| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335391 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 12/06/2024 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Elderwood at Grand Island | 2850 Grand Island Blvd<br>Grand Island, NY 14072 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Reasonably accommodate the needs and preferences of each resident.<br><br>22485<br><br>Based on observations, record review, and interviews conducted during a Standard survey completed on 12/6/24, the facility did not ensure that all residents received services that provided reasonable accommodations of the resident's needs and preferences for one (Resident #1) of four residents reviewed. Specifically, the call system was not within reach as planned and unable to be used if desired.<br><br>The finding is:<br><br>The policy and procedure titled, Call Light/Call Bell/Nurse Call System with a revision date of 9/6/18, documented the Unit Manager/designee will ensure residents will be provided access to a call light when not in a common area of the facility, and the call light will be answered promptly by all nursing staff and unit clerks/designee when a resident signals for assistance. The Team Leader/Nursing Assistant is responsible for ensuring the call light signal apparatus is within reach of residents who remain in their rooms and are immobile. The call light is normally placed on the bed if the resident is not present in his/her room; or in the location designated by the resident who can move about on their own and locate the call light easily.<br><br>Resident #1 had diagnoses of multiple sclerosis, hemiplegia (parallelization on one side of the body), hemiparesis (one sided muscle weakness) following a cerebral infarction (a block in the blood flow to the brain) affecting Resident #1's right dominant side. The Minimum Data Set (a resident tool assessment) dated 9/19/24 documented Resident #1 was moderately cognitively impaired and was sometimes understood and sometimes understands. Resident #1 was totally dependent on staff for bed mobility and transfers.<br><br>The comprehensive care plan dated 10/6/24, documented Resident #1 had safety risks and their call light was to be kept within reach and provide a safe environment. Additionally, Resident #1 had an alteration in communication-speech/hearing and interventions included to instruct and reinforce the use of adaptive equipment to promote communication.<br><br>The Kardex (a guide by staff to provide care) dated 9/19/24, documented that Resident #1 was to have their call light within reach and staff were to encourage use.<br><br>During an observation on 12/2/24 at 9:00 AM there was a handwritten note signed by Occupational Therapist #2 posted on the wall in Resident 1's room at the head of the bed that documented the call bell was to be pinned at all times to Resident #1's stomach and chest area.<br><br>(continued on next page) |

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

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335391 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 12/06/2024 |
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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An Occupational Therapy progress note dated 9/1/23, documented the writer promoted self-advocacy with use of modified call button multiple times during session; writer created sign and placed it next to call light for positioning of call button to ensure that patient can reach with range of motion.<br><br>During a continuous observation on 12/02/24 from 9:00 AM through 10:41 AM Resident #1 was lying in their bed, their call light was on the floor and was not within their reach. During this time Resident #1 was heard moaning and was observed several times attempting to reposition themselves and sit up. At 10:41 AM the surveyor handed the resident their call bell and they were able to tap the bell for staff assistance.<br><br>During an observation on 12/02/24 11:20 AM, Resident #was lying in bed, their call bell was pinned to the bed sheets below the resident's stomach and out of their reach.<br><br>During an observation on 12/03/24 9:45 AM, Resident #1's was lying in bed and the call bell was on the floor.<br><br>During a continuous observation on 12/04/24 from 8:34 AM to 11:00 AM Resident #1's call bell was hanging over the headboard behind the resident out of their reach.<br><br>During an interview on 12/04/24 at 9:28 AM, Support Aide #1 stated they saw Resident #1's call bell hung behind the resident on the headboard. They stated Resident #1 would not have been able to reach their call bell if they needed to. Support Aide #1 took the call bell from behind the headboard and pinned it to Resident #1's stomach/chest area.