STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335376	A. Building B. Wing	08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Schoellkopf Health Center	621 Tenth Street Niagara Falls, NY 14302

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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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review conducted during the Standard survey completed on 08/22/2025, the facility did not maintain a pest- free environment and an effective pest control program. Specifically, there was of evidence of rodents (dead rodents, rodent droppings) and complaints of rodent sightings in resident rooms. The findings are:The policy and procedure titled Pest Control, revised 11/2024, documented pests can present significant health risks, including the spread of disease, contamination of supplies, and deterioration of hospital infrastructure. The Environmental Services Department is responsible for daily cleaning and maintenance of facilities to minimize conditions conducive to pest infestations. Facilities Management will ensure the physical infrastructure is secure and free of entry points for pests. Food Service will implement sanitation and food handling procedures to prevent pest attraction and contamination in food storage, preparation, and service areas. When an infestation is suspected or confirmed, immediate measures will be taken to address the situation. This may involve the use of pest control specialists, who will assess the infestation and recommend appropriate actions. Review of Pest Sighting Log from 07/07/2025-08/22/2025 provided by the Director of Environmental Services documented pest concerns of mice or a mouse, with vague description of specific location of concern and action taken. On 7/7/25 removed eight (8) dead mice from dietary; 7/8/25 removed mouse from dietary office; 7/10 and 7/11 caught mouse removed, new trap; 8/4 inspected mouse citing in dietary; and 8/22 removed dead mouse, replaced trap in room [ROOM NUMBER] nursing home.Review of Pest Company Service Inspection Reports 07/02/2025 through 08/18/2025 completed by Licensed Exterminator documented: -07/14/2025 one (1) catch in resident room [ROOM NUMBER] that was disposed of.-08/13/2025 one (1) catch was found in resident room [ROOM NUMBER].During the Resident Council Meeting on 08/19/2025 at 2:36 PM, Resident #8 stated that they had seen a mouse a couple of nights ago (over the weekend), and their family member brought in a plug-in device to distract the mice. Observations and interviews on the first floor were as follows: -08/18/2025 at 10:45 AM, revealed a black plastic enclosed box trapper pest monitor on floor next to air conditioning/heat unit under window inside resident room [ROOM NUMBER]. Dry rodent droppings and dust was noted along the outside wall. The resident residing in the room stated a few months ago they had mice in their room and that mice were gross, and they did not want them in their room.-08/18/2025 at 11:45 AM, Resident #45 stated they had seen two (2) mice, one (1) early that morning and one (1) late last night in their room. They stated they saw the mice run across the floor from their closet, and one (1) of them went behind a bag positioned on the floor next to their dresser. Rodent droppings were observed along outside wall in room, and on floor behind the headboard of the bed. A black plastic enclosed box trapper pest monitor was present in room under the window. -08/20/2025 at 9:15 AM, Resident #45 stated they had not seen any mice since 08/18/2025 in their room. They stated maintenance has been to their room, pulled the closet out to check for holes in the wall and that occasionally someone will come into their room to check the bait box. -08/21/2025 at 8:49 AM and 08/22/2024 at 8:25 AM, revealed four (4) black trays with a clear substance were noted in resident room [ROOM NUMBER], three (3) along the walls and one (1) in front of the closet. The resident in the room stated a family (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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	member placed the mice traps down on the evening of 08/20/2025 because they complained to them about seeing mice and droppings in their room. The resident stated mice were nasty and it was not homelike and that they should not have to live with mice. During an interview on 08/21/2025 at 4:42 PM, Certified Nurse Aide #11 stated about two (2) weeks ago while providing care in resident room [ROOM NUMBER] during the night shift they saw a mouse run towards the door. They stated they reported the sighting to Registered Nurse #3. During an interview on 08/21/2025 at 4:49 PM, Licensed Practical Nurse #8 stated they have not observed any mice but had heard rumors from staff about mice. If they observed any mice they would call the supervisor immediately. They stated it was an infection control concern to have mice in the facility, was unsanitary and they would not want mice in their home.-08/22/2025 at 8:34 AM, revealed a white cardboard trap between the wall and the side of the closet in resident room [ROOM NUMBER] with a dead mouse present inside of it. -08/22/2025 at 9:23 AM, Registered Nurse #3 stated they were notified of mouse activity on the first floor in room [ROOM NUMBER] or 1008 by a Certified Nurse Aide on the night shift of 08/13/2025-08/14/2025. They stated they did not observe the mouse and notified the Director of Nursing and left a voicemail for the Director of Environmental Services regarding the sighting. Registered Nurse #3 stated there should not be mice in resident rooms due to infection control, mice carry diseases, and it is unsanitary. Registered Nurse #3 observed the dead mouse in resident room [ROOM NUMBER] and stated they would notify the Director of Environmental Services to remove and replace the trap. Review of first (1) floor pest logbook documented on 7/10 in hallway near resident room [ROOM NUMBER], ran to resident room [ROOM NUMBER] or #1037; 7/27/25 at 10:30 a mouse ran out of the bathroom went behind door; 8/14/25 mouse droppings on windowsill in activities room; and 8/21/25 6 PM, mouse ran out bathroom over my shoe. Observations and interviews on the second floor were as follows:-8/20/25 at 11:45 AM revealed a dead mouse was inside a black plastic enclosed box (trapper pest monitor) inside resident room [ROOM NUMBER], which was occupied. At the time of the observation, the resident stated the last time they saw a rodent was about two to three weeks ago and it was in the hallway near their room. Review of second (2) floor pest logbook documented: 7/11/25 mice in resident room [ROOM NUMBER]; 7/14/25 mouse in resident room [ROOM NUMBER] ran across the floor; 7/20/25 resident saw mice running in to their room; 8/10/25 resident in room [ROOM NUMBER] saw mouse running down hallway; 8/11/25 resident in room [ROOM NUMBER] saw a mouse run across their floor; 8/12 9:30 PM resident in room [ROOM NUMBER] saw a mouse in their room, the mouse came out of wardrobe closet headed toward the door; 8/17 resident in room [ROOM NUMBER] saw mouse in their bathroom.Observations and interviews on the third floor were as follows: -8/20/25 at 12:18 PM revealed a dead mouse inside a black plastic enclosed box (trapper pest monitor) inside resident room [ROOM NUMBER]. -8/21/25 at 1:40 PM, [NAME] #1 stated there was an approximate three inch wide by two-inch-high piece of vinyl cove base glued to the wall to the right of the door inside resident room [ROOM NUMBER]. At the time of the observation, [NAME] #1 stated they did not personally glue the piece of cove base to the wall, but it appeared as if it was a temporary fix and they would need to schedule a time to return to the room and do complete drywall repair to several areas in this room, including the area behind the resident bed and to the right of the door. During an interview on 8/21/25 at 4:55 PM, Licensed Practical Nurse #9 stated there was a rodent sighting in the high side hallway (north hallway) about one or two weeks ago. They stated they did not personally add it to the exterminator's communication notebook at the Nurses' Station, but there were multiple staff members present at the time of the sighting. During an interview on 08/22/2025 at 8:43 AM, Certified Nurse Aide #9 stated there have been resident complaints of mice in the facility, most recent was on 08/16/2025 while working on the third floor. They stated mice should not be in the resident's home. During an interview