool) dated 1/17/25 documented Resident #19 was understood, understands and had moderate cognitive impairment. Resident #19 required total dependence of staff for dressing and used a trunk restraint daily while in their wheelchair. (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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	335357	A. Building B. Wing	03/07/2025

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The comprehensive care plan dated 11/23/23 documented Resident #19 had limited physical mobility related to Parkinson's disease and contractures of bilateral shoulders. Interventions included Certified Nurse Aides were to bring Resident #19 to the Licensed Practical Nurse in the morning to apply the harness (trunk restraint). Licensed Practical Nurses were to release the harness every two hours for ten minutes then reapply; monitor for the ten minutes harness was removed. The Kardex (a guide used by staff to provide care) dated 3/6/25 documented Certified Nurse Aides were to bring Resident #19 to the Licensed Practical Nurse in the morning to apply the harness. Licensed Practical Nurses were to release the harness every two hours for ten minutes then reapply; monitor for the ten minutes harness was removed. Review of the order summary report dated 8/7/24 through 3/5/25 revealed there was no order for the use of a trunk restraint (harness). On 3/6/25 and order was received that documented, Licensed Practical Nurse in morning to apply harness. Licensed Practical Nurses to release harness every two hours for ten minutes then reapply. Monitor for the ten minutes harness was removed every two hours for release harness when up in wheelchair. Review of the Medication Administration Treatment Administration Records dated 1/1/25 through 3/5/25 lacked documented evidence of release of restraint. Review of the Provider Visits dated 8/7/24 through 2/12/25 lacked documented evidence for use of a restraint. Review of the Restraint - Physical Quarterly/Annual Evaluation dated 5/17/24 documented Resident #19 had frequent falls, was sliding out of their wheelchair, had generalized weakness, poor trunk stability and abnormal posture. Additionally, an alternative chair was previously trialed which improved positioning, however the chair style could not be self-propelled by Resident #19. Resident #19 was care planned for a chest strap in the wheelchair for maintenance of independence with wheelchair mobility. Recommendations included continued use of restraint. There were no additional Restraint - Physical Quarterly/Annual Evaluations between 5/17/24 and 3/6/25. Review of the Restraint - Physical Initial Evaluation dated 8/7/24 with a locked date of 2/10/25 documented Resident #19 presented with generalized weakness, poor positioning, and poor trunk stability/ability reposition self in wheelchair. Resident #19 was found tipped forward in the wheelchair due to leaning and shifting weight forward secondary to poor trunk control abilities. The date of the first application of the chest strap was 1/23/23. Additionally, it was documented that a physician order was required and received. There were no additional Resident - Physical Initial Evaluations completed between 5/17/24 and 2/10/25. Review of the nursing progress notes dated 1/1/25 through 3/5/25 lacked documented evidence that the restraint was released every two hours. Review of the Physical Therapy Evaluations and Progress notes dated 8/8/24 through 3/6/25 lacked documented evidence an assessment for the use of a restraint. Review of the Occupational Therapy Evaluations and Progress notes dated 8/8/24 through 3/6/25 lacked documented evidence an assessment for the use of a restraint. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 3/3/25 at 11:08 AM, Resident #19 was in their room sitting up in their wheelchair. There was a black strap around Resident #19's chest that wrapped around the back of their wheelchair and was secured in the back. During an interview on 3/6/25 at 11:11 AM, Certified Nurse Aide #6 stated Resident #19 reaches for things a lot and leans to one side, so they wear a strap around their them to help them sit up. They stated they did not think that Resident #19 could release the strap themselves and the nurses release the strap every two hours for about 15-20 minutes. During an interview on 3/6/25 at 11:20 AM, Certified Nurse Aide #7 stated Resident #19 wore a holster to keep them from leaning and falling out of their chair. Prior to using the holster, a different type of wheelchair was tried to help Resident #19 with their positioning, but they did not like that wheelchair because they were unable to self-propel in it. They stated they were not sure if anything other than a wheelchair was tried prior to using the holster. They described the holster as a strap that goes around the front of Resident #19 and hooks around the back of their wheelchair. Certified Nurse Aide #7 stated the Certified Nurse Aides were unable to watch and monitor Resident #19 at all times and that was probably why it was being used. During an interview on 3/6/25 at 11:27 AM, Licensed Practical Nurse #5 stated Resident #19 wore a safety strap for positioning. Prior to using the strap, therapy attempted to work with Resident #19 using a different type of wheelchair, but they were unable to self-propel themselves in that chair. Resident #19 was given a grabber to help reach for things, but they would still fall from their chair without wearing the strap. They stated the strap goes around Resident #19's chest, around the