<br><br>During an interview on 12/04/24 at 9:55 AM, Certified Nurse Aide #1 stated they had left the call bell hung over the back of the bed (head board) when they completed Resident #1's care that morning and must have forgotten to pin it to within their reach. The resident would not have been able to reach their call. They stated it was important for the resident to be able to reach their call bell in case they needed help.<br><br>During an interview on 12/06/24 at 10:02 AM, Licensed Practical Nurse #1, stated Resident #1 had a sign over their bed to place their call bell near their chest/stomach area so they could access the call bell easily. They stated Resident #1 had limited range of motion, poor dexterity and had a modified call bell designed to tap when help was needed.<br><br>During an interview on 12/6/24 at 10:05 AM, Occupational Therapist #1 stated Resident #1 had a modified call device and it should rest near their stomach/chest area because they did not have the dexterity to press a button due to limited range of motion. They stated during the resident's assessment they were able to tap the modified device and a sign was posted above the resident's bed to notify the staff where to place the call bell so the resident would be able to utilize it. Occupational Therapist #1 stated the assessment was completed to ensure Resident #1's needs were accommodated, and the plan should be followed to ensure the resident's safety.<br><br>(continued on next page) |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 12/06/24 at 10:08 AM, Registered Nurse Unit 1 Manager #2 stated they did not know there was a sign posted over Resident #1's bed, but they had a touch pad call bell put in place due to their poor dexterity. They stated it was important to have the call bell within reach so they could have their needs met. They stated it was everyone's responsibility to ensure when they leave the room the call bell was within reach.<br><br>NYCRR 10 415.5 (e) (1) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22485<br><br>Based on observation, interview, and record review conducted during the Standard survey completed on 12/6/24, the facility did not develop a comprehensive person-centered care plan for each resident, consistent with the resident rights and that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental, and psychosocial needs for one (Resident #18) of three residents reviewed for elopement. Specifically, Resident #18 was assessed as a high risk for elopement and did not have a comprehensive care plan developed with interventions to address their wandering and exit seeking behaviors.<br><br>The finding is:<br><br>The policy and procedure titled Care Planning (IDT) last modified 1/22/19, documented the comprehensive care plan would include services that are to be furnished to attain or maintain the residents highest practicable physical, mental, and psychosocial wellbeing. Designated staff of all disciplines will be responsible for the evaluation and updating of the inter-disciplinary resident care plan after the resident care planning meeting and as needed following changes in the status of the resident. The interdisciplinary team will review/revise the care plan after each assessment, including both the comprehensive and quarterly review assessments per the RAI (Resident Assessment Instrument - a guide that provides instructions to assess residents in nursing homes.) manual.<br><br>The policy and procedure titled Elopement-Wandering-Missing Resident last modified 10/8/18, documented all residents are assessed upon admission, annually, and as needed to determine risk level for unsafe wandering/elopement. Appropriate safety measures are put into place for residents determined to be at risk.<br><br>Resident #18 had diagnoses that included Alzheimer's Disease, vascular dementia, and post-traumatic stress disorder (a mental health disorder caused by extreme stress or terrifying event). The Minimum Data Set (MDS, a resident assessment tool) dated 11/14/24 documented Resident #18 was usually understood and usually understands and had severe cognitive impairment. The Minimum Data Set documented Resident #18 was independent with ambulation and displayed wandering behaviors that had occurred 1-3 days during the review. Additionally, the Minimum Data Set assessment documented these wandering behaviors would be care planned to avoid complications and minimize risks.<br><br>Review of the comprehensive care plan dated 11/14/24 identified as the current care plan by the Registered Nurse Unit Manager #1 revealed there was no care plan developed for wandering and elopement.<br><br>The Kardex Report (a guide used by staff to provide care) dated 12/3/24 documented Resident #18 was independent with transfers and ambulation. There were no documented safety interventions in place for wandering and elopement risk.