on 8/22/25 at 9:59 AM, Housekeeping Staff #1 stated they have seen mice a few times in the facility and residents have complained to them. They inform their supervisor, and the supervisor put mice traps in the resident's room. They stated it was hard to control the mice because the residents were always eating in their rooms and leaving (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	droppings that attract mice. During an interview on 8/22/25 at 10:44 AM, the Licensed Exterminator stated they had just completed an inspection in resident room [ROOM NUMBER]. They stated they found an open sugar packet and a jelly packet on the floor under the resident's bed with mice droppings beside it. They stated some resident's family members brought in plug in devices that send off a scent to keep the mice away but felt they did not work. They stated they cannot use rodenticide in the interior of the building. During an interview on 8/22/25 at 10:48 AM, Resident #8 stated they used to have a parade of mice and now they only see one or two occasionally. Review of third (3) floor pest logbook documented on 7/12/25 mice in resident room [ROOM NUMBER]; 7/17 mouse in resident room [ROOM NUMBER]; 7/24 two (2) mice in resident room [ROOM NUMBER]; 8/2 ceiling tile in hallway near resident room [ROOM NUMBER] moved out of place and heard scrambling footsteps in ceiling; 8/6 mouse in resident room [ROOM NUMBER]; 8/19 mouse in resident room [ROOM NUMBER] in bathroom; 8/21/25 at 3:50 AM mouse in resident bathroom room [ROOM NUMBER] and ran under recliner; 8/21/25 resident in room [ROOM NUMBER] stated they saw a rat. During an interview on 8/20/25 at 3:15 PM, the Licensed Exterminator stated they were on-site at the facility three times per week. They stated they personally checked the containerized traps inside each resident room during the last week of each month and disposed of any catches. The Licensed Exterminator stated there had been progress with this issue and the Administrator and Director of Nursing were responsive to their requests and concerns, but there was still an outstanding issue in resident room [ROOM NUMBER]. They stated they informed the facility of a breakthrough hole in the wall of resident room [ROOM NUMBER] and maintenance staff placed a temporary patch over it, but they were advised a more permanent fix was needed. During an interview on 08/22/2025 at 9:41 AM, the Director of Environmental Services stated they oversaw pest control for the facility. They stated environmental staff, housekeeping, try to monitor mouse traps as much as possible and report finding to them. They stated the exterminator, with the pest control company, comes to the facility three (3) times per week, reviews pest logbooks on each floor, checks mouse traps and addresses concerns documented in the logbooks. They stated resident rooms have cardboard traps that were started with first by the exterminator and then in addition the black trapper pest monitor were added to resident rooms to catch mice. They stated it was important to maintain pest control for resident, staff safety because mice carried diseases and was not homelike. Additionally, the Director of Environmental Services stated ninety (90) percent of pest issues had been addressed since June/July, except for exterior issues, such as exterior doors not closing flush, exterior doors with opening at bottom, and holes in walls. During an interview on 08/22/2025 at 10:40 AM, the Administrator stated rodents were an ongoing, standing issue that has significantly improved. They stated the exterminator was there three (3) days a week, containers had been provided to the residents for food, issues have been discussed with environmental services and rodent traps were in place. They stated they do not know what else they can do. During an interview on 08/22/2025 at 11:30 AM, the Director of Facilities stated they have nothing to do with pest control. During an interview on 08/22/2025 at 12:35 PM, the Director of Nursing #1 stated mice should not be present in resident rooms; it was a sanitary issue having rodents in the facility as they can carry diseases. During an interview on 08/22/2025 at 1:15 PM, Social Worker #1 stated they were aware there was a problem with mice in the facility. They had no residents complain, but family members had complained that it was gross. They did not have any formal grievances regarding the mice, it was strictly verbal complaints. Social Worker #1 stated that rodents in the facility had a negative effect on the residents' quality of life. 10NYCRR 415.29 (j)(5)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, and record review conducted during a Standard survey completed on 08/22/2025, the facility did not ensure a resident was assessed by the interdisciplinary team to determine a resident's ability to safely administer their own medications if clinically appropriate for one (1) (Resident #45) of one (1) resident reviewed. Specifically, Resident #45 was observed with medication in their room. Self-administration was determined through interviews despite the lack of an assessment to determine the resident's ability to safely do so. The finding is: The policy titled Self-Administration of Medications undated, documented residents have the right to self-administer medications if they choose and the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge. If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan. Resident #45 had diagnoses that included chronic obstructive pulmonary disease (COPD-lung disease), congestive heart failure (chronic heart condition), and atrial fibrillation (irregular heart rate). The Minimum Data Set (a resident assessment tool) dated 05/11/2025 documented Resident #45 was cognitively intact.The Comprehensive Plan of Care, reviewed 08/11/2025, documented Resident #45 was at risk for cerebral vascular event and cardiac/respiratory distress. Approaches included to administer medications/treatments per medical doctor orders, monitor for and report any possible adverse effects. The comprehensive plan of care did not reflect Resident #45's ability to self-administer medications.Review of the Active Order Profile documented an active physician's order dated 05/28/2024 for Albuterol (medication used to open airway and make breathing easier)90 micrograms/inhaler inhalation aerosol, 180 micrograms inhalation every four (4) hours as needed for wheezing. There were no physician's orders for Resident #45 to self-administer medications or to leave medications at the bedside. Review of the Medication Administration Record dated 06/01/2025-08/20/2025 documented Resident #45 received Albuterol 90 micrograms/inhaler inhalation aerosol 180 micrograms on 08/20/2025 at 10:30 AM. There was no other documented evidence that Resident #45 had received the albuterol inhaler as ordered. Review of progress notes-nurse dated 06/01/2025 to 08/21/2025 revealed there was no documentation that Resident #45 was self-administering albuterol inhaler and the Albuterol inhaler was kept at their bedside. During an observation on 08/19/2025 at 11:30 AM, an albuterol inhaler was observed on Resident #45's tray table at bedside. During an observation and interview on 08/20/2025 at 9:15 AM, Resident #45 had an Albuterol inhaler in their room, on their lap. Resident #45 stated they took the Albuterol inhaler every four (4) hours as needed but had been taking it more frequently due to swelling. Resident #45 could not specify how frequently they were using the Albuterol inhaler daily. They stated they had used, the Albuterol inhaler that morning before their shower and again after their shower. Resident #45 stated the nurses were aware that they used the inhaler frequently but did not ask them about when they used it or why they used it. Additionally, Resident #45 stated the nurses reordered the Albuterol inhaler for them and allowed them to keep it in their room. During an interview on 08/20/2025 at 10:33 AM, Licensed Practical Nurse #5 stated they were aware that Resident #45 had an albuterol inhaler at their bedside. They stated they removed it from Resident #45 that morning because they couldn't have the Albuterol inhaler at their bedside without a physician's order. Licensed Practical Nurse #5 stated they did not know how frequently Resident #45 was self-administering their inhaler, as it was not documented. Licensed Practical Nurse #5 stated it needed to be determined if a resident was alert enough, and able to self-administer medications before medications were left at a bedside. During an interview on 08/22/2025 at 9:23 AM, Registered Nurse #3 stated residents need to be evaluated to self-administer medications, must be reviewed with the physician and documented. They stated it was important for residents to be evaluated for safety. Registered Nurse #3 stated Resident #45 had not been evaluated to self-administer medications and was not to have medications at their bedside. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 08/22/2025 at 11:46 AM, Licensed Practical Nurse #7 stated residents needed a physician's order to be able to keep medications at their bedsides. They stated that Resident #45 kept an Albuterol inhaler at their bedside and thought they had an order to do so. Licensed Practical Nurse #7 stated they were not aware of any monitoring for self-administering of medications and that the use of bedside medications was not documented to their knowledge. Additionally, Licensed Practical Nurse #7 stated they reordered Resident #45's Albuterol inhaler when low, so Resident #45 would not run out of it. During an interview on 08/22/2025 at 12:35 PM, the Director of Nursing stated they expected residents to be evaluated for the ability to self-administer medications. They stated residents need to be evaluated for safe handling of medications including knowing what they were taking, why, and how often. They stated there needed to be accountability for what medications residents were taking to ensure proper use and safety. 10 NYCRR 415.3 (f)(1)(vi)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on interview and record review conducted during the Standard survey completed on 8/22/2025, the facility did not provide services consistent with professional standards of quality for one (1) (Resident #119) of one (1) resident reviewed for change in condition. Specifically, Resident #119, who had a recent history of seizures, did not receive Levetiracetam (anti-seizure/anti-convulsant medication) as ordered by the physician and the physician was not notified of the omission.The finding is:The policy titled Unavailable Medication last revised 09/27/2016 documented that residents would receive necessary medications as ordered by the physician, if medications were not available the physician would be notified and would adjust medications accordingly. The nurse would indicate on the MAR (medication administration record) that drug was not given and document that physician was notified and when indicated the directive for alternate administration time or medication. The nurse would notify the pharmacy of unavailable medication and notify supervisor. The nurse must document on the 24-hour report sheet that medication was missed to allow for a follow up resolution.Resident #119 had diagnoses that included seizure disorder, history of cerebrovascular accident (stroke), and dementia. The Minimum Data Set (a resident assessment tool) dated 06/06/2025 documented Resident #119 was moderately cognitively impaired, sometimes understood, sometimes understands and received anti-convulsant medication.The comprehensive care plan dated 06/20/2025 documented Resident #119 was at risk for falls related to their seizure diagnosis with interventions to give medications as ordered; monitor and report any adverse effects.The closet care plan (a guide used by staff providing care) dated 06/20/2025 documented Resident #119 required two staff assist with mechanical lift for transfers, was non ambulatory, a total assist of one staff member for bed mobility and had a safety intervention in place for seizure precautions.The physicians' orders dated 08/21/2025 documented Resident #119 had an active order dated 05/21/2025 to administer Levetiracetam 750 (seven hundred and fifty) milligrams (mg) by mouth twice a day (BID).Review of nursing progress notes dated 07/29/2025 at 2:49 PM and 07/29/2025 5:00 PM revealed Resident #119 experienced two separate seizures, one lasting 6 minutes in length where Resident #119 became unresponsive. Review of the Medication Administration Record dated 07/31/2025 revealed Levetiracetam 750 milligrams by mouth was not administered by Licensed Practical Nurse #4 to Resident #119 at 5:34 PM due to the medication not being available.Review of facility identified 24-hour report sheet dated 07/31/2025 revealed there was no documented evidence that the nursing supervisor or physician were updated on Resident #119s missed dose of Levetiracetam.Review of nursing progress notes dated 07/31/2025 revealed there was no documented evidence that the physician was updated on Resident #119s missed dose of Levetiracetam.During a telephone interview on 08/21/2025 at 9:19 AM Licensed Practical Nurse #4 stated they were unfamiliar with Resident #119 and had floated down from a different unit on 07/31/2025, went to administer Resident #119s Levetiracetam, and did not see it in the cart. Licensed Practical Nurse #4 stated they alerted Registered Nurse #4 Nursing Supervisor who said they would call the pharmacy to see if it was due to be delivered soon. Licensed Practical Nurse #4 stated the medication had not been delivered by the end of their shift and they did not check on it. They stated they should have checked up the situation prior to leaving for the day.During a telephone interview on 08/21/2025 at 9:25 AM, Pharmacy Consultant #1 stated they did not think that missing one dose of Levetiracetam would cause a person to have a seizure, but it potentially could. Pharmacy Consultant #1 stated the physician should have been updated on Resident #119s missed dose, seizure medication like Levetiracetam was important, and the pharmacy should have been contacted as well.During an interview on 08/21/2025 at 9:29 AM, the Director of Nursing stated the facility protocol for when a medication was not available was to notify the supervisor, who would notify the physician for further orders, and all would be documented. The Director of Nursing stated they would have expected Licensed Practical Nurse #4 to have documented that the supervisor and physician were updated on Resident #119s missed dose and (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	document any new orders, if some, based on what the provider said and significance of the medication.During a telephone interview on 08/21/2025 at 10:02 AM, Medical Director #1 stated they were not updated on Resident #119 missing a dose of their Levetiracetam on 07/31/2025 and would have expected to have been updated on the missed dose; they had been updated that Resident #119 had multiple seizures two days prior. Additionally, Medical Director #1 stated it was possible Nurse Practitioner #1 was updated if Medical Director #1 was unable to be reached, but they were unsure.Attempts to contact Registered Nurse #4 Nursing Supervisor on 08/21/2025 at 10:13 AM and 12:22 PM were unsuccessful.During a telephone interview on 08/21/2025 at 11:11 AM, Nurse Practitioner #1 stated they were out of town on 07/31/2025 and was not taking any calls, they did not receive any update on Resident #119 missing a dose of their Levetiracetam on that date. Nurse Practitioner #1 stated they were familiar with Resident #119 and if they had been updated they missed a dose of Levetiracetam, they would have ordered lab work such as a Keppra (Levetiracetam brand name), a complete blood count, a basic metabolic panel (blood test that measures several key substances in the blood), and an absolute neutrophil count (blood test that measures the number of infection-fighting white blood cells in the body), especially since Resident #119 had seizure activity two days prior. During a telephone interview on 08/21/2025 at 3:14 PM, the Medical Records Supervisor from the pharmacy stated the facility last refilled Resident #119s Levetiracetam on 07/07/2025 and it had not been requested again until 08/04/2025. There was no call or request for the medication on 07/31/2025. The Medical Records Supervisor stated the process for reordering medications was that the facility had automatic reorder sheets, they placed the sticker from the card onto that sheet and faxed it over to the pharmacy, there was a 24 hour turn around. If the facility needed an emergency delivery they would call the pharmacy, it would be profiled as urgent and would arrive the same day. Medical Records Supervisor stated if the facility had ordered the medication on 07/31/2025 in the evening, they would have received the medication the same day.10 NYCRR 415.12