back of their chair, and clips in the back of the wheelchair. They stated if Resident #19 spun the strap around they would probably be able to unclip it, but if they were unable to do that, then it would be considered a restraint. They stated it was unclipped every two hours for about 15 minutes. Licensed Practical Nurse #5 stated there used to be a place in the Treatment Administration Record to document that the strap was released but it was no longer there. They stated it should probably be documented to show that Resident #19 wasn't restrained to their chair all the time. They stated Resident #19 had good days and bad days and there should have been an attempt made at some point to reduce the use of the strap. When Resident #19 was out of their room, it was easier for staff to monitor them, but Resident #19 liked to be in their room and staff would not be able to monitor them at those times. During an interview on 3/6/25 at 11:37 AM, Licensed Practical Nurse #4 Unit Manager stated Resident #19 wore a positioning strap across their chest that wrapped around the back of their wheelchair. Resident #19 was unable to self-remove the strap, so in a way it was considered a restraint. Therapy completes restraint assessments. They stated Resident #19 was unable to hold themselves up well and the strap allows them to be more independent by keeping them from slumping over or leaning too far forward. They stated they believed there was not an order or documentation that the strap was removed every two hours because it was listed in the Kardex, but they had to double check with Registered Nurse Supervisor #1. During an interview on 3/6/25 at 11:56 AM, Registered Nurse Supervisor #1 stated they felt it was a gray area if a physician's order was needed for the strap because it was just a strap. They stated the nurses should document when it has been released. They stated because the strap was used for safety, and they did not believe it was a restraint. (continued on next page)

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	335357	A. Building B. Wing	03/07/2025

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/6/25 at 12:37 PM, the Director of Rehabilitation stated they referred to the strap that went around Resident #19 as a lap band and it was to support their trunk. They stated prior to using it, Resident #19 was always leaning forward and having falls. Resident #19 was unable to undo the lap band. The therapy department was responsible for completing restraint evaluations every quarter. They were informed in February 2025 that there was a restraint initial evaluation that was opened for 8/10/24, and it was blank. The form was completed and locked on 2/10/25 by therapy. They stated there should have been a restraint evaluation completed by therapy in August and November of 2024. The Director of Rehabilitation stated in the restraint evaluation that was completed 2/10/25, it was indicated that a physician order was required, and it was the responsibility of the Nursing Supervisors to communicate the need for an order to the Medical Director. During an interview on 3/6/25 at 4:03 PM, Licensed Practical Nurse #6 stated Resident #19 wore a strap that went around their chest and wheelchair. Resident #19 was unable to reach behind the wheelchair to unhook the strap, which would make it a restraint. They stated they have seen Resident #19 moving their torso back and forth while wearing the strap trying to reach and pick stuff off the floor. Resident #19 had a grabber to help reach for items as well but did not always use it. Licensed Practical Nurse #6 stated the documentation in the Medication Administration Record began on 3/6/25 and before that, they did not document anywhere that the strap was released. It should have been documented when it was released so that anyone who read the chart knew that it was released every two hours when they were in their wheelchair. During an observation and interview on 3/7/25 at 8:50 AM, Resident #19 was in their room sitting upright in their wheelchair. Licensed Practical Nurse #4 Unit Manager requested Resident #19 to remove their chest strap. Resident #19 stated, they were unable to remove it because the clip was behind the wheelchair, and they were unable to reach it. They stated the strap keeps them from plopping out of their wheelchair. Licensed Practical Nurse #4 Unit Manager stated they knew that different type of wheelchairs, the grabber and different types of straps and harnesses were trialed with Resident #19, but they were unsure of any recently attempted interventions trialed to reduce the use of the strap between August 2024 and March 2025. During an interview on 3/7/25 at 11:23 AM, the Director of Nursing stated they expected evaluations to be completed quarterly by therapy and for a physician's order to be in place for any restraint. They stated they believed the breakdown in communication occurred when the facility switched therapy companies, and they were unaware that the evaluations needed to be completed quarterly. They stated they 100% believed Resident #19 required the strap to assist with positioning and so they were able to be as independent as possible; without it, they were unable to hold themselves up to complete hygiene or feeding tasks and participate fully in activities. They stated a few steps were missed and they would expect the nurses to document when the strap was released to show that it was released every two hours. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/7/25 at 12:14 PM, the Administrator stated they expected therapy to complete the evaluations for restraints quarterly and if they had missed an evaluation, it was the Minimum Data Set Coordinator's responsibility to notify them of any missed evaluations. The purpose of the evaluations was to ensure the least restrictive interventions were trialed prior to using a restraint. They stated they were not sure if Resident #19 required a physician's order for their strap because it was a positioning device. But they did expect for nursing to document the strap was released every two hours because that was a requirement. The Unit Manager, Nursing Supervisor and ultimately the Assistant Director of Nursing and Director of Nursing were responsible to make sure the nurses were documenting the strap was released every two hours. During a telephone interview on 3/7/25 at 12:34 PM, the Medical Director stated they were somewhat familiar with Resident #19, but they did not recall any straps going around the chest of the resident and clipping behind the back of the wheelchair. They stated that sounded like a restrictive thing and there was no order for that. They stated they were not aware of this, and they expected someone from the facility to notify them that it was being used and for what purpose. They stated it fell under restriction and whoever decided it was necessary at the facility was responsible to let them know about it. During an interview on 3/7/25 at 12:42 PM, the Minimum Data Set Coordinator stated their most recent Minimum Data Set on 1/17/25 indicated Resident #19 used a trunk restraint because they had a restraint that went across their trunk area. They stated they received that information by looking at the therapy documentation and that was when they realized there was a blank restraint evaluation open from last August. They stated they usually let therapy know when there were missing quarterly assessments, but they were late reporting the missing the restraint evaluation to the therapy department. They stated they did not remember if they let anybody in nursing know that there was an order missing for the restraint. 10 NYCRR 415.4(a)(2)(iii)

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	335357	A. Building B. Wing	03/07/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 36415 Based on interview and record review conducted during a Complaint investigation (#NY00343645) during a Standard survey completed on 3/7/25, the facility did not ensure that all alleged violations involving abuse or mistreatment were reported immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse, to the administrator of the facility and to other officials (including to the State Survey Agency) for one (Resident #99) of two residents reviewed for abuse. Specifically, facility staff did not immediately, or no later than two hours, report an allegation of verbal abuse to the Administrator. Additionally, once the Administrator was aware of the verbal abuse allegation, it was not reported to the State Survey Agency in the required timeframe. The finding is: The policy titled Abuse Prevention and Reporting last revised 2/25 documented it is the policy to prevent, identify and investigate incidents of resident abuse; treat all residents with kindness, dignity and consideration; ensure all residents are free from verbal abuse; and to comply with all State and Federal Regulations regarding abuse. Verbal abuse was documented to include, but not limited to use of profanity, swearing; sarcasm, threats; teasing or degrading. Employees are required to report any act of resident abuse to their supervisor and/or the facility Director of Nursing and/or Administrator immediately. The New York State Department of Health will be notified by the Nursing Director and/or Administrator/Designee per reporting manual guidelines. Resident #99 had diagnoses that included dementia, stroke affecting right side, and anxiety disorder. The Minimum Data Set (a resident assessment tool) dated 4/20/24 documented Resident #99 had moderate cognitive impairment was understood and understands. The comprehensive care plan initiated on 4/14/22 documented Resident #99 had an activities of daily living self-performance deficit related to confusion, mild right sided weakness and impaired balance. Approaches included one assist with personal hygiene and toileting hygiene. On 1/29/24, Resident #99 had the potential for mood state/behavior status issues related to anxiety. Approaches included caregivers to provide opportunity for positive interaction and attention. Review of the Department of Health Nursing Home Facility Incident Report submitted successfully on 5/29/24 at 2:55 PM, documented an allegation type of mental/verbal abuse to Resident #99 in the resident's bathroom and unit hallway by Certified Nurse Aide #8. The incident date/time was documented as 5/25/24 at 10:00 AM and the date/time the Administrator was first made aware of the incident was on 5/28/24 at 2:20 PM. The facility investigation submitted on 6/4/24 at 4:29 PM, documented there was a verified finding of abuse toward Resident #99. The facility investigation revealed verbal abuse was not reported to the Assistant Director of Nursing by staff members involved until three days after the incident occurred. (continued on next page)

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	335357	A. Building B. Wing	03/07/2025

