| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 335406 | A. Building<br>B. Wing | 11/26/2024 |

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

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Allow residents to self-administer drugs if determined clinically appropriate.<br><br>47642<br><br>Based on observations, interviews, and record review conducted during the Recertification Survey 11/20/2024 to 11/26/2024 for three (Residents #89, #119 and #130) of three residents reviewed, the facility did not ensure residents were assessed by an interdisciplinary team to determine their ability to safely self-administer medications or have medications left at their bedside unsupervised. Specifically, Resident #89 reported that nursing staff frequently left their pills in a medicine cup at their bedside for them to take later. Resident #119 had a nasal spray left unsupervised at their bedside. Resident #130 had an unlabeled and unsupervised medicine cup containing multiple pills in front of them at the table. None of the residents had an order to self-administer medications and had not been evaluated to have medications left with them unsupervised. This was evidenced by the following:<br><br>The facility's policy Residents' Self-Administration of Medications, reviewed June 2024, documented a thorough assessment will be done by a nurse to determine if the resident is capable of safe self-administration of drugs. Resident's cognitive abilities to understand how and when to take the medications will be included in the assessment for safe administration of drugs. The care planning team will review the assessment and determine if the resident is capable. Nursing will provide the resident with information on medication usage and side effects via the electronic medical record. The resident will read, acknowledge, and sign the agreement for self-administration of their medications. The resident will be provided a locked box or locked drawer to secure their medications. Nurses will double-check that the drugs are appropriately labeled per the physician's orders and the Medication Administration Record must state that the person may self-administer.<br><br>1. Resident #130 had diagnoses that included Alzheimer's disease, dementia, and anxiety. The Minimum Data Set Resident Assessment, dated 10/01/2024, documented the resident had moderately impaired cognition.<br><br>Review of the current Comprehensive Care Plan revealed that Resident #130 had impaired cognition related to dementia and was at risk for wandering and elopement with staff interventions to provide the resident with reorientation to their surroundings and environment (initiated 03/27/2024). The resident's care plan did not include documentation pertaining to self-administration of medication.<br><br>Review of Resident #130's active medical orders did not include orders for self-administration of medications.<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 |
|---|---|---|

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an observation on 11/22/2024 at 9:09 AM, Resident #130 was sitting at the dining room table with a medicine cup by their plate containing approximately six to seven pills of different sizes and shapes. No nursing staff were in sight at the time.<br><br>2. Resident #89 had diagnoses that included Parkinson's disease, chronic pain, and depression. The Minimum Data Set Resident Assessment, dated 09/08/2024, documented the resident was cognitively intact.<br><br>Review of Resident #89's current Comprehensive Care Plan did not include documentation pertaining to self-administration of medication.<br><br>During an interview on 11/22/2024 at 11:22 AM, Resident #89 stated they could have their nasal spray, eye drops, and inhalers left at the bedside unsupervised, but were not supposed to have their pills left there. Resident #89 stated the nurses would often bring their medications to them in a medicine cup, and if they were not ready to take them, the nurse would leave them at their bedside. The resident stated no one had explained to them what their medications were, and they were not familiar with all of their medications. The resident also stated there had been times when they dropped their pills on the floor and had to call the nurse.<br><br>During an interview on 11/22/2024 at 11:35 AM, Licensed Practical Nurse #2 stated medical orders specified which medications could be left at the bedside unsupervised and there was no indication that Resident #89 could have pills left at their bedside unsupervised. Licensed Practical Nurse #2 stated for medications to be left unsupervised, the resident would have to be evaluated, be cognitively intact, able to voice their needs, have a medical order in place, and be care planned for self-administration of medications.<br><br>3. Resident #119 had diagnoses that included congestive heart failure, anxiety, and depression. The Minimum Data Set Resident Assessment, dated 09/24/2024, documented the resident had moderately impaired cognition.<br><br>Review of the current Comprehensive Care Plan revealed that Resident #119 had impaired cognitive function with memory issues (initiated 06/06/2023). Staff interventions included to cue, reorient, and supervise the resident as needed, and administer medications as ordered. The resident's care plan did not include documentation pertaining to self-administration of medication.<br><br>Review of Resident #119's active medical orders did not include orders for self-administration of medications.<br><br>During an observation on 11/20/2024 at 1:18 PM, Resident #119 had normal saline nasal spray at their bedside unsupervised with no nurses in sight.<br><br>During an interview on 11/26/2024 at 10:39 AM, the Director of Nursing stated before a resident could self-administer medications, they should have a completed evaluation form in place and a physician's order. The Director of Nursing stated nurses should educate the resident on their medications, what they are for, and should be discussed at the resident's care plan meeting. The Director of Nursing stated even if something were to come up, the nurses should take the medications with them and not leave them unsupervised with a resident who had not been assessed for safe self-administration.<br><br>(continued on next page) |