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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. Based on observation, interview, and record review conducted during a Standard Survey completed on 08/22/2025, the facility did not ensure that each resident who was unable to carry out Activities of Daily Living received the necessary services to maintain grooming and personal hygiene for 1 (one) (Resident #126) of 2 (two) residents who were reviewed for activities of daily living. Specifically, Resident #126 was not assisted/provided with nail care and was observed with dirty long jagged fingernails. The finding is:The undated policy and procedure titled Nail Care documented that nails are observed daily by staff providing direct care. Nails are to be inspected weekly by a nurse and CNA on bath day and trimmed as indicated. The procedure included but was not limited to gently cleaning under nails with an orange stick, trimming with nail clippers, clipping nails straight across, and shaping nails with a nail file as needed.The policy and procedure titled Activities of Daily Living revised 03/2011 documented that residents are provided with care, treatment, and services as appropriate to maintain the ability to carry out activities of daily living. Residents who are unable to carry out activities of daily living independently receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene.Resident #126 had diagnoses of dementia, orthostatic hypotension (a sudden drop in blood pressure when standing up), and chronic pain. The Minimum Data Set (a resident assessment tool) dated 06/16/2025 documented Resident #126 was moderately cognitively impaired. The resident required partial to moderate assistance for personal hygiene.The Comprehensive Care Plan dated 06/20/2025 documented that Resident #126 required limited assistance x1 (one) with grooming. The resident had no behavioral issues. Resident #126 was at risk for alteration in skin integrity. Interventions included to assesses skin weekly during bath/shower and showers were to be completed per schedule. Review of a document titled Single Patient Task List - Scheduled Patient Care for Resident #126 documented that weekly skin evaluations on shower days were to be completed on Mondays on the 3:00 PM-11:00 PM shift. During an observation on 08/18/2025 at 9:40 AM, Resident #126 was up and dressed sitting in their wheelchair. The resident's fingernails were long (approximately 1/2 inch long beyond their fingertips), jagged, and had chipped nail polish. During an observation on 08/19/2025 at 8:56 AM, Resident #126 was in bed eating breakfast. Their fingernails were long (approximately 1/2 inches long beyond their fingertips), jagged, with debris noted at the base of their fingertips.During an observation on 08/20/2025 at 9:00 AM Resident #126 was in the television room. their fingernails remained long (approximately 1/2 inches long beyond their fingertips), were jagged, had chipped nail polish and debris was noted at the base of their fingertips.During an observation on 08/21/2025 at 11:01 AM, Resident #126's fingernails were long and jagged with chipped nail polish. The resident's palms were red and irritated, with an intact fluid-filled, purplish blister about 1/2 inch long in the center of the left palm, and another open blister about 1/4 inch noted on the same palm.During an attempted interview on 08/18/2025 at 9:40 AM, Resident #126 was confused and appeared anxious. They attempted to show their palms of their hands, which appeared pink, irritated, and blistered. Licensed Practical Nurse #2 approached and asked if the resident's hands were bothering them. The resident stated they did not know what was happening and showed the nurse their palms. Licensed Practical Nurse #2 stated the resident had contact dermatitis (a skin rash due to contact of a substance) and that they would administer Benadryl. During an interview on 08/20/2025 at 11:39 AM, Licensed Practical Nurse #1 stated Resident #126 got their nails painted during activities, but it was the Certified Nursing Aides' responsibility to clean, file, and trim them. Licensed Practical Nurse #1 stated the resident had contact dermatitis and had a new order that required their hands be always covered, but the Certified Nursing Aide did not inform them that morning care was completed. During an interview on 08/22/2025 at 9:24 AM, Certified Nursing Aide #2 stated when they performed morning care, they cleaned, trimmed, and filed nails if needed, but this was usually done on shower days. They stated the importance of keeping residents' nails cleaned, trimmed, and filed was to prevent accidental (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335376	A. Building B. Wing	08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Schoellkopf Health Center	621 Tenth Street Niagara Falls, NY 14302