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/7/25 at 9:23 AM, Certified Nurse Aide #3 stated they recalled Resident #99 asked Certified Nurse Aide #8 for something and Certified Nurse Aide #8 replied rudely. Certified Nurse Aide #3 stated if they heard verbal abuse, they would report it to their charge nurse or supervisor so no harm came to the residents, and so management could take care of the matter as soon as possible to ensure the safety of all the residents. Certified Nurse Aide #3 reviewed their interview/statement given on 5/28/24 and stated Licensed Practical Nurse #1 was already aware as they witnessed Licensed Practical Nurse #1 advising Certified Nurse Aide #8, they could not say things like hold off, let me think before I strangle you to a resident. During an interview and observation on 3/7/24 at 9:54 AM, Licensed Practical Nurse #1 stated if an aide reported abuse to them, they would immediately make sure the resident was safe and notify the supervisor. Licensed Practical Nurse #1 reviewed their interview/statement given on 5/29/24, and stated they remembered telling Certified Nurse Aide #8 to leave Resident #99's room during care because of how they were speaking to Resident #99, it was verbal abuse. Licensed Practical Nurse #1 stated they called Registered Nurse Supervisor #1 to report what was going on with Resident #99 but could not recall if they reported what Certified Nurse Aide #8 said to Resident #99. They stated they usually reported any abuse concerns immediately but felt they handled it at that time and did not think Registered Nurse Supervisor #1 would have addressed the situation. During an interview on 3/7/25 at 10:24 AM, Registered Nurse Supervisor #1 stated any allegation of abuse was reported to the Director of Nursing as soon as it was reported to them. Registered Nurse Supervisor #1 stated everyone was responsible to report abuse for resident safety. They stated any abuse that has caused injury has to be reported within two hours, if no injury then within twenty-four hours. They stated the Director of Nursing was responsible for reporting abuse to the Department of Health. Registered Nurse Supervisor #1 denied that any abuse allegation regarding Resident #99 was brought to their attention. They stated Certified Nurse Aide #8 was known to be verbally loud, animated, eccentric and residents would indicate they did not like Certified Nurse Aide #8's demeanor. During an interview and observation on 3/7/25 at 10:37 AM, Certified Nurse Aide #4 stated an allegation of verbal abuse was brought to their attention by Certified Nurse Aide #3 regarding Certified Nurse Aide #8. Certified Nurse Aide #4 reviewed their interview statement provided on 5/29/24, during the facility investigation, and stated the verbal abuse allegation was reported to them on 5/28/24 and had occurred over the weekend. Certified Nurse Aide #4 stated the staff should not have waited to report the verbal abuse and should have reported it immediately to the nursing supervisor. During an interview on 3/7/25 at 1:25 PM, the Administrator in the presence of the Director of Nursing Home Deputy of County Administrator, stated staff should have reported the verbal abuse made to Resident #99 immediately and they did not. They stated it was important for abuse to be reported immediately because there was a time constraint on reporting abuse to the Department of Health. They stated they have two hours to report abuse with serious bodily injury and any other abuse would be reported within twenty-four hours. 10 NYCRR 415.4(b)(2)

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	335357	A. Building B. Wing	03/07/2025

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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. 36415 Based on observation, interview, and record review conducted during a Complaint investigation (#NY00363844) during a Standard survey completed on 3/7/25, the facility did not ensure residents with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing for one (1) (Resident #16) of three (3) residents reviewed. Specifically, Resident #16 lacked pressure ulcer assessments that included accurate pressure ulcer staging, and there was the lack of medical provider documentation to include the resident's pressure ulcer and treatment plan. The finding is: The policy and procedure titled Pressure Ulcer/Wound Management and Treatment revised 3/15/23 documented to ensure a resident with a pressure ulcer receives necessary treatment and services to promote healing a Registered Nurse will accurately assess and reassess all pressure ulcers on a weekly basis, document pressure ulcer assessments in the medical record, abide by the National Pressure Ulcer Advisory Panel (NPUAP) publications, Pressure Ulcer Prevention and Treatment Clinical Practice Guideline on staging pressure ulcers and measurement of pressure ulcers. The Wound Evaluation will be completed and documented in the Wound and Skin Module in the electronic medical record weekly. Licensed Practical Nurses may measure and document on established wounds. Description may include when applicable: exudate (fluid released from wound), necrotic (dead) tissue, drainage, tissue type, and stage (only pressure ulcer) per the National Pressure Ulcer Advisory Panel guidelines. Purpose and Function of Wound/Pressure Ulcer Management Team to provide consultation to unit nurses and physicians in the treatment of pressure ulcers; monitor the healing of existing pressure ulcers through weekly team meeting discussions with rounds on units as determined by team. Review of an undated Wound Assessment and Documentation in-service packet provided by the Director of Nursing documented to assess