STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335406	A. Building B. Wing	11/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wayne County Nursing Home	1529 Nye Road Lyons, NY 14489

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review conducted during an Abbreviated Survey (Intake ID: 2652860) from 11/03/2025 to 11/07/2025, the facility failed to ensure each resident received adequate supervision and assistive devices to prevent accidents for one (1) of three (3) (Resident #10) residents reviewed for accidents. Specifically, Resident #10 was transferred on 10/24/2025 using an extra-large mechanical lift sling that did not fit the resident's body size, and a registered nurse or therapist did not assess the resident upon readmission to determine the correct sling size which resulted in the resident falling from the sling and sustaining a subdural hematoma (bleeding around the brain) and an orbital fracture (fracture around the eye). The facility's failure to conduct a registered nurse or therapist assessment to determine correct sling size, failure to document sling size in the comprehensive care plan and care card, failure to ensure staff were trained or competent in sling selection, and allowing staff to use any available sling regardless of fit resulted in actual harm to Resident #10 and a likelihood for serious injury, serious harm, serious impairment, or death for all residents requiring the use of a mechanical lift in the facility (census 139), that was Immediate Jeopardy and Substandard Quality of Care.The findings include:The facility policy Lift/Transfer/Positioning, last reviewed November 2024, included nursing will determine a resident's ability to transfer upon admission and within 48 hours, a therapist will assess the resident's ability to lift and transfer. Approaches for resident lift/transfer will be incorporated in the resident care plan as determined per nursing or therapy. Lift and sling type are to be written on the care plan/care card. When a resident cannot be transferred per care plan or there is a change in resident condition placing a resident at risk, a Stop and Watch (communication tool used to help staff recognize and report changes in a resident's condition) should be done and reported to the nurse immediately. The resident must be reassessed for lift/transfer by the registered nurse or therapist, and the reassessment will be documented in the resident record. Any change in approaches for lift/transfer will be incorporated in the resident care plan and transcribed to the care plan flow sheet. The registered nurse or therapist may assign an alternate transfer/lift to a resident and will document specifics on when to use the alternate transfer/lift in the care plan and certified nursing assistant instructions. If staff are uncertain about the resident's ability to perform the transfer recommended or alternate transfer as posted, the staff may always opt to complete a transfer/lift that is physically less demanding (higher level of care), and the nurse must be notified if this occurs. The resident assessment should include examination of factors such as the level of assistance the resident requires, the size and weight of the resident, the ability and willingness of the resident to understand and cooperate, and any medical conditions that may influence the choice of methods for lifting or repositioning.The Medline (manufacturer) sling Instructions For Use, dated 2022, included: to always confirm the weight capacity of the sling against the patient's weight and ensure proper placement before performing a lift; use clinical judgement for body shape and patient comfort when selecting between sizes; do not remove sling labels and if labels are removed or no longer legible, the sling must be immediately removed from use.The undated Medline Model: MDS450EL Patient Lift Owner's Guide, included: to select a sling that will properly fit the patient and has the appropriate weight capacity; always ensure the sling is the correct size and capacity for the patient being transferred; use only Medline slings on Medline patient lifts; use of non-Medline slings could be unsafe and may result in injury to the patient or caregiver.Resident #10 had diagnoses including vascular dementia, dysphagia (difficulty swallowing), and chronic kidney disease. The Minimum Data Set (a resident assessment tool) dated 12/24/2024 documented the resident had severely impaired cognition. Review of the Comprehensive Care Plan dated 08/08/2025 and care card (used by certified nursing assistants to guide care), effective 10/24/2025, revealed Resident #10 required substantial/maximal assistance (significant physical help to complete task) by one (1) staff using a two (2) wheeled walker and gait belt (a safety tool used to help individuals who have difficulty walking, standing, or balancing) for transfers. There was no documented evidence of mechanical lift use, sling size, sling type, or any instruction on loop (used to attach a sling to the mechanical lift and helps to adjust the resident's position during a transfer) configuration.Resident #10 was hospitalized from [DATE] to 10/24/2025 for acute respiratory failure (inadequate gas exchange by the respiratory system) related to pneumonia. Review of a hospital After Visit Summary dated 10/24/2025, revealed Resident #10's weight was 125 pounds and height was 67 inches. The resident was readmitted to the facility on [DATE]. In a progress note dated 10/24/2025 at 3:19 PM, the Director of Nursing documented Resident #10 returned to the facility by