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	scratching. During an interview on 08/22/2025 at 11:38 AM, Manager Registered Nurse #1 Unit Manager stated they assisted with showering Resident #126 that morning and cleaned the resident's nails but did not trim them, believing it was best not to disturb skin on the hands. Registered Nurse #1 acknowledged they did not file the resident's nails and stated they should have because they were jagged. They emphasized the importance of keeping residents' nails cleaned, trimmed, and filed, as some residents eat with their hands. They further stated nails can harbor bacteria and increase the risk of infection. 10 NYCRR 415.12 (a) (3)

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	335376	A. Building B. Wing	08/22/2025

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. Based on observation, interview, and record review conducted during a Standard survey completed on 08/22/2025, the facility did not ensure that each resident received proper treatment to maintain vision for one (1) (Resident #30) of one (1) resident reviewed. Specifically, Resident #30's optometrist appointment on 06/06/2025 required an outside consult visit that was not scheduled. Additionally, Resident #30 complained that they were unable to see well with their current eyeglass prescription.The finding is:The policy titled Dental, Hearing, and Vision Evaluations, dated 03/2011, documented that the facility will assure residents can function at their highest practical level of oral health, vision, and hearing. The policy states to assess functional status on admission, quarterly, as per the MDS schedule, and when concerns are reported. If a resident or surrogate decision-maker agrees to a consult/evaluation, the facility is to arrange for the consult as soon as possible.Resident #30 had diagnoses including unspecified fracture of the shaft of the left fibula (the smaller of the two lower leg bones), fracture of the left ankle; and diabetes with diabetic neuropathy (nerve damage causing numbness or weakness). The Minimum Data Set, (a resident assessment tool) dated 05/13/2025 documented Resident #30 was cognitively intact, could understand others, and could be understood by others. Resident #30's vision was adequate with corrective lenses. They had impairment of one lower extremity and utilized a wheelchair for mobility.Review of the Comprehensive Care Plan dated 08/13/2025 documented that Resident #30 wore glasses, had impaired vision, but could see large print. Interventions included but were not limited to assessing and reporting changes that may indicate a change in vision and arranging eye consults as per policy/procedure and as needed.Review of the Closest Care Plan dated 08/13/2025 documented that Resident #30 wore prescription glasses.Review of the Eye Consult Form dated 06/06/2025 documented that Resident #30 was seen in the facility on 06/06/2025 and was to have a referral sent to an outside optometrist to determine if a new prescription would improve their vision or if cataract surgery was indicated. The form was signed by the Unit 2 Manager, Registered Nurse #1.During an observation and interview on 08/19/2025 at 12:01 PM, Resident #30 stated they told a Certified Nursing Aide that their glasses no longer helped them see but could not remember the aide's name. They also stated they informed a family member, who notified staff. Resident #30 further stated they had seen an eye doctor a couple of months prior and were supposed to see another one, but the appointment was never scheduled. Resident #30 put their glasses on, picked up an activity program, and said they could not read the small print.During an interview on 08/20/2025 at 11:21 AM, a PACE (Program of All-Inclusive Care for the Elderly) Case Manager #1 stated there were no records indicating that Resident #30 required an outside consult. They stated it was the facility's responsibility to notify them if an outside appointment was needed. They stated the facility should fax physicians' recommendations and consult referrals to them, and they would schedule the appointments, notify the facility, and arrange transportation. They confirmed there were no notifications in their system regarding an outside eye doctor appointment for Resident #30.During an interview on 08/20/2025 at 2:54 PM, the nurse educator, Registered Nurse #3, stated that all follow-up appointments were to be made by the Unit Manager. They stated Resident #30's appointments were scheduled through their case manager, but it was the Unit 2 Manager Registered Nurse #1's responsibility to contact Resident #30's case manager at the Program of All Care for the Elderly to inform them that an outside referral with an Ophthalmologist was needed.During an interview on 08/22/2025 at 9:30 AM, Resident #30's family member stated they had informed staff that Resident #30 needed an outside consult with an optometrist. They reported that someone contacted them about this but were unsure who. They also stated that during a visit on the following day, they told an aide or a nurse their loved one needed a referral from the 06/06/2025 eye doctor appointment, and it was staff's responsibility to follow up with their case manager from the Program of All Care for the Elderly.During an interview on 08/22/2025 at 11:22 AM, Unit 2 Manager Registered Nurse #1, stated that they knew the Program of (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335376	A. Building B. Wing	08/22/2025

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	All Care for the Elderly scheduled outside consult appointments for Resident #30 and it was their responsibility to contact the case manager. They stated they were not aware this was their responsibility in June 2025 because they were never informed. They stated they contacted a family member at the end of June and thought the family member would follow up with the case manager. They confirmed that they had not yet contacted the Program of All Care for the Elderly regarding Resident #30's optometrist appointment.During an interview on 08/22/2025 at 3:15 PM, the Director of Nursing stated they expected staff to provide them with any referrals for an outside consult. They stated Unit 2 Manager Registered Nurse #1 was responsible to follow up with the resident's case manager at Program of All Care for the Elderly so they could make the optometrist appointment for Resident #30. They stated the case manager would follow up and arrange with the resident, the facility, and transportation. They stated after appointments were followed up on, Unit Managers would bring them referrals to scan.NYCRR 415.11(c)(3)(i)

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	335376	A. Building B. Wing	08/22/2025