characteristics, amount (document in percentage) and location of tissue types which included: Necrotic Tissue (dead; non-viable, included slough-yellow, green, grey, nonviable (necrotic) tissue, usually lighter in color, thin, wet stringy; and eschar-black, brown, dry, nonviable (necrotic) tissue, usually darker in color, thicker, hard. Staging system- assessment system that classifies pressure ulcers, documented: Stage 2: partial thickness loss of dermis (skin) presenting as a shallow open ulcer with a red, pink wound bed, without slough; Stage 3: full thickness tissue loss. Slough may be present but does not obscure the depth of the tissue loss; Un-stageable: full thickness tissue loss in which the base of the ulcer is covered by slough and/or eschar in the wound bed. Further description: until enough slough and/or eschar is removed to expose the base of the wound, the true stage, cannot be determined. Resident #16 had diagnoses which included pressure ulcer of sacral (sacrum) region, type 2 diabetes mellitus, and neuromuscular dysfunction of bladder. The Minimum Data Set (a resident assessment tool) dated 2/1/25, documented Resident #16 was understood, understands and was cognitively intact. Resident #16 had an indwelling catheter, was always incontinent of bowel, was at risk for the development of pressure ulcers and had an unhealed stage 2 present on admission. (continued on next page)

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	335357	A. Building B. Wing	03/07/2025

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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	The comprehensive care plan initiated 3/31/2024 documented Resident #16 had the potential for pressure ulcer/impairment of skin integrity related to fragile skin, and immobility. Interventions included to keep skin clean and dry, report abnormalities, failure to heal, maceration to the Medical Doctor/Nurse Practitioner, turn and reposition every 2-3 hours while in bed. The goal was revised 9/5/2024 and documented the resident would remain free from injury/skin impairment with a target date of 5/6/25. Additionally, nutritional care plan revised 1/21/2025 documented risk altered skin integrity-stage 2 coccyx (tailbone). The Order Summary Report, order date range 7/23/24-3/31/25, documented stage 2 to coccyx (tailbone), cleanse with normal saline, pat dry, apply silver alginate (antimicrobial dressing) and cover with foam dressing every shift and as needed, start date 1/17/25. On 2/5/25 treatment order changed frequency to everyday shift and as needed. Review of Provider Visit progress notes dated 1/22/25 and 2/21/25 revealed there was no documented evidence of pressure ulcers evaluation. On 2/21/25 Nurse Practitioner #1 documented the resident's skin had no rashes or lesions. Review of Skin and Wound Evaluation; and Wound Evaluation (picture) revealed the following: -1/17/25, completed by Registered Nurse Supervisor #1, documented Stage 2 pressure ulcer to coccyx present on admission (1/17/25). Wound measurements 3.9 centimeters length by 0.5 centimeters width, slough (dead tissue) filled 80 percent of the wound bed. -1/22/25, completed by Licensed Practical Nurse #2, Head Nurse, documented Stage 2 pressure ulcer to coccyx. Wound measurements 1.4 centimeters length by 0.8 centimeters width. -1/29/25, completed by Registered Nurse Supervisor #2, documented Stage 2 pressure ulcer to coccyx. Wound measurements 1.2 centimeters length by 0.6 centimeters width. -2/5/25, completed by Licensed Practical Nurse #2, Head Nurse, documented Stage 2 pressure ulcer to coccyx. Wound measurements 2.0 centimeters length by 0.8 centimeters width. -2/12/25, completed by Licensed Practical Nurse #2, Head Nurse, documented Stage 2 pressure ulcer to coccyx. Wound measurements 1.8 centimeters length by 0.8 centimeters width. -2/19/25, completed by Licensed Practical Nurse #2, Head Nurse, documented Stage 2 pressure ulcer to coccyx. Wound measurements 1.2 centimeters length by 0.5 centimeters width. -2/26/25, completed by Licensed Practical Nurse #2, Head Nurse, documented Stage 2 pressure ulcer to coccyx. Wound measurements 1.6 centimeters length by 0.5 centimeters width. -3/5/25, completed by Licensed Practical Nurse #2 Head Nurse, documented Stage 2 pressure ulcer to coccyx. Wound measurements 1.0 centimeters length by 0.3 centimeters width. Review of the wound pictures as documented above revealed slough was visualized to the pressure ulcer wound bed on the following dates: 1/17/25,1/22/25, 1/29/25, 2/5/25, 2/12/25, 2/26/25 and 3/5/25. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335357	A. Building B. Wing	03/07/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/5/25 at 11:46 AM, Resident #16 stated they have a hole on their buttocks that was acquired while in the hospital. They stated treatment to their buttocks was completed daily. Additionally, they stated the hole on their buttock has not been seen by a specialist, or wound provider to their knowledge. During an observation of wound care on 3/6/25 at 12:37 PM revealed Resident #16 had a pressure ulcer to sacral area with full thickness tissue loss, with the base of the ulcer covered by slough in the wound bed (un-stageable). During an interview at the time of the observation Licensed Practical Nurse #1 stated the pressure ulcer was documented as Stage 2 to the coccyx. At this time, Licensed Practical Nurse #1 described the pressure ulcer wound bed as yellow. During an interview and observation on 3/6/25 at 1:07 PM, Licensed Practical Nurse #2 Head