STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335533	A. Building B. Wing	05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Absolut Center for Nursing and Rehabilitation at G	4540 Lincoln Drive Gasport, NY 14067

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. Based on interviews and record reviews during a survey the facility failed to 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, both the Director of Nursing #1 and the Director of Nursing #2 worked as a charge nurse when the facility had a daily average census of greater than 60. The findings include: An undated document titled Director of Nursing Job Summary provided by the facility documented duties to include but were not limited to organize documented plans, organizes and directs the overall operations of the Nursing Service Department in accordance with all state, federal and local guideline/regulations to ensure that the highest degree of quality care was always maintained. The Director of Nursing shall maintain and adhere to a master staffing plan, provide adequate and professional nursing and paraprofessional personnel sufficient and commensurate with the type and amount of nursing needs of individual residents. The facility policy and procedure tilted Daily Staffing revised on 08/2025, documented minimum critical staffing levels will be addressed in the facility assessment. The Nursing supervisor was instructed to contact the Director of Nursing and/or Administrator any time staffing levels fall below minimum/critical to initiate an emergency plan. The State Operations Manual dated 07/23/2025, documented a Charge Nurse as 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. The facility assessment with a review date of 04/06/2026 documented the staffing plan to meet the needs of the residents for day shift consisted of one (1) full time Director of Nursing, one (1) full time Assistant Director of Nursing, two (2) full time Unit Coordinators (one (1) Licensed Practical Nurse and one (1) Registered Nurse), four (4) Licensed Practical Nurses and ten (10) Certified Nursing Aides. The evening shift required two (2) part time Nursing Supervisors, three (3) Licensed Practical Nurses and eight (8) Certified Nursing Aides. The overnight shift required one (1) full time nursing supervisor, two (2) Licensed Practical Nurses and four (4) Certified Nursing Aides. Review of the facility daily staffing sheets dated 04/19/2026- 05/27/2026 revealed Director of Nursing #1 and #2 were counted in the facility's numbers to meet their minimum staffing for direct care to the residents. Review of the daily schedule report for May 10th and May 20th documented Director of Nursing #1 worked as a charge nurse on 05/10/2026 from 7:00 PM to 7:00 AM, and on 05/20/2026 from 3:00 PM to 1:00 PM to meet the facility's minimum staffing requirements. On 05/26/2026 Director of Nursing #2 was scheduled from 7:00 AM to 1:40 PM as the Director of Nursing and scheduled as a charge nurse from 11:00 PM to 7:00 AM to meet the facilities minimum staffing numbers. Review of the Facility Daily Staffing dated 05/10/2026 documented the resident census was 76. Review of the Facility Daily Staffing dated 05/20/2026 documented the resident census was 77. Review of the Facility Daily Staffing dated 05/26/2026, documented the resident census was 80. During an interview on 5/26/2026 at 10:41 AM, the Staffing Coordinator stated if the Director of Nursing was on call and a nurse had called off, they would rely on the Director of Nursing to meet the minimum staffing requirements. They stated they would first try to get per diem staff, agency staff and/or would go around the entire building to ask staff if anyone would stay to fill the vacant shift. They stated they would also send out a mass text (continued on next page)

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