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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. Based on observation, interviews and record review conducted during the Standard survey completed on 08/22/2025, the facility did not ensure correct installation, use, and maintenance of bed rails including assessing the resident for risk of entrapment for one (1) (Resident #12) of one (1) resident reviewed. Specifically, Resident #12's bed cane bedrail was loose, not secured to the bedframe, and there was no documentation of routine inspections. In addition, there was no care plan developed for use of the bed cane. The finding is:The policy titled Mobility Assist Rails or other Assist Devices revised 06/22/2023, documented therapy screens each resident to determine bed mobility and what, if any, mobility assist device is warranted. The Comprehensive Care Plan and Closet Care Plan will indicate what mobility assist devices are to be used. A new Evaluation for Mobility Assist Rail/Device Use is to be initiated with each therapy screen if use remains warranted. Nursing Supervisor is to be contacted if mobility assist devices are not available on the unit, and maintenance is to be contacted with concerns regarding application.Review of the Medical Equipment Management Plan reviewed 05/25, provided by the Director of Nursing, documented to ensure that hospital clinical equipment is in optimal and safe condition, Clinical Engineering Department is responsible for testing, repair and schedule maintenance of all equipment that will be used in the patient care area. All patient care equipment shall be included in the master device inventory database with safety and preventative maintenance schedules. Hospital beds are supported and tested by the Facilities Management Department.The bed User-Service Manual dated 2015, provided by Senior Mechanic on 8/22/25, documented warning: possible injury or death. Gap between assist device must be small enough or large enough to prevent resident from getting their head or neck caught in this location (see specific Assist Device Installation Instructions for more information). Entrapment zones involve the relationship of components often assembled by the healthcare facility. Therefore, compliance is the responsibility of the facility. Preventative Maintenance, follow all warnings and cautions in the User Manual. A thorough inspection should be conducted monthly.Resident #12 had diagnoses that included obesity, osteoarthritis, and hypertension (high blood pressure). The Minimum Data Set (a resident assessment tool) dated 05/25/2025 documented Resident #12 was understood, understands, and was cognitively intact. Partial/moderate assistance was needed with rolling left and right, sit to lying, and lying to sitting on side of bed.Comprehensive Plan of Care dated 5/20/25 documented Resident #12 required assist with transfers and activities of daily living due to decreased strength, endurance and peripheral edema. Approaches included bed mobility extensive assist of one (1).An undated approach, handwritten documented a bed cane to the right side of the bed.Review of Closet Care Plan dated 06/02/2025 on 08/20/2025 at 10:41 AM, documented for bed mobility the resident was an extensive assist of one (1) and there was an undated, handwritten entry that documented a bed cane to the right side. Review of the Active Order Profile documented an active order dated 3/21/2025 for a bed cane to the right side of bed for turning and position.The Evaluation for Enabler Use dated 03/20/2025, documented Resident #12 had a right-side enabler/bed cane on their bed, a physician's order was obtained, and care plan was updated. It was documented that Resident #12 used the bed cane for turning and positioning self.The Evaluation for Mobility Rail/Assist Device dated 05/23/2025, documented Physical Therapist #1 recommended a right mobility rail for Resident #12. A physician order, device on bed and care plan were documented as completed on 05/23/2025 and signed by interdisciplinary team members. There was no documented evidence of an assessment for entrapment included in the evaluation. During an observation and interview on 08/18/2025 at 10:45 AM and 8/19/2025 at 9:57 AM, an upside down U shaped black bedrail was located on the right side of Resident #12's bed. The bedrail moved very easily when grabbed, sliding out from under the mattress and was not secured to the bedframe. Resident #12 was sitting in their recliner during these times (continued on next page)

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	335376	A. Building B. Wing	08/22/2025

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and stated they needed the bedrail to assist them with positioning in bed and that the bedrail belonged to them. Review of Resident #12's Closet Care Plan dated 6/2/2025 that was hanging on their bathroom door documented for bed mobility the resident required extensive assist and did not document they used a bedrail.During an observation and interview on 08/20/2025 at 9:09 AM, Resident #12 was in bed with the head of bed elevated. Bedrail portion towards head of bed pulled out from under mattress while the resident was in bed with very little effort. Resident #12 stated It is loose. It needs to be put under the mattress more. Resident #12 stated their family member brought the bedrail in for them and they could not recall if their family member or a staff member applied it to their bed. They stated they have had the bedrail for about one (1) year. During an observation and interview on 08/20/2025 at 9:41 AM, Certified Nurse Aide #8 stated assistive devices were indicated on resident care plans. Certified Nurse Aide #8 stated they did not see the use of a bedrail indicated on Resident #12's Closet Care Plan hanging on bathroom door. Certified Nurse Aide #8 stated they would be responsible to report safety concerns related to bedrail use, or if a resident no longer utilized the bedrail. They stated maintenance would be responsible for installing and checking the bedrails on the beds. Certified Nurse Aide #8 observed the bedrail on the right side of the bed and stated the bedrail was not secured to the bed. Upon pulling on the bedrail, it slid out from under the mattress. Certified Nurse Aide #8 stated the bedrail was not safe and if Resident #12 pulled on the bedrail they could fall.During an observation and interview on 08/20/2025 at 11:07 AM, Senior Mechanic and the Director of Nursing were observed removing the upside down U shaped bedrail from Resident #12's bed. Senior Mechanic stated they had never seen a bedrail like that before. The Director of Nursing stated the bedrail in use was not sturdy and was not provided by the facility. The Senior Mechanic and the Director of Nursing were then observed to apply a facility provided bed cane bed rail to Resident #12's bed. During an interview on 08/20/2025 at 11:21 AM, Senior Mechanic stated they were responsible to apply and remove bedrails from resident beds in the facility. They stated once they were applied, they did not generally check the bedrails again, unless they were notified of a concern. They stated they were not aware of any concerns regarding Resident #12's bedrail prior to that day. They stated to their knowledge there was no routine or preventative maintenance performed on the resident's beds or bedrails. They stated there could be a concern for safety, injury, if bedrails were not applied or maintained correctly to the resident or anyone for that matter. During an interview on 08/20/2025 at 11:33 AM, Registered Nurse #3 stated they were notified that morning by Certified Nurse Aide #8 that Resident #12's bedrail was loose, and they reported it to the Director of Nursing. Registered Nurse #3 stated they knew Resident #12 was supposed to have a bedrail for assisting them with turning and positioning. They stated they had seen bed canes bedrails before but did not recall the particular bed cane that was on Resident #12's bed. They stated therapy completed bed mobility evaluations and made the recommendation for the use of bedrails. They stated maintenance was responsible for applying bedrails to resident's beds. Registered Nurse #3 stated it was important for bedrails to be secured to the bed for resident safety and did not want anyone to fall out of the bed.During an interview on 8/22/25 at 8:58 AM, Physical Therapist #1 stated therapy was responsible for evaluating the need for a bedrail on a resident's bed. They stated they assessed residents' ability to use bedrails safely and if bedrail use was appropriate. They stated they evaluated Resident #12 and completed an assessment form a couple of weeks ago. They stated they physically assessed Resident #12 while in bed and did not recall the type of bedrail on the bed or what it looked like. Physical Therapist #1 stated nursing was responsible for updating the care plan for the use of a bedrail.During an interview on 8/22/25 at 11:30 AM, the Director of Facilities stated maintenance was responsible to complete work orders pertaining to beds. They stated there was no routine or preventative maintenance performed on resident beds. When maintenance gets notified of an issue, they fix the issue or pull the equipment out of service, so it was safe. The Director of Facilities stated they had not looked at any bed manuals and did not know if they even had manuals for all the beds used in the facility. They stated it would not be a bad idea to (continued on next page)