<br><br>The SNF (skilled nursing facility) Elopement assessment dated [DATE], documented Resident #18 was at high risk for elopement. They were regularly awake during the night, difficult to re-direct back to bed and would enter other resident's rooms.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of a behavior monitoring progress note dated 12/1/24 completed by Licensed Practical Nurse #2, documented Resident #18 had been pacing continuously and exit seeking. Licensed Practical Nurse #2 documented that these behaviors had lasted over 60 minutes.<br><br>Review of a behavior monitoring progress noted dated 11/23/24 completed by Registered Nurse Supervisor #2, documented Resident #18 had been pacing episodically and wandered into inappropriate places. Registered Nurse Supervisor #2 documented that these behaviors had lasted over 60 minutes.<br><br>Review of nursing progress notes dated 11/22/24, 11/25/24, and 11/28/24, documented Resident #18 exhibited pacing and wandering behaviors in and out of other resident's rooms and hallways.<br><br>During an observation on 12/2/24 at 3:28 PM, Resident #18 was observed on the unit wandering up and down north and south hallways going towards exit doors and had verbalized wanting to know how to get downstairs.<br><br>During an observation on 12/4/24 at 3:58 PM, Resident #18 was observed to be ambulating down the south hall towards the exit door, Resident #18 had stopped by the door turned around and walked back up the hallway. Resident #18 verbalized while ambulating that they did not want to be here and were leaving. At 4:04 PM Resident #18 had ambulated down the north hallway to the exit door, which leads to a stairwell. They had grabbed and turned the doorknob of the exit door, the door was locked and did not open. Resident #18 then turned around and ambulated back up the hallway and headed towards the south hall exit door. Resident #18 grabbed and turned the doorknob of the south hall exit door. The door was locked and did not open.<br><br>During an observation and interview with Certified Nurse Aid #2 on 12/4/24 at 4:08 PM, Certified Nurse Aide # 2 redirected Resident #18 away from the south hall exit door. Certified Nurse Aide #2 stated that Resident #18 could be anxious and confused and would wander the unit to try and find their way out. Certified Nurse Aide #2 stated they had just saw Resident #18 grab the doorknob on the south hall exit door and that was why they had intervened and redirected Resident #18 back to their room.<br><br>During an interview on 12/5/24 at 9:04 AM, Certified Nurse Aide #3 stated Resident #18 was confused and could become agitated. They stated Resident #18 would wander up and down the unit hallways and would verbalize show me the exit. They stated Resident #18 would go to the exit doors on their unit but had not observed them attempting to open the doors. Certified Nurse Aide #3 stated that they would notify the nurse with resident's behaviors.<br><br>During an interview on 12/5/24 at 11:11 AM, Licensed Practical Nurse #2 stated Resident #18 would wander the unit going hallway to hallway and had displayed exit seeking behaviors. They stated that Resident #18 would pull on doors but had not attempted to get on the elevator. They stated these wandering behaviors could last for hours and would need to be re-directed often. Licensed Practical Nurse #2 stated that they would document resident behaviors in the medical record.<br><br>(continued on next page) |

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|---|---|---|---|
| | 335391 | A. Building<br>B. Wing | 12/06/2024 |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 12/5/24 at 1:31 PM, Registered Nurse Unit Manager #1 stated the Interdisciplinary Team (IDT) would be responsible to update their own sections of the care plan. They stated that wandering and elopement would be care planned if the elopement assessment determined a resident to be at high risk. Registered Nurse Unit Manager #1 stated that Resident #18 would wander the entire unit and would go room to room actively trying to leave. They stated they had not seen Resident #18 grab at doors or make attempts to get on elevator and would expect staff to document and notify them of resident's exit seeking behaviors. Registered Nurse Unit Manager #1 stated that Resident #18 should be care planned for their wandering behaviors. During the interview Registered Nurse Unit Manager #1 reviewed Resident #18's current comprehensive care plan in the electronic medical record, and stated that Resident #18 did not have an active care plan in place to address their wandering or risk for elopement behaviors. Registered Nurse Unit Manager #1 then reviewed the quarterly elopement assessment completed on 11/14/24 for Resident #18 and stated the assessment documented Resident #18 was at high risk for elopement. They stated Resident #18 did wander the unit but did not feel they would leave the unit and was not sure if Resident #18 should be care planned for wandering and elopement.