

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335423	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/03/2025
NAME OF PROVIDER OR SUPPLIER  Premier Genesee Center for Nrsng and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 278 Bank Street Batavia, NY 14020	

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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 33313</p> <p>Based on interview and record review conducted during a Complaint (#NY00369028) investigation completed on 2/3/25, the facility did not ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan and the residents' choice for one (Resident #1) of three residents reviewed. Specifically, Resident #1 was permitted by staff to leave the facility at 5:30 AM and independently walk to a nearby hospital. Upon their return the facility initiated an electronic monitoring device without adequate indications for its use.</p> <p>The findings are:</p> <p>Resident #1 had diagnoses which included intellectual disabilities, anxiety, and chronic obstructive pulmonary disease (airflow obstruction and breathing problems). The Minimum Data Set (a resident assessment tool) dated 1/8/25 documented the resident was cognitively intact and did not have wandering or exit seeking behaviors.</p> <p>a. The Physician Order Activity Report as of 1/12/25 revealed the resident did not have an order for ALOA (approved leave of absence).</p> <p>The Health Care Decision-Making Capacity Determination signed and dated 4/28/23 by the Medical Director documented Resident #1 lacked complete, lifelong, personal medical decision-making capacity secondary to intellectual disability.</p> <p>The Progress Noted dated 1/12/2025 at 11:58 AM, authored by Registered Nurse Assistant Director of Nursing, documented the resident requested to go to local hospital for evaluation of anxiety and insomnia. The resident was educated on staying in the facility and a call can be placed to on-call provider. Resident preferred to sign out on pass instead of being transferred by emergency medical services. Resident #1 signed out and left the facility around 5:30 AM.</p> <p>Documentation request was e-mailed on 1/31/25 at 9:10 AM to the Administrator for the facility to provide a Release of Responsibility form signed by the resident at their time of departure from the facility and they were unable to provide one.</p> <p>(continued on next page)</p>

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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 1/31/25 at 10:30 AM, Licensed Practical Nurse #2 (11:00 PM -7:00 AM nursing supervisor on 1/12/25) stated on 1/12/25 Licensed Practical Nurse #3 reported Resident #1 couldn't sleep and was hearing voices. Licensed Practical Nurse #2 stated they responded to the unit and Resident #1 was very aggressive, adamant about seeing a doctor immediately. Licensed Practical Nurse #2 stated they had Resident #1 sign a Release of Responsibility form and the resident left the facility at 5:30 AM.</p> <p>During a telephone interview on 1/31/25 at 10:23 AM, Licensed Practical Nurse #3 stated they were assigned to Resident #1's unit on the 11:00 PM -7:00 AM shift on 1/12/25. Licensed Practical Nurse #3 stated at 5:00 AM Resident #1 was walking about the unit stating they were hearing voices, and they administered 5:00 AM medications to the resident. The nurse stated they were unaware Resident #1 had left the unit.</p> <p>During an interview on 1/31/25 at 11:45 AM, the Director of Nursing stated Licensed Practical Nurse #2 should have contacted them or the Assistant Director of Nursing to get direction on how to proceed with the resident. The medical provider should have been contacted if the resident required medical assistance and the resident should have been transported by emergency medical services to the emergency department. Additionally, the nursing supervisor should not have allowed the resident to leave the facility at 5:30 AM to walk through the parking lot to the hospital.</p> <p>During an interview on 1/31/25 at 1:42 PM, the Director of Social Work stated it was unsafe to allow a resident that complained of auditory hallucinations to leave the facility at 5:30 AM, when it was cold and dark outside. Additionally, the Director of Social Work stated Resident #1 lacked the capacity to make health care decisions.</p> <p>During a telephone interview on 1/31/25 at 1:53 PM, the Nurse Practitioner stated Resident #1 had cognitive impairments secondary to intellectual disabilities and serious mental health issues. Additionally, the resident lacked capacity to make complex decisions, the supervisor did the wrong thing.</p> <p>The facility policy Leave of Absence (LOA) last date revised 3/14/23, documented it is the policy of the facility to encourage outside socialization for the resident when appropriate. A cognitively intact resident can leave the facility independently with the appropriate physician order. The facility will track the departure and return of a resident on the Release of Responsibility for leave of absence form. When a leave of absence is to occur evaluate resident for a change in condition, notify physician of any concerns/changes.</p> <p>b. The Elopement Risk assessment dated [DATE] documented the resident was not an elopement risk.</p> <p>The Physician Order Activity Detail Report dated 1/12/2025 - 2/3/2025 revealed a physician's order dated the 1/14/25 that documented to check placement of wander guard (electronic monitoring device) to the LLE (left lower extremity) Q (every) shift and check functioning of wander guard to LLE (left lower extremity) Q (every) shift.</p> <p>The undated Certified Nurse Aide Care Guide included Safety: Wander Guard (electronic monitoring device).</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Progress Note dated 1/12/2025 at 11:54 AM, authored by Licensed Practical Nurse #1, documented wander guard (electronic monitoring device) placed to left lower extremity, resident educated on needing to have a staff member take them off the unit.</p> <p>The Progress Noted dated 1/12/2025 at 11:58 AM, authored by Registered Nurse Assistant Director of Nursing, documented Resident #1 signed out on pass at 5:30 AM and left the facility to go to a local hospital.</p> <p>During an observation on 1/31/25 at 10:05 AM Resident #1 was observed with an electronic monitoring device on their left lower extremity. Resident #1 stated the facility placed the device on their ankle a few weeks ago, and the resident felt they were being punished. Resident #1 stated they enjoyed leaving the unit to go on the first floor to the vending machines, the facility store, and interacting with residents from other units. Additionally, the resident stated, I can't move around and go where I want to with this wander guard (electronic monitoring device) on.</p> <p>During a telephone interview on 1/31/25 at 11:28 AM, Licensed Practical Nurse #4 stated they placed a wander guard on the residents left lower extremity because it was reported the resident left the unit and didn't notify the nurse.</p> <p>During an interview on 2/3/25 at 10:58 AM, the Director of Nursing stated they removed the wander guard from Resident #1 on 1/31/25 secondary to the resident was not at risk for wandering, there was no reason for them to have a wander guard. Additionally, Resident #1 was educated to sign out at the nurses' station when they leave the unit.</p> <p>The facility policy Abuse Policy Prevention and Management dated 9/2023, documented the facility must provide a safe resident environment and protect residents from abuse including involuntary seclusion. Involuntary seclusion was defined as separation of resident from other residents against their will, that may take many forms including but not limited to confinement, restriction, or isolation of a resident.</p> <p>The facility policy Elopement Prevention and Management review dated 8/2023, documented the facility recognizes mobility as strength to be supported and promoted. The facility will strive to identify residents at risk for unsafe wandering and exit seeking behavior and to develop individualized prevention and management interventions based on Exit Seeking/Elopement Evaluation.</p> <p>10 NYCRR 415.12(h)(2)</p>		