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	to all staff before they would utilize the Director of Nursing. During an interview on 05/27/2026 at 9:14 AM, (former) Director of Nursing #1 stated they worked from 7:00 AM to 3:00 PM Monday through Friday and would also work as a supervisor when the facilities minimum staffing number could not be met. They stated on 05/10/2026 they worked as the Director of Nursing during the day (7:00 AM to 3:00 PM), and from 7:00 PM to 7:00 AM as a charge nurse. They stated on 05/20/2026 worked from 7:00 AM to 3:00 PM as the Director of Nursing and as charge nurse from 3:00 PM to 11:00 PM to meet the facilities minimum requirements for staffing. They stated they were not aware of the regulation that the Director of Nursing was unable to work as a charge nurse unless the census was 60 or below. During further interview 05/27/2026 at 9:52 AM, the Staffing Coordinator stated Director of Nursing #2 worked from 7:00 AM until 1:30 PM on 05/26/2026. They stated Director of Nursing #2 left early because they were scheduled to return to work for the overnight shift. They had come in again on 05/26/2026 at 10:39 PM and left on 05/27/2026 at 7:51 AM. They stated they had to rely on the Director of Nursing on occasions to meet their minimum staffing requirement. They stated they were not aware of the regulation that the Director of Nursing was unable to work as a charge nurse only when the census was 60 residents or below. They stated they relied on the Director of Nursing as minimal as possible and were usually able to get a per diem nurse or an agency nurse but not always. During an interview on 05/27/2026 at 10:25 AM, the Administrator stated when it came to meeting the minimum staffing requirement, they would require all departments to chip in. They stated all department managers would be expected to come in if required. They stated if the Staffing Coordinator tried to contact sister facilities, per diem nurses and agency nurses with no luck the Director of Nursing would have to come in. They stated they were aware of the regulation the Director of Nursing was not to work as a charge nurse when the facility had a daily average census of 60 or above. They stated they were also aware the Director of Nursing #2 came in to work the overnight shift as a charge nurse on 05/26/2026. They stated the Director of Nursing #2 was a Registered Nurse and they did not have a lot of Registered Nurses, so they had no choice. On 05/27/2026 at 11:15 AM an attempted telephone interview with Director of Nursing #2 was mad, a voice mail was left with no repsonse. During an interview on 05/27/2026 at 11:40 AM, (former) Administrator #2 stated it was a directive of the organization per their union contract not to pull a cart nurse (charge nurse) to also act as a supervisor unless they were fully staffed. They stated it fell onto the facility management to cover shifts that required management to meet the needs of staffing. They stated they recalled when multiple ill staff were out, they relied on Director of Nursing #1 to pick up shifts to ensure the minimum staffing requirements were met, if no one else was available. During an interview on 05/27/2026 at 12:39 PM, the Corporate Clinical Director stated the Director of Nursing cannot work any additional role simultaneously in their 40-hour work week. They stated that above and beyond their 40 hours a week they could pick up additional shifts to meet the minimum staffing requirement or for extra money. They stated they felt this was a common practice utilized among many facilities. 10 New York Codes Rules Regulations 415.13(b)(1)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations, interviews and record review conducted during a survey, the facility failed to provide food and drink that was palatable, attractive, and at a safe and appetizing temperature for three (3) (Heritage unit (C/D), Main Dining Room, and Woodland Heights unit (A/B)) of three (3) test trays. Specifically, food and beverages during meals were served at suboptimal temperatures, were not palatable, and were not attractive looking. Residents #1, #2, #3, #7, #11, #21, #42, #56, #61, and #85 were involved. The findings include:The policy titled Food Preparation, Service and Distribution dated 10/2022 documented the facility would assure safe and sanitary food preparation, holding, transport and distribution to prevent food borne illness. Tray line and/or alternate meal preparation and service areas may include steam tables, where hot prepared foods are held and served, and chilled areas where cold foods are held and served. The facility will avoid the following potential risks to reduce food borne illness: not holding food in the danger zone (temperatures above 41 degrees Fahrenheit and less than 135 degrees Fahrenheit). The policy documented dining locations includes any area where one or more residents eat their meal. These include dining rooms or mobile food carts that maintain food at a proper temperature and out of danger zone. The facility staff will serve hot foods hot and cold foods cold in accordance