<br><br>During an interview on 12/5/24 at 3:01 PM, Licensed Practical Nurse #3/PPS(Prospective Payment System) Coordinator stated they were responsible to complete the quarterly elopement assessments. They stated they would review the nurses' notes and Kardex prior to completing the elopement assessments and that they were familiar with the residents. Licensed Practical Nurse #3/PPS Coordinator stated they had just completed the assessments and were not responsible to update care plan and did not update the interdisciplinary team with changes noted on the assessments or the Minimum Data Set assessment. During the interview with Licensed Practical Nurse #3/PPS Coordinator, reviewed the most recent comprehensive assessment for Resident #18 dated 11/14/24 and stated that it documented that wandering behaviors were present and the Care Area Assessment (CAA) of the Minimum Data Set documented these behaviors would be addressed in the care plan. The Licensed Practical Nurse #3/PPS Coordinator stated that any care area that was triggered on the Minimum Data Set assessment should be care planned.<br><br>During an interview on 12/6/24 at 10:50 AM, the Director of Nursing stated that nursing was responsible to complete elopement assessments on admission and quarterly; and that the interdisciplinary team would be responsible for updating the care plans. Interim Director of Nursing #1 stated that if a resident was wandering on the unit, exit seeking and triggered as a high risk for elopement, they would expect those behaviors to be care planned. They stated that Resident #18 would wander on the unit but would not exit seek. They stated exit seeking behaviors consisted of going to doors, grabbing handles, and attempting to get out. Interim Director of Nursing #1 stated that if a resident triggered as a high risk on the elopement assessment it would be up to the interdisciplinary team to decide if the care plan should be developed.<br><br>10NYCRR 415.11 (c) (1) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>22485<br><br>Based on observation, interview, and record review conducted during a Standard survey completed on 12/11/24, the facility did not ensure that services being provided met professional standards of quality for one (Resident #37) of one resident reviewed. Specifically, provider orders were not implemented resulting in a delay in treatment.<br><br>The finding is:<br><br>Review of the policy titled Clinics and Consultations (dentist, podiatrist, optometrist, audiologist, other), last revised 03/19, documented designated staff will assist the resident in obtaining outside optometry services as ordered by a physician. The Unit Manager/Charge Nurse contacts the attending physician about the orders or recommendations of the consult. All onsite clinics are recorded in the nursing progress notes, including any recommendations from the medical consultant. The attending physician approves, modifies, or cancels the order with a physician's order.<br><br>Review of the policy titled Nursing Supervisor, last revised 04/21, documented the Nursing Supervisor assists with ensuring the health and well-being of our residents by being responsible for nursing care rendered at the facility during the assigned shift. Document as applicable in the care plans, nursing notes, medical administration records, treatment administration records and other required records according to the service excellence standards and goals. Contact physician for orders or update according to resident response to treatment plan and/or situation and participates in change-of shift report and is responsible for bringing personnel of next shift up to date about the care and needs of residents.<br><br>Review of the policy titled Unit Manager, last revised 04/21, documented the Unit Manager is responsible for the Nursing services and oversight of social programming for all residents on their assigned unit for a twenty-four-hour basis; involves communication with physicians. This individual is responsible for nursing care reporting, documentation planning, implementation, and evaluation. Identifies residents' problems and nursing interventions and solicits interdisciplinary approaches to problems or needs of the residents.<br><br>Resident #37 had diagnoses which included unspecified macular degeneration (gradual loss of sharp central vision), type 2 diabetes, and dementia with anxiety, mood, and psychotic disturbances. The Minimum Data Set (a resident assessment tool) dated 9/5/24 documented Resident #37 was moderately cognitively impaired, was usually understood, and usually understands. Additionally, the Minimum Data Set documented that Resident #37 was dependent on staff for personal hygiene.