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	335376	A. Building B. Wing	08/22/2025

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	see what the bed manuals recommended for routine maintenance. The Director of Facilities stated they were not aware of any process for checking for entrapment with the use of bedrails. They stated administration provided guidance on entrapment and purchased bedrails that were compatible with the bed frames.During an interview on 08/22/2025 at 12:35 PM, the Director of Nursing stated when a bedrail was recommended by therapy, a work order was placed to maintenance to install. They stated Resident #12 had a facility provided bedrail on the bed, but it was swapped out by a family member, per therapy. They stated per therapy recommendations Resident #12 had a bedrail initiated 03/2025 and the bedrail should have been reviewed during care plan meetings to ensure it was reflected on their care plan. They stated it was important for the bedrail to be part of a care plan, so staff knew about it. The Director of Nursing stated the maintenance department was responsible for routine, preventative maintenance on the beds used in the facility. The Director of Nursing stated they did not have any evidence that entrapment measurements were completed prior to 08/20/2025. They stated they were revamping the process for measuring for entrapment because there was a failure in the process and a risk for injury with the use of bedrails. They stated they had updated the Closet Care Plan and the Comprehensive Plan of Care when they were notified the bed cane was not present because it needed to be fixed (on 08/20/2025).During an interview on 08/22/2025 at 1:15 PM, the Administrator stated ideally, they would not like to see bedrails utilized in the facility. They stated therapy should be evaluating use of bedrails in person in the resident's rooms. They stated staff as a team were responsible for educating residents, families on bedrail use and review bedrail use during change in conditions, Minimum Data Set review, referral and care plan review. They stated they were not aware of any routine maintenance to the beds and bedrails. They stated nursing and therapy were responsible for evaluating for hazards associated with bedrail use.10 NYCRR 415.12(h)(1)

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	335376	A. Building B. Wing	08/22/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review conducted during a Standard survey completed on 08/22/2025, the facility did not establish and maintain an effective Infection Prevention and Control Program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of communicable diseases and infections one (1) (Resident #30) of four (4) residents reviewed. Specifically, the resident had a draining Stage 3 pressure ulcer (a full-thickness skin loss that extends into the subcutaneous tissue but does not involve muscle, tendon, or bone) and was not placed on enhanced barrier precautions (infection control strategy designed to the reduce transmission of multidrug resistant organisms in nursing homes, involving staff to wear a gown and gloves during high contact care). Additionally, staff did not wear appropriate personal protective equipment during pressure ulcer care/treatment.The findings are:The policy and procedure titled Infection Prevention, Transmission-Based Precautions, dated 12/14/2024, documented the staff were to use enhanced barrier precautions in addition to standard precautions for residents with chronic wounds during high-contact care activities. The policy documented staff were to wear gloves and gown during high-contact care activities. Review of the State Operational manual dated 4/25/25 documented Enhanced Barrier Precautions are used in conjunction with standard precautions and expands the use of gown and gloves during high contact resident care activities such as wound care (any skin opening requiring a dressing). Wounds generally include wounds, not shorter lasting wounds such as skin tears covered with a Band Aide or similar dressing. Chronic wounds include but not limited to pressure ulcers, diabetic foot ulcers, unhealed surgical wounds and venosus stasis ulcers. Resident #30 had diagnoses of a fractured left fibula (the smaller of the two lower leg bones), and ankle, and diabetes. The Minimum Data Set (a resident assessment tool) dated 05/13/2025, documented Resident #30 was cognitively intact. The assessment documented the resident had moisture associated skin damage (skin damage caused by prolonged exposure to moisture).Review of the Comprehensive Care Plan dated 08/13/2025 documented that Resident #30 was at risk for altered skin integrity related to decreased mobility, diabetes, and morbid obesity, as well as age-related considerations. Interventions included barrier cream to buttocks every shift, weekly skin assessments during bathing/showering, daily skin monitoring during personal care and toileting/incontinence episodes, and consultation with the wound care nurse as needed. The care plan did not include MASD (moisture associated skin damage) or a Stage 3 pressure ulcer. An Initial Wound Evaluation and Management Summary dated 08/18/2025 at 12:39 PM, documented at the request of the referring provider, a thorough wound care assessment and evaluation was performed today by the facility Medical Doctor. Resident #30 presents with a Stage 3 pressure ulcer on their left buttocks. The documented measurements: length 3.9 centimeters by width 0.7 centimeters, by 0.1 centimeters in depth. Surface area 2.73 centimeters with light serous exudate (drainage-a thin watery clear or yellow fluid) with 100 % (percent) granulation tissue (a type of new, temporary tissue that forms in response to an injury or wound). Dressing treatment plan: primary dressing, add a gauze island with border once daily and as needed if saturated, soiled or dislodged, peri wound add house barrier cream and dressing every day and as needed for thirty days. Review of a physician's order on 08/18/2025 at 14:56 (2:56 PM) documented by the Director of Nursing revealed cleanse the left buttock pressure injury-cleanse with normal saline, apply boarder gauze and house barrier ointment to peri wound.During an observation on 08/20/2025 at 9:41 AM, Licensed Practical Nurse #2 and Certified Nursing Aide #1 entered Resident #30's room to complete pressure ulcer care. There was no signage on the resident's door indicating the resident was on enhanced barrier precautions and there was no personal protective equipment readily available. Both staff members entered the resident's room without applying a protective gown. Certified Nursing Aide #1 their washed hands and applied clean gloves, and assisted with turning the resident onto their side. Licensed Practical Nurse #1 washed their hand and applied clean gloves, and removed the soiled dressing from the resident's left buttocks. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335376	A. Building B. Wing	08/22/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was a moderate amount of serous drainage noted on the dressing. Licensed Practical Nurse #1 completed the pressure ulcer treatment as ordered. During an interview on 08/20/2025 at 9:42 AM, Licensed Practical Nurse #1 they did not apply a gown prior to entering Resident #30's room because they believed Resident #30's pressure ulcer was a Stage 2 (open shallow partial-thickness skin injury that involves damage to the epidermis (outer layer of skin) and part of the dermis (middle layer of skin) and enhanced barrier precautions were only required for Stage 3 and higher-pressure ulcers. They stated they did not check the residents medical record prior to completing the treatment but did look at the 24-hour report and there were no new orders for Resident #30 to be placed on enhanced barrier precautions. During an interview on 08/20/2025 at 10:24 AM, Registered Nurse Unit Manager #1, stated there were no new orders documented on the 24-hour report dated 08/18/2025 and the Licensed Practical Nurse on that shift may have failed to complete the reports. They viewed Resident #30's electronic medical record and stated on 08/18/2025, new orders were entered to cleanse left buttock pressure injury with NS (normal saline), pat dry, apply border gauze daily and PRN (as needed), and to apply A&D to the peri-wound (around the wound). They stated they were not certain if Resident #30 should be on enhanced barrier precautions but believed any chronic wound should qualify. During an interview on 08/20/2025 at 2:54 PM, Registered Nurse Educator #3 stated residents should be placed on enhanced barrier precautions if they have pressure ulcers that were a Stage 2 and higher; or required a dressing. They stated this was important because it would protect residents and staff from cross contamination and decrease infection risks. During an interview on 8/20/2025 at 3:02 PM, the Director of Nursing stated only chronic wounds, such as Stage 3, generally require enhanced barrier precautions, but acute or moisture associated skin damage-related wounds may differ. They stated the wound doctor documented that it was an acute Stage 3 wound, so they did not consider this to be a chronic wound. They stated they put the new orders in the system for wound care on 08/18/2025 and believed enhanced barrier precautions were not necessary for an acute wound. During an interview on 08/22/2025 at 1:03 PM, Licensed Practical Nurse #2 stated the wound care doctor informed them Resident #30's moisture associated skin damage on the left buttocks had now been confirmed to be a Stage 3 pressure ulcer. They stated that a Stage 3 pressure ulcer required a resident to be placed on enhanced barrier precautions, but no one had instructed them to do so. They also stated they did not document on 24-hour report because they assumed the Director of Nursing would process the medical doctors' notes/orders. 10 NYCRR 415.19 (a) (1-2).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335376	A. Building B. Wing	08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Schoellkopf Health Center	621 Tenth Street Niagara Falls, NY 14302