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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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. (continued on next page)

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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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review conducted during an Abbreviated Survey (Intake ID: 2652860) from 11/03/2025 to 11/07/2025, the facility did not ensure it was administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically, Resident #10 was transferred on 10/24/2025 using an extra-large mechanical lift sling that did not fit the resident's body size, and a registered nurse or therapist did not assess the resident upon readmission to determine the appropriate mode of transfer, including the mechanical lift sling size, which resulted in the resident falling from the sling and sustaining a subdural hematoma (bleeding around the brain) and an orbital fracture (fracture around the eye). Additionally, Administration did not ensure proper equipment was used, or the Medical Director was notified of any issues related to the equipment used during the transfer, and there were inconsistencies amongst staff with regard to who made the determination of a resident's transfer status and equipment needs. The findings included:For additional information see Centers for Medicare/Medicaid Services Form 2567, refer to F689 (Free of Accident Hazards/Supervision/Devices): The facility failed to ensure each resident received adequate supervision and assistive devices to prevent accidents for one (1) of three (3) (Resident #10) residents reviewed for accidents. This issue resulted in actual harm to Resident #10 and a likelihood for serious injury, serious harm, serious impairment, or death for all residents requiring the use of a mechanical lift in the facility (census 139), that was Immediate Jeopardy and Substandard Quality of Care. The facility policy Lift/Transfer/Positioning, last reviewed November 2024, included nursing will determine a resident's ability to transfer upon admission and within 48 hours, a therapist will assess the resident's ability to lift and transfer. Approaches for resident lift/transfer will be incorporated in the resident care plan as determined per nursing or therapy. Lift and sling type are to be written on the care plan/care card. When a resident cannot be transferred per care plan or there is a change in resident condition placing a resident at risk, a Stop and Watch (communication tool used to help staff recognize and report changes in a resident's condition) should be done and reported to the nurse immediately. The resident must be reassessed for lift/transfer by the registered nurse or therapist, and the reassessment will be documented in the resident record. Any change in approaches for lift/transfer will be incorporated in the resident care plan and transcribed to the care plan flow sheet. The registered nurse or therapist may assign an alternate transfer/lift to a resident and will document specifics on when to use the alternate transfer/lift in the care plan and certified nursing assistant instructions. If staff are uncertain about the resident's ability to perform the transfer recommended or alternate transfer as posted, the staff may always opt to complete a transfer/lift that is physically less demanding (higher level of care), and the nurse must be notified if this occurs. The resident assessment should include examination of factors such as the level of assistance the resident requires, the size and weight of the resident, the ability and willingness of the resident to understand and cooperate, and any medical conditions that may influence the choice of methods for lifting or repositioning.The Medline (manufacturer) sling Instructions For Use, dated 2022, included: to always confirm the weight capacity of the sling against the patient's weight and ensure proper placement before performing a lift; use clinical judgement for body shape and patient comfort when selecting between sizes; do not remove sling labels and if labels are removed or no longer legible, the sling must be immediately removed from use.The undated Medline Model: MDS450EL Patient Lift Owner's Guide, included: to select a sling that will properly fit the patient and has the appropriate weight capacity; always ensure the sling is the correct size and capacity for the patient being transferred; use only Medline slings on Medline patient lifts; use of non-Medline slings could be unsafe and may result in injury to the patient or caregiver.Resident #10 was hospitalized from [DATE] to 10/24/2025 for acute respiratory failure (inadequate gas exchange by the respiratory system) and was readmitted to the facility on [DATE]. There was no documented evidence Resident #10's transfer status was assessed by a registered nurse or therapist following readmission to the facility. Review of Resident #10's Comprehensive Care Plan dated 08/08/2025 and care card (used by certified nursing assistants to guide care), effective 10/24/2025, did not include documented evidence of mechanical lift use, sling size, sling type, or any instruction on loop (used to attach a sling to the mechanical lift and helps to adjust the resident's position during a transfer) configuration.Review of the facility's investigation summary dated 10/30/2025, revealed on 10/24/2025, Certified Nursing Assistant #1 and Certified Nursing Assistant #2 attempted to