<br><br>The comprehensive care plan dated 9/19/22 documented Resident #37 had impaired vision related to macular degeneration with interventions to monitor visual status and Ophthalmology/Optometrist consult as needed.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Optometrist consult form, dated 11/12/24, documented Resident #37 was seen by Optometrist for a dilated fundus exam (a procedure that uses eye drops to enlarge the pupil, to allow an examiner to view the inside of the eye). Recommendations were made to provide a prescription for lid hygiene twice a day for blepharitis (inflammation along the edges of the eye lids caused from bacteria on the eye lids and base of eye lashes) to both eyes. There were two sets of initials with dates next to them, dated 11/13 and 11/14, on the bottom of the document.<br><br>Review of Resident #37's physician orders dated 11/12/24 to 12/03/24 revealed there was no physicians order for lid hygiene.<br><br>Review of a secure conversation message thread dated 11/13/24 documented Registered Nurse Nursing Supervisor #1 sent a message to Nurse Practitioner #1 at 10:37 AM regarding recommendations for lid hygiene twice a day made by Optometrist for Resident #37. Nurse Practitioner #1 responded at 11:05 AM ok-did you order lid hygiene. The secure conversation documented 12+ people received message thread. There was no documented evidence of a response until 12/04/24 by Registered Nurse Unit Manager #1 at 10:26 AM.<br><br>Review of Nursing Report sheets dated 11/12/24 and 11/13/24 revealed there was no documented evidence that recommendation was carried out for Resident #37.<br><br>During an observation on 12/02/24 at 9:40 AM, Resident #37 was sitting in their wheelchair in the common area. The sclera (white portion) of both their eyes was red and glossy and there was a large amount of yellow dried debris in the inner corner of their left eye. There was dried white debris and clear drainage running down the left side of their face from their left eye.<br><br>During an observation on 12/03/24 at 8:47 AM, Resident #37 was sitting in their wheelchair in the common area. Both eyes remained red and glossy. The lashes on both eyes had dried yellow crust on them.<br><br>During a follow up observation on 12/04/24 at 8:37 AM, Resident #37 was sitting in the lounge area. Both eyes remained red and glossy, there was drainage coming from their left eye and dried yellow crust was in their eye lashes on both eyes.<br><br>During an interview on 12/04/24 at 10:03 AM, Registered Nurse Unit Manager #1 stated the process for consultant recommendations would be to update provider through secure conversation message of the recommendation and obtain order to follow through with recommendation if they agreed. Registered Nurse Unit Manager #1 stated Resident #37 had an eye consultation in November of this year. They reviewed the eye consult in the resident's medical record and reviewed the physician orders and stated, I don't see that the order was carried through, the provider was not updated and there was never an order placed for this recommendation from the Optometrist. Registered Nurse Unit Manager #1 identified that one signature on the bottom of the consult as Registered Nurse Supervisor #1, dated 11/13, and the second signature was from Nurse Practitioner #1, dated 11/14. Registered Nurse Unit Manager #1 stated the nurse that received the consult was responsible for ensuring the order recommendations were carried out.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a telephone interview on 12/04/24 at 11:17 AM, Registered Nurse Supervisor #1 stated the provider should be updated through a secure conversation message of consultants recommendation and obtain an order if the provider agreed with recommendation. The order then would be added into the resident's medical record. Registered Nurse Nursing Supervisor #1 stated they did not recall specifically about Resident #37's consult recommendations, but they stated they recalled there were eye exams conducted that day in the facility. They stated if there were any consults from that day, they would have been placed into the providers folder for them to sign. They stated if there was a recommendation, they would have written it on the 24-hour report sheet to alert staff to new order.<br><br>During an interview on 12/04/24 at 11:44 AM, Certified Nurse Aide #4 stated they noticed Resident #37 had dried yellow debris in the corners of their eyes that morning, so they cleaned them.