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 10 NYCRR 415.3 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>49447<br><br>Based on observations, interviews, and record review conducted during the Recertification Survey 11/20/2024 to 11/26/2024, for four (Residents #36, #37, #91, #94) of 10 residents reviewed, the facility did not maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Specifically, Residents #36 and #94 who were on Enhanced Barrier Precautions (a strategy in nursing homes to decrease transmission of infectious disease using enhanced personal protective equipment [PPE]) had indwelling urinary catheter drainage bags that were observed on the floor. Resident #36 received hands on care from staff who were not wearing the required personal protective equipment. Resident #37 received wound care and nursing staff did not change gloves or wash their hands appropriately during the wound care. Resident #91 was being transferred with a mechanical assistive device that had been used on another resident without being cleaned prior to use. This is evidenced by the following:<br><br>The facility policy Standard,Transmission and Enhanced Barrier Techniques, revised July 2024, included Enhanced Barrier Precautions is an approach to the use of personal protective equipment to reduce transmission of Multidrug-Resistant Organisms between residents in skilled nursing facilities and expands the use of gowns and gloves to be worn during high contact activities with residents with indwelling medical devices. Indwelling medical devices include urinary catheters and high contact activities include transferring and device care or use. Contact precautions reduce the risk of transmission of microorganisms by direct or indirect contact. Gowns and gloves must be worn the entire time while in the room, must be removed prior to exiting the room, and hands must be washed with soap and water. Standard Precautions include infection control practices that are followed at all times with all residents, including properly cleaning, disinfecting, or sterilizing reusable equipment before use on another resident.<br><br>The facility policy Urinary Incontinence Management and Prevention of Urinary Tract Infections, reviewed July 2024, included any resident with a catheter will be provided with a privacy bag in which the urinary collection bag is to be covered and serve as a barrier.<br><br>The facility Skin Care policy for Wound and Skin Care, Protection, Identification, Risk factors, Staging, and Documentation, revised April 2024, included proper hand hygiene is to be completed prior to, between, and after all wound care including between different wound sites.<br><br>1. Resident #36 had diagnoses that included Alzheimer's disease, benign prostate hyperplasia (a condition where the prostate is enlarged, making it difficult to urinate), and diabetes. The Minimum Data Set Resident Assessment, dated 10/30/2024, documented Resident #36 had severe cognitive impairment and had an indwelling urinary catheter.<br><br>The Comprehensive Care Plan, revised 09/12/2024, and the current undated Kardex (care plan used by the Certified Nursing Assistants for daily care) included that Resident #36 was on Enhanced Barrier Precautions, had an indwelling urinary catheter, and to follow the indwelling urinary catheter policy.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an observation on 11/20/2024 at 1:01 PM, Resident #36's door had a sign that included the resident was on Enhanced Barrier Precautions and for staff to wear gowns and gloves with all resident contact. Certified Nursing Assistant #1 and Certified Nursing Assistant #2 transferred Resident #36 using a mechanical lift device from their wheelchair to the bedside recliner. Both Certified Nursing Assistants had gloves on, but neither were wearing a gown. During the transfer, Certified Nursing Assistant #2 moved the urinary drainage bag that was attached to the indwelling urinary catheter and placed the drainage bag on the floor without a barrier. Certified Nursing Assistant #2 emptied the urine drainage bag without putting on a gown.<br><br>During an observation and interview on 11/22/2024 at 9:29 AM, Certified Nursing Assistant #3 assisted Resident #36 to sit up on the side of the bed to get dressed and then transferred to the wheelchair. During care, the urinary drainage bag was sitting on the floor without a barrier. During an interview at this time, Certified Nursing Assistant #3 stated there should be a barrier between the urinary drainage bag and the floor, but they forgot to put a cover on the urinary drainage bag or a towel to set it on.<br><br>During an interview on 11/25/2024 at 2:00 PM, Certified Nursing Assistant #1 stated residents on Enhanced Barrier Precautions have a sign outside their door which included when to wear personal protective equipment. Resident #36 was on Enhanced Barrier Precautions, and they should have worn a gown while transferring them.