Nurse stated a Registered Nurse must initiate a wound/pressure ulcer assessment. They stated once the initial assessment was completed, they complete the weekly wound/pressure ulcer picture and evaluation in the electronic medical record. Licensed Practical Nurse #2, stated they complete their weekly unit skin rounds usually with a Certified Nurse Aide only. They stated every Wednesday the Wound Team, consisting of Head Nurses/Unit Managers, Dietary Technician, Therapy Director, Social Worker, Minimum Data Set Coordinator, and Inservice Coordinator/Infection Preventionist meet to discuss weekly pictures and evaluations. They stated the Wound Team discusses if the wound/pressure ulcer was deteriorating, improving, interventions and need for treatment change. Review of Wound Evaluation picture dated 3/5/25, Licensed Practical Nurse #2, stated Resident #16's base of pressure ulcer to coccyx could not be seen due to the presence of yellow tissue. Additionally, they stated the Registered Nurse determines the staging of pressure ulcers with the initial assessment. LPN #2 stated the wound team meets every Wednesday and reviewed wound pictures from their wound rounds and they discussed if wound was deteriorating, improving, if there was a need to change treatment, or interventions. They stated there was no new recommendations given. During an interview and observation on 3/6/25 at 2:01 PM, Inservice Coordinator/Infection Preventionist/Wound Care Certified Registered Nurse stated a Registered Nurse determines the stage of pressure ulcers. They stated once a pressure ulcer was established, they expected the weekly evaluating nurse to take pictures and document on the condition of the pressure ulcer, drainage, wound bed appearance with percentages, peri wound, signs/symptoms of infection and treatment. They stated this was part of the regulation and was important to see if the treatment, and modalities being utilized were assisting in wound healing. They stated review of pressure ulcer staging by the Wound Team was based on observing of the pictures in the electronic medical record. They stated they do not lay eyes on every wound/pressure ulcer and could not say if they had ever laid eyes on Resident #16's pressure ulcer. Inservice Coordinator/Infection Preventionist/Wound Care Certified Registered Nurse reviewed Resident #16's Wound Evaluation pictures in the electronic medical record from 1/17/25 - 3/5/25 and stated the pressure ulcer should have been staged as a Stage 3, as the wound bed presented with slough/fibrin: narcotic tissue. They stated they would not have staged Resident #16's pressure ulcer as an unstageable pressure ulcer on 1/17/25 as the pressure ulcer was not covered with eschar. After reviewing the Wound Evaluation pictures, they stated there was no improvement to the wound bed of the pressure ulcer and the current treatment was not effective. Additionally, they stated they had no answer as to why Resident #16's pressure ulcer was incorrectly staged but stated it was not a Stage 2 and it should have been staged as a 3. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/7/25 at 11:12 AM, Registered Nurse Supervisor #1 stated they were aware Resident #16 had a pressure ulcer. They stated they were taught if they are unable to see what the wound bed looked like it was staged as unstageable, and a pressure ulcer with yellow slough would be staged as unstageable. Registered Nurse Supervisor #1 reviewed pictures of Resident #16's pressure ulcer to coccyx and stated they would have staged pressure ulcer as unstageable on 1/22/25, 1/29/25, 2/5/25, 2/12/25, 2/19/25, 2/26/25, 3/5/25 based on slough completely covering the wound bed. Additionally, they stated taking a picture of a pressure ulcer may not be the best way to stage a wound, as it could be improperly staged depending on glare, and angle when picture was taken. During a follow up interview on 3/7/25 at 11:35 AM, Inservice Coordinator/Infection Preventionist/Wound Care Certified Registered Nurse stated they would expect the evaluating nurse completing weekly wound rounds to be documenting on the appearance of the pressure ulcer wound bed. They stated a wound bed with 80 percent slough would not be considered a Stage 2 pressure ulcer. They stated any ulcer with slough/fibrin would be a Stage 3 or Unstageable. Additionally, they stated the medical providers do not attend the weekly Wound Team meeting but can look through a resident's electronic medical record to view the Skin and Wound evaluation and pictures. During an interview on 3/7/25 at 11:54 AM, the Director of Nursing stated it was important for pressure ulcers to be staged and wound bed described correctly to determine proper wound care, treatment plan, and monitoring of pressure ulcers. The Director of Nursing stated that a Registered Nurse can be notified to lay eyes (in person) on a wound and assess it if there were any concerns or questions when needed. During a telephone interview on 3/7/25 at 12:35 PM, Medical Director #1 stated they were made aware of resident pressure ulcers when they make rounds by the nurse, and they can review wounds in the computer. They could not say if they had ever assessed Resident #16's pressure ulcer. They stated if a pressure ulcer was improving, they would not expect any communication and they would not review pressure ulcer pictures. They stated the only time they expected communication regarding a pressure ulcer is if there was a concern, otherwise they expected the nursing staff to follow protocol. Medical Director #1 stated if a concern was brought to their attention, they would make a progress note to that affect. Additionally, they stated if slough was covering a wound base, it would have to be removed to see how far the pressure ulcer goes. During an interview on 3/7/25 at 12:52 PM, Nurse Practitioner #1 stated they were aware Resident #16 had a pressure ulcer but was unable to recall for sure if they have physically seen the pressure ulcer. They stated if they had seen a pressure ulcer it would be documented under skin assessment with stage and progress. Upon review of Wound Evaluation dated 3/5/25, Nurse Practitioner #1 stated the wound base could not be seen be seen and staging wound be undetermined/unstageable until it was clean. 