<br><br>During an interview on 12/04/24 at 1:28 PM, Nurse Practitioner #1 stated they received a secure conversation message on 11/13/24 regarding Resident #37 and pulled up the text thread on the computer to review. They stated they responded to the message that they agreed with the Optometrist recommendation and asked if the lid hygiene was ordered. There was no response. Nurse Practitioner #1 stated they expected that the recommendation for Resident #37 would have been carried through. Nurse Practitioner #1 stated there was never an order placed for lid hygiene for Resident #37 on 11/13/24, and they were unable to enter orders themselves. They observed all staff the message was sent to and stated the Unit Manager and Nursing Supervisor were on the message thread, along with 10 other people but no one replied or carried the order out, and any person on the message thread could have carried the order out. Nurse Practitioner #1 stated Registered Nurse Unit Manager #1 replied to message on 12/04/24 at 10:36 AM and lid hygiene was ordered for Resident #37 as of 12/04/24.<br><br>During an interview on 12/05/24 at 10:12 AM, Registered Nurse Unit Manager #1 stated their secure conversation messenger was not working properly after the last update and they were not receiving alerts. Registered Nurse Unit Manager #1 reviewed secure conversation message thread regarding Resident #37 and stated they were unaware they received a message from Nurse Practitioner #1. They stated no one had documented there was a new recommendation for Resident #37. Registered Nurse Unit Manager #1 stated whoever sent the message was responsible for following through with recommendation order. They stated it should have been written on the 24-hour nurse report sheet, and a nursing progress note should have been written so the next shift coming on was aware of the new recommendation.<br><br>During an interview on 12/05/24 at 12:31 PM, the Director of Nursing stated the person that received the recommendation should follow through with any new order if there was one. It should be documented in the nursing progress noted and written on the 24-hour nurse report sheet. The Director of Nursing stated they do not know why the secure message was sent to multiple people, it only needed to be sent to whoever was normally in charge of Resident #37. They stated there should have been was no documentation and it was important to carry out recommendations from providers to ensure residents' quality of life.<br><br>10NYCRR 415.11(c)(3)(i) |

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| Elderwood at Grand Island | 2850 Grand Island Blvd Grand Island, NY 14072 |

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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 0727<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many<br><br>Note: The nursing home is disputing this citation. | Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22485<br><br>Based on observation, interview, and record review conducted during a Standard survey completed on 12/06/24, the facility did not ensure the Director of Nursing served as a charge nurse, only when the facility had an average daily occupancy of 60 or fewer residents. Specifically, the Director of Nursing worked as a charge nurse when the facility had a daily average census of greater than 60.<br><br>The finding is:<br><br>Review of a facility provided document titled Director of Nursing, last revised 2/2024, revealed the Director of Nursing ensures the health and well-being of our residents by being responsible for oversight and operations of the nursing department and its staff including staffing, training, and development, and management of personnel. The Director of Nursing is responsible for upholding and following state, local, and federal regulations, and best practices within their scope of practice. Additionally, the Director of Nursing, in conjunction with the scheduler, monitors the master staffing plan for the department and approves the schedule. Responsible for the overall direction and ongoing supervision of all direct care carried out by department staff.<br><br>The State Operational Manual dated 11/21/22 documented a charge nurse is a licensed nurse with specific responsibilities designated by the facility that may include staff supervision, emergency coordinator, physician liaison, as well as direct resident care.<br><br>The untitled facility resident census reports for November 2024 documented the following:<br><br>11/05/24 the census was 82.<br><br>11/06/24 the census was 82.<br><br>11/07/24 the census was 80.<br><br>11/11/24 the census was 78.<br><br>11/19/24 the census was 79.<br><br>11/25/24 the census was 81.<br><br>The facility census at the time of survey entrance on 12/02/24 at 8:30 AM was 78 out of 90 available beds.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335391 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 12/06/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Elderwood at Grand Island | | STREET ADDRESS, CITY, STATE, ZIP CODE 2850 Grand Island Blvd Grand Island, NY 14072 | |