with resident preference. Serving temperatures are not to be confused with proper cooking and holding temperatures.During an interview on 05/19/2026 at 9:55 AM, Resident # 21 stated the food in the facility was not good, some things were overcooked, the vegetables were always mushy, and the grilled cheese sandwich was usually burnt and greasy.During an interview on 05/19/2026 at 10:25 AM, Resident #7 stated the meals were always cold, bland and late. During an interview on 05/19/2026 at 1:46 PM, Resident #85 stated the food was nasty and the temperature of the food was usually cold.During an interview on 05/20/2026 at 8:27 AM Resident #1 stated the food was just not good. The meat was too tough to chew and sometimes dry. They stated they preferred to eat in their room, and the food was sometimes cold by the time staff brought their tray.During the Resident Council meeting on 5/20/26 at 8:50 AM, Residents #2, #42, and #61 all stated the vegetables were always mushy, there was not enough variety and occasionally the food was cold.During an interview on 05/20/2026 at 10:41 AM, Resident #56 stated the temperatures of the food are always cold and the lids covering the food do not help. They stated they wait for an hour to get their tray in their room.During an interview on 05/20/2026 at 11:02 AM, Resident #3 stated all meals are served cold.During an interview on 05/20/2026 at 11:04 AM, Resident #11 stated that food is always served cold and sometimes it would taste good but sometimes it did not.During an observation in the Main Kitchen on 05/21/2026 at 11:30 AM, temperatures were taken of the foods in the steam table by [NAME] #1 using a facility stem-type thermometer. The temperatures were as follows:-Ham with pineapple-150 degrees Fahrenheit-Ground ham-140 degrees Fahrenheit-Rice-180 degrees Fahrenheit-Chicken breast-135 degrees Fahrenheit-Chili-160 degrees Fahrenheit-Cooked spinach-150 degrees FahrenheitDuring an interview on 05/21/2026 at 11:32 AM, [NAME] #1 stated ideal hot holding temperatures of the foods in the steam table were between 145- and 150-degrees Fahrenheit, and a plate warmer was used.Additional temperatures were taken of foods in the steam table on 05/21/2026 at 12:00 PM as follows:-Mixed vegetables in water-140 degrees Fahrenheit-Ground ham-second temperature taken-150 degrees Fahrenheit1. During an observation on 05/21/2026 at 12:29 PM, the test tray for the Heritage unit (also known as Unit C/D) left the Main Kitchen in an enclosed cart. The meal cart arrived to the unit at 12:29 PM and the last tray was delivered at 12:44 PM. At 12:46 PM the test tray observation was started, and the meal contained the alternate meal choice, a plate with a covered bowl of chili and a serving of steamed spinach, milk and juice. The meal did not look attractive. The following temperatures were obtained with the Evening Dietary Supervisor, using the facility's manual thermometer:-Steamed Spinach-115 degrees Fahrenheit, looked watery, tasted slightly warm and was flavorless. -Chili with beef -140 degrees Fahrenheit, it had no beans and looked thin.During an interview on 05/21/2026 at 12:49 PM, the (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Evening Dietary Supervisor stated hot foods should be served between 145 degrees Fahrenheit to 165 degrees Fahrenheit, and cold foods should be served between 35 degrees Fahrenheit to 45 degrees Fahrenheit.During an interview on 05/21/2026 at 12:54 PM, Resident #21 stated they did not like the look of the meal, so they were not going to eat it. They requested a sandwich.During an interview on 05/21/2026 at 12:55 PM, Resident #1 stated they did not want to try the meal, they ordered a bowl of soup and a peanut butter and jelly sandwich.2. During an observation on 05/21/2026 at 12:59 PM, the test tray for the Main Dining Room left the Main Kitchen in a small open cart. At 1:00 PM a test tray observation started, and the meal contained mechanical soft (easily chewed and swallowed) foods. The following temperatures were obtained with the Director of Dietary using the facility's thermometer:-Ham-115 degrees Fahrenheit, tasted lukewarm.-Rice-90 degrees Fahrenheit, tasted bland and cold.