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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 0730 Level of Harm - Potential for minimal harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on interview and record review conducted during the Standard survey completed on 08/22/2025, the facility did not ensure Certified Nurse Aide performance reviews were completed at least once every 12 months for three (3) (Certified Nurse Aides #3, #4, and #5) of five (5) Certified Nurse Aide files reviewed. Specifically, there was no evidence Certified Nurse Aides #3, #4, and #5 who had worked at the facility more than 12 months had performance reviews completed at least once every 12 months. The findings are:The facility policy titled Non-Management Employee Performance Evaluation Program with an effective date of 11/78 and a revision date of 12/24 documented the purpose of the program was to improve work performance of individual employees, recognize and correct work deficiencies, and identify individual training and education needs.Review of Certified Nurse Aide #3's employee file revealed they were hired 12/03/2023 and their file contained a 90-day performance evaluation dated 03/05/2024. There was no evidence in the employee file that a performance evaluation had been completed in the last 12 months.Review of Certified Nuse Aide #4's employee file revealed they were hired 03/31/2008 and their file contained a most recent performance evaluation dated 04/30/2023. There was no evidence in the employee file that a performance evaluation had been completed in the last 12 months.Review of Certified Nurse Aide #5's employee file revealed they were hired 11/11/2021 and their file contained a 90-day performance evaluation dated 02/10/2022. There was no evidence in the employee file that a performance evaluation had been completed in the last 12 months.During an interview on 08/21/2025 a 11:07 AM, the Director of Nursing #1 stated they were running behind on completing performance evaluations for all staff and that the Human Resources department usually sends out an email when annual performance evaluations were due to be completed, and they had not received an email for this year. They stated annual performance evaluations were completed for all employees at the same time each year and it was important to give staff feedback on how they were doing and what they need to work on. The Director of Nursing #1 provided a performance evaluation for Certified Nurse Aide #3 that had been signed on 04/15/2024 and a performance evaluation for Certified Nurse Aide #4 that had been signed on 04/27/2024. The Director of Nursing #1 stated they had not sent these performance evaluations to the Human Resources department, yet. During an interview on 08/21/2025 at 3:36 PM, the Administrator stated they were aware that annual performance evaluations were due, and they currently had the annual performance evaluation for their management staff on their desk to be completed. They stated performance evaluations were sent out by the Human Resources department in July. The Administrator stated that Unit Managers would be responsible for completing performance evaluations with Certified Nurse Aides.During an interview on 08/22/2025 at 9:29 AM, the [NAME] President of Human Resources #1 stated they were overseeing Human Resources functions for the Hospital and the Nursing home employees, and they had sent out an email to all department management staff on 5/30/2025 instructing them to complete performance evaluations for all of their staff and return the completed performance evaluations to the Human Resources department by 07/09/2025. They stated that it was the Unit Manager's responsibility to complete performance evaluations for Certified Nurse Aides. The [NAME] President of Human Resources #1 stated they had not sent out any reminders about performance evaluations, yet and did not know if any or how many had been returned to the Human Resources Department. They were unsure who the Unit Managers were at the time the email was sent out. The email had been sent to a list titled Department Management List.During an interview on 08/22/2025 at 10:30 AM, Registered Nurse #2 Unit Manager stated they had been the Unit Manager for Unit 3 since the beginning of July 2025 and previously were a part time evening supervisor. They knew that Certified Nurse Aides received performance evaluations annually but stated no one had gone over this process with them.During an interview on 08/22/2025 at 10:42 AM, Registered Nurse #1 Unit Manager stated they had been the Unit Manager for Unit 2 since March 2025 and did not remember receiving an email to complete (continued on next page)

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	335376	A. Building B. Wing	08/22/2025

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F 0730 Level of Harm - Potential for minimal harm Residents Affected - Some	performance evaluations with the certified nurse aides on their unit and had not been informed of the process.During an interview on 08/22/2025 at 10:54 AM, Registered Nurse #3 Interim Unit Manager 1/Nurse Educator stated they had been filling in for the Unit 1 Unit Manager since June. They checked their emails and had not received an email to complete performance evaluations with their staff. They stated they had not been asked to complete any performance evaluations.During an interview on 08/22/2025 at 11:50 AM, the Payroll/HR Clerk #1 stated they maintained employee files and received performance evaluations from the Director of Nursing, once they were reviewed and signed by all parties. They did not have employee evaluations dated within the last 12 months for the above Certified Nurse Aide (#3, #4, and #5) employee files.10NYCRR 415.26 (d)(7)