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| F 0727<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many<br><br>Note: The nursing home is disputing this citation. | Review of the Facility assessment dated [DATE] documented the facility's daily average census was 84. The services and programs the facility provides to its population include long term care/skilled nursing, subacute and rehabilitation services, respite care and memory care. Special treatments included but were not limited to assessment, respiratory treatments (tracheostomy care), bladder ultrasound, behavioral health needs, IV (intravenous) medications, ng (nasogastric) tubes, ostomy care, advanced wound care (wound vacs and drain management), cardiac care, and emergency services (life vest monitoring and left ventricle assist device).<br><br>Review of the attached Facility Assessment Staffing Plan documented the minimum staffing numbers for nurses on the night shift with a census of 84 was one Nurse on Unit 1 and one Nurse on Unit 2. Adequate (budgeted staffing) staffing documented one Night Supervisor, one Nurse on Unit 1 and one Nurse on Unit 2. State mandated staffing numbers for nursing was the same as adequate staffing.<br><br>Review of The Facility Daily Staffing Sheets dated 11/5/24 through 12/4/24 documented the following and revealed the Director of Nursing was counted in the facilities numbers to meet their minimum assessed numbers to provide direct care to the residents.<br><br>11/5/24 10:00 PM to 6:00 AM Shift:<br><br>Unit 1 - there was no nurse scheduled.<br><br>Unit 2 - there was one Registered Nurse and the Director of Nursing scheduled.<br><br>11/6/24 10:00 PM to 6:00 AM Shift:<br><br>Unit 1 - there was no nurse scheduled.<br><br>Unit 2 - there was one Registered Nurse and the Director of Nursing scheduled.<br><br>11/7/24 10:00 PM to 6:00 AM Shift:<br><br>Unit 1 - there was one Licensed Practical Nurse scheduled.<br><br>Unit 2 - the Director of Nursing was nurse scheduled.<br><br>11/11/24 10:00 PM to 6:00 AM Shift:<br><br>Unit 1 - there was one Licensed Practical Nurse scheduled.<br><br>Unit 2 - the Director of Nursing was nurse scheduled.<br><br>11/19/24 10:00 PM to 6:00 AM Shift:<br><br>Unit 1 - there was one Licensed Practical Nurse scheduled.<br><br>Unit 2 - the Director of Nursing was the nurse scheduled.<br><br>11/25/24 10:00 PM to 6:00 AM Shift:<br><br>(continued on next page) |

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| F 0727<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many<br><br>Note: The nursing home is disputing this citation. | Unit 1 - there was one Licensed Practical Nurse scheduled.<br><br>Unit 2 - the Director of Nursing was the nurse scheduled.<br><br>During an observation and interview on 12/4/24 at 8:04 AM, the Director of Nursing stood at the 2nd floor team 2 medication cart. They stated they were passing medication until the Unit Manager arrived. They also stated they worked the night shift last night (12/3/24) because they were supposed to train a new employee, but that employee had called off.<br><br>During an interview on 12/05/24 at 1:12 PM, the Scheduling Supervisor stated the Director of Nursing was on the schedule whenever there was a new nurse, and the educator was unavailable to train them. They also stated they preferred a Licensed Practical Nurses not to train a Registered Nurse because the Licensed Practical Nurse could not do intravenous therapy. They stated they prefer to have a Registered Nurse and a Licensed Practical Nurse on the units for overnights because if there was a fall the Registered Nurse was there to assess the resident.<br><br>During an interview on 12/5/24 at 3:05 PM, the Director of Nursing<br><br>they stated they picked up shifts in addition to their dedicated 8 hours as the Director of Nursing. They stated if there was an opening on the overnight shift that could not be filled, they would sign up for them.<br><br>During an interview on 12/6/24 at 10:58 AM, the Supervisor Scheduler, stated the Director of Nursing worked the overnight shift of 10:00 PM - 6:00 AM on 11/5/24, 11/6/24, 11/7/24, 11/19/24 and 11/25/24 because there were no other nurses available. On 11/11/24 they worked the 10:00 PM to 6:00 AM because they needed a Registered Nurse to work because they will not schedule a Licensed Practical Nurse without a Registered Nurse on duty for the overnight shift. They stated that on 11/18/24, 11/26/24, and 11/29/24 the Director of Nursing worked overnight shift along with two other Registered Nurses because the Director of Nursing trained one of the nurses. They stated new Registered Nurses would train for four months, and the Director of Nursing would train them if no one else was available.<br><br>During an interview on 12/06/24 at 1:14 PM, the Administrator stated the Director of Nursing was never acting as a charge nurse simultaneously with their Director of Nursing duties.<br><br>During an interview on 12/6/24 at 3:34 PM, the Director of Nursing stated they worked their 40 hours per week as the Director of Nursing and when they worked on a cart that was in addition to the 40 hours of their Director of Nursing duties.<br><br>10NYCRR 415.13(b)(1) |