10 NYCRR 415.12 (c)(2)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 36415 Based on observation, interview, and record review conducted during the Standard survey completed 3/7/25, the facility did not ensure residents were assessed for risk of entrapment from bed rails prior to installation, review the risks and benefits of bed rails with the resident or resident representative, and obtain informed consent prior to the installation of bed rails for one (1) (Resident #18) of one (1) resident reviewed for bed rails. Specifically, Resident #18 was not assessed for risk of entrapment from bed rails, the risks and benefits of bed rails were not reviewed with the resident or their representative, and no consents were obtained prior to bed rail use. The finding is: The policy titled Side Rail Policy dated 4/16, documented side rails will be used if requested by a cognitively intact person or activated health care proxy. Such use is facilitated following education of the requestor and a signed risk benefit analysis. All residents will be evaluated for side rail use at admission/re-admission using the Side Rail and Alternative Equipment Decision Tree. Such use is permitted only after educational material and explanation has been provided to the requestor. The policy titled Safety Devices (Bed) dated 9/23 documented the facility maintains the safety of the resident and prevents injury and harm. The resident beds meet the Food and Drug Administration entrapment guidelines. The facility will provide and utilize devices to assist in bed mobility, and/or prevent injury. Such devices may include bed mobility handles. All residents will be evaluated for safety device use at admission/re-admission, and as needed. The User-Service Manual copyright 2017, for the bed series utilized in the facility, documented when assessing the risk for entrapment you need to consider assist devices and other accessories. It is important to review the resident's physical and mental condition and initiate an appropriate individual care plan to address entrapment risk. The State Operations Manual dated 8/8/24 documented examples of bed rails include but are not limited to grab bars and assist bars. Resident #18 had diagnoses that included Alzheimer's disease, vascular dementia, legal blindness and repeated falls. The Minimum Data Set (a resident assessment tool) dated 2/8/25 documented the resident sometimes understands, sometimes understood, had severely impaired vision and had severe cognitive impairment. Resident #18 was dependent with rolling left and right in bed. No bed rail use was indicated on the assessment. The Kardex (guide used by staff to provide care) dated 3/3/25, documented for bed mobility the resident required bilateral bed mobility handles to aid in turning and repositioning in bed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The comprehensive care plan revised on 11/12/23, documented Resident #18 had an activities of daily living self-care performance deficit related to confusion and dementia. Approaches initiated on 12/9/22 documented Resident #18 used mobility handles to maximize independence with turning and repositioning in bed. On 6/20/24 the resident required bilateral bed mobility handles to aid in turning and repositioning while in bed. A revision on 5/25/2024 documented the resident was at high risk for falls related to confusion, vision/hearing problems. The Nursing Admission Screen and History effective 10/21/22, documented Resident #18 required assistance with bed mobility and could not use a side rail to assist with positioning while care was being provided by staff. The Physical Therapy evaluation dated 8/27/24 documented for bed mobility the resident was dependent, they rarely/never had the ability to understand, and their ability to follow one step directions was inconsistent, even with prompts/cues. There was no documented evidence of an evaluation or use of bed mobility handles. During observations on 3/5/25 at 9:53 AM, 3/6/25 at 9:41 AM, 3/7/25 at 9:05 AM Resident #18's bed had bilateral bed rails secured to the bed frame at the head of the bed. During a continual care observation and interview on 3/6/25 from 9:41 AM to 9:55 AM, Resident #18 was in bed with bilateral bed rails at the head of bed in the up position. During turning and repositioning of Resident #18 in bed, Resident #18 did not utilize the bed rails, their bilateral arms were observed crossed over their chest while being turned during care. Certified Nurse Aides #3 and #5 did not offer instruction or encourage the resident to use the bed rails during care. Certified Nurse Aides #3 and #5 both stated that Resident #18 did not usually use the bed mobility handles (bed rails) at the head of bed to assist with turning and repositioning. During an interview on 3/6/25 at 10:03 