<br><br>During an interview on 11/26/2024 at 9:22 AM, Certified Nursing Assistant #2 stated they knew Resident #36 was on Enhanced Barrier Precautions, but did not know they needed to wear a gown to transfer the resident or empty the urinary drainage bag. Certified Nursing Assistant #2 stated they had received education on Enhanced Barrier Precautions, but were confused on when personal protective equipment should be worn.<br><br>During an interview on 11/26/2024 at 10:00 AM, Registered Nurse Manager #1 stated Certified Nursing Assistant #1 and Certified Nursing Assistant #2 should have worn gowns and gloves while transferring and emptying the urinary drainage bag for Resident #36. The urinary drainage bag should never be on the ground without a cover or barrier to protect Resident #36 from contamination and potential urinary tract infections.<br><br>2. Resident #37 had diagnoses that included diabetes, osteomyelitis (an infection in the bone) of a foot ulcer, and malnutrition. The Minimum Data Set Resident Assessment, dated 08/29/2024, documented Resident #37 was cognitively intact, had a diabetic foot ulcer, and received wound care and dressings to the feet.<br><br>During observations and interview on 11/25/2024 at 8:11 AM, Licensed Practical Nurse #1 performed wound care to two diabetic ulcers on the resident's left foot and one on their right foot. During the course of the wound care, Licensed Practical Nurse #1 did not change gloves or perform hand hygiene between removing the old, soiled dressings and placing clean dressings or in between wound sites. During an interview at this time, Licensed Practical Nurse #1 stated they should have changed gloves and performed hand hygiene after removing the soiled dressings before placing a clean dressing and in between care for each wound site, but they forgot to.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 11/26/2024 at 10:00 AM, Registered Nurse Manager #1 stated they expect wound care to be performed following infection control practices. Gloves should be changed and hand hygiene completed after removing a soiled dressing prior to placing a clean dressing and should be completed in between each wound site.<br><br>3. Resident #91 had diagnoses that included Alzheimer's disease, depression, and repeated falls. The Minimum Data Set Resident Assessment, dated 10/04/2024, documented Resident #91 was rarely or never understood, was unable to complete the cognitive assessment, and was dependent on staff for transfers.<br><br>During an observation on 11/20/2024 at 1:01 PM, Certified Nursing Assistant #2 removed a mechanical lift and sling (a device that is attached to the resident and the machine to assist in transfers) from Resident #36's room that had an Enhanced Barrier Precautions sign outside the door and took it to Resident #91's room that did not have an Enhanced Barrier Precautions sign on the door. Certified Nursing Assistant #2 and Certified Nursing Assistant #6 used the lift sling and the mechanical lift to transfer Resident #91. Neither the mechanical lift nor the sling was cleaned between use on Resident #36 and Resident #91.<br><br>During an interview on 11/26/2024 at 9:22 AM, Certified Nursing Assistant #2 stated they brought the mechanical lift from Resident #36's room to Resident #91's room and did not recall if they had cleaned or sanitized the machine (or sling) in between residents, and that they should have cleaned the machine after using it on Resident #36 and before using it for Resident #91.<br><br>During an interview on 11/26/2024 at 10:00 AM, Registered Nurse Manager #1 stated all equipment that is shared between residents should be cleaned and sanitized after every use and should not be used on more than one resident without cleaning.<br><br>4. Resident #94 had diagnoses including obstructive uropathy (inability to urinate) and bladder dysfunction.<br><br>Review of the current Comprehensive Care Plan, revised 05/25/2022, revealed the resident had a suprapubic catheter (catheter inserted directly into the bladder via the abdomen). Interventions included to monitor for signs of infection.<br><br>During an observation on 11/22/2024 at 9:50 AM, Resident #94's urinary drainage bag was lying directly on the floor with no barrier under it.<br><br>During an interview on 11/26/2024 at 9:43 AM, Licensed Practical Nurse #3 stated the urinary drainage bags should have a cover over them to provide a barrier and should never be left on the ground.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 11/26/2024 at 10:54 AM, the Infection Preventionist stated hand hygiene should be performed before and after wound care, when gloves are changed after removing a soiled dressing, and before applying the new dressing and in between wound sites. Any equipment shared between residents should be cleaned prior to use with another resident, and all staff should wear personal protective equipment per the posted signs outside the resident room. The Infection Preventionist also stated residents with an indwelling catheter are placed on Enhanced Barrier Precautions and gowns and gloves should be worn with all direct care, including emptying the urinary drainage bags. Urinary drainage bags should be kept off the floor at all times. The Infection Preventionist stated Enhanced Barrier Precautions and the required personal protective equipment is an area that all staff have expressed confusion regarding when personnel protective equipment should be worn.<br><br>10 NYCRR 415.19(a)(1-3)(b)(4) |