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| F 0840<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service.<br><br>22485<br><br>Based on interview and record review conducted during the Standard survey completed on 12/6/24, the facility did not employ a qualified professional to furnish a specific service to be provided by the facility and the facility did not have that service furnished to residents by a person or agency outside the facility under an arrangement. Specifically, the facility did not have a dentist on their staff and did not have dental services provided by an outside person or agency under an arrangement. This had the potential to affect 78 of 78 residents.<br><br>The finding is:<br><br>The policy titled Dental Care Arrangements dated 6/18/18 documented routine or emergency dental services will be offered onsite on either staff or fee-for-services basis, as administered by or under either the personal or general supervision of a licensed and currently registered Dental consultant.<br><br>Review of the Facility Survey Report (Form DOH-1550), signed by the Administrator on 12/2/24, revealed a handwritten note in the dental services section that the facility was in the process of procuring a new contract. The question Are routine dental services provided within your facility was inaccurately documented as yes and the question Does your facility have a cooperative agreement with an outside dental service, was left blank.<br><br>The facility's Admission Agreement, provided by the Administrator on 12/3/24, documented services provided by the facility included physician services and the following physician-ordered services ancillary-services are available through duly licensed, registered, and/or certified practitioners: dental services.<br><br>During an interview on 12/5/24 at 4:14 PM, the Registered Nurse Unit Manager #1 stated the facility didn't have a dentist and residents would have to wait for routine dental services. For any emergent dental issues, they assumed the resident would be sent to (the county medical center). They were not sure how long there had been no dentist.<br><br>During an interview on 12/6/24 at 9:20 AM, the Unit Clerk #1 stated there had not been a dentist coming into the facility since April. If someone needed to see a dentist, they would send them to (the county medical center), but it took a little time to be seen. The last time they called to set up an appointment it was a 3 month wait. For routine cleanings or exams, they would talk to the family to see if they had a family dentist and go from there.<br><br>During an interview on 12/6/24 at 9:33 AM, Registered Nurse Unit Manager #2 stated there was no dentist and they weren't sure how long it was been. If a resident had an issue that needed immediate attention, they would send them to an emergency room . They stated it was important to have a dentist for the resident's dental health and possibly their nutrition.<br><br>(continued on next page) |

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| F 0840<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During an interview on 12/6/24 at 11:59 AM, the Director of Nursing stated they didn't know how long they haven't had a dentist. They knew they were working on a contract. The medical provider will look at residents to see if there were any issues with their teeth, the Unit Clerks kept track of who needed annual exams. They haven't needed to use (the county medical center) for anything emergent, they would send a resident to the emergency room if it were very emergent. Routine oral or dental exams were not being completed by a dentist.<br><br>During an interview on 12/6/24 at 12:56 PM, the Administrator stated corporate was in the process of obtaining a dental contract, there was no specific date as to when the contract will be in place. The Administrator stated the dentist used to come monthly, and they haven't had a dental contract since April (2024). They did not send a letter out to families or residents. The Administrator stated there should be a dentist available for residents because it was part of the regulations, and they didn't know if it was part of the facility admission agreement.<br><br>10 NYCRR 415.26(e) |