AM, Certified Nurse Aide #3 stated they would know if a resident had bed mobility handles if they looked in the resident's room and it would be on the residents' care plan. Certified Nurse Aide #3 stated they did not consider Resident #18's bed mobility handles to be a restraint because it was not a full bed rail. Certified Nurse Aide #3 stated Resident #18 would not be able to follow direction for use of the bed mobility handles to assist with their bed mobility. They stated the therapy department determined if a resident received bed mobility handles. During an interview on 3/6/25 at 10:24 AM, Licensed Practical Nurse #3 stated residents have bed mobility handles for positioning and mobility in bed; some residents preferred them for comfort and safety because they thought they were going to fall out of bed. They stated nursing staff were responsible to make sure that the bed mobility handles were present per the care plan and were still needed. They stated nursing staff could notify therapy to evaluate a resident for the use of bed mobility handles if needed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/6/25 at 5:24 PM, the Director of Rehab stated that therapy evaluated residents for bed mobility handles upon admission, annually and as needed. They stated the therapy department had maintenance install the bed mobility handles to a bed after they felt a resident could utilize them appropriately and safely. They stated bed mobility handles were given to residents to promote more independence with bed mobility. The Director of Rehab did not know whether the bed mobility handles were considered a restraint, or a risk for entrapment and stated they should know for resident safety. The Director of Rehab stated to their knowledge there was not an assessment form, or consent required for the use of the bed mobility handles. During an interview on 3/6/25 at 5:38 PM, the Director of Nursing stated therapy evaluated each resident to see if the use of bed mobility handles was appropriate and able to be used safely. They stated that bed mobility handles were not considered bed rails; they were too short and were used for rolling and repositioning. The Director of Nursing stated no consent forms or bed rail forms were completed for bed mobility handles. The Director of Nursing stated they did not believe the bed mobility handles were a risk for entrapment. They stated if a resident was unable to follow instructions, they would not be appropriate for the use of the bed mobility handles. During an interview on 3/7/25 at 9:10 AM, Registered Nurse #1, Head Nurse, stated they were unaware of any risk, benefit or consents that were needed prior to the installation of the bed mobility handles. They stated they weren't aware of which residents on their unit had bed mobility handles. Registered Nurse #1 stated Resident #18 was not of sound mind, had severe cognitive impairment and did not know they had bed mobility handles. They stated the bed mobility handles were small and did not think they posed an entrapment risk to the residents. During an observation and an interview on 3/7/25 at 9:38 AM, the Superintendent of Buildings and Grounds measured the bed rails attached to Resident #18's bed. They stated the height of the bed rails was fifteen inches and the width was nine and three quarters inches. The Superintendent of Buildings and Grounds stated all residents had to be care planned before installation of bed rails. They stated a mobility handle was a bar that the residents used to be able to move in bed. They stated they always used the most non-restrictive devices as possible. During an interview on 3/7/25 at 11:50 AM, the Minimum Data Set Coordinator stated the bed rail was only supposed to be used to assist the residents in rolling back and forth, these residents should be able to hold on to the rail to support themselves while care was being provided. They stated it did not mean the resident could turn and rotate independently but they would be able to assist in supporting themselves partially while staff provided care. The Minimum Data Set Coordinator stated if Resident #18 was not able to follow instructions to hold on to the bar during care, it would not be appropriate to leave the bar on the bed. They stated that physical therapy did bed mobility assessments yearly and they were required to do quarterly assessments as well. During a follow up interview on 3/7/25 at 1:25 PM, the Director of Rehab stated therapy was responsible to review bed mobility annually or as needed by referral from nursing. They stated they would have expected a physical therapist to have assessed Resident #18's bed mobility handles, bed rails in August 2024 to see if Resident #18 was still capable of using them safely. The Director of Rehab stated if Resident #18 was incapable of using the bed rails, therapy should have documented that, and they should have been removed from the care plan and bed. They stated if Resident #18 could use the bed rails safely, and there was no risk for injury with use that should have been documented. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/7/25 at 1:25 PM, the Administrator stated they were familiar with bed rails regulations and that the facility did not use bed rails. They stated there was not a risk assessment completed for the use of the bed mobility handles. They stated therapy or the head nurse would address the use of the bed mobility handles with family and would expect it to be documented on the evaluation or in a progress note. 10 NYCRR 415.12 (h)(1)