-Vegetable Mix, zucchini and cauliflower -110 degrees Fahrenheit tasted bland and lukewarm.During an observation and interview on 05/21/2026 at 1:00 PM, the Director of Dietary tasted the test tray items and stated the ham was not too cold for them but would prefer the temperature to be at least 140 degrees Fahrenheit for the residents. They stated the rice was bland and could be warmer, the vegetables were bland but not undercooked, not overcooked and would like them to be a little warmer. They stated when the food came out of the kitchen, they allowed the residents to season the food to their liking so that was why the food tasted bland. They stated condiments are left on the tables and residents can season to taste. 3. During an observation on 05/21/2026 at 1:13 PM, the test tray for the Woodland Heights unit (also known as Unit A/B) left the Main Kitchen in a small open cart. The first meal cart arrived at 1:08 PM and the second small open cart arrived at 1:13 PM. The last tray was delivered at 1:23 PM and a test tray observation started at 1:25 PM. The following temperatures were obtained with the Evening Dietary Supervisor using the facility's thermometer:-Ham-112 degrees Fahrenheit, tasted lukewarm.-Vegetable Mix, zucchini and cauliflower-114 degrees Fahrenheit. It tasted watery, with no flavor and was lukewarm.-Coffee: 124 degrees Fahrenheit, tasted warm, not hot.During an interview on 05/21/2026 at 1:34 PM, the Evening Dietary Supervisor stated the food temperatures should have been higher. They stated the temperatures were not warm enough for eating and palatability. They stated the vegetables were not seasoned and were cooked in water. They stated Woodland Heights Hall trays were the last to be served and that during serving the lids covering the food are removed. They stated if the food was kept covered more it could help with maintaining warmer temperatures of the food. During an observation and interview on 05/21/2026 at 1:40 PM, Resident #11 received rice, ham and zucchini for lunch. Resident #11 stated the food was not warm enough and the coffee was never hot; it was just warm.During an interview on 05/21/2026 at 1:54 PM, Resident #3 stated the vegetables had no flavor and were not hot.During an interview on 05/27/2026 at 12:13 PM, the Corporate Clinical Director stated they were unsure what the safe temperature ranges were that food should be served at but cold food needed to be served cold and hot foods needed to be served hot and the food items could not sit around too long. They stated the facility should be following the safe food temperatures to prevent any food borne illness.During an interview on 05/27/2026 at 12:54 PM, the Director of Dietary stated they would expect the hot foods to be served to the residents between 145 -155 degrees Fahrenheit and cold foods be served at least 38 degrees Fahrenheit or lower. They stated that temperature ranges were for safe health, properly cooked foods and palatability. The Director of Dietary stated that they speak to residents at random and participate in the resident council meeting and the resident's biggest food complaints were cold coffee and occasionally cold foods. They added that the facility changed their food distributor at the beginning of the month, and they feel the food quality has improved along with the residents' complaints.10 New York Codes Rules Regulations 415.14 (d) (1) (2)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews conducted during the survey, the facility failed to ensure a Pre-admission Screening and Resident Review (PASSAR), Level I identification screen, was completed prior to admission for two (2) (Residents #5 and #32) of two (2) residents reviewed. Specifically, there was no evidence that the screen was completed prior to admission for Residents #5 and #32. The findings are:The policy titled Pre-admission Screening and Resident Review, revised 11/2023, documented a screen is required for every resident prior to admission regardless of length of stay. A copy of the resident's most recent screen accompanies the resident upon transfer to a hospital or another Residential Health Care Facility.The policy titled Pre-admission Process, revised 12/16/2021, documented that all residents will have a completed screen which shows the minimum qualifications for admission to a Residential Health Care Facility are met.1. Resident #5 had diagnoses including bipolar disorder (a mental health condition that causes extreme, unusual shifts in mood, energy, activity levels, and concentration), anxiety and depression. The Minimum Data Set (a resident assessment tool), dated 03/27/2026, documented they were cognitively intact, always understood and always understands others.Review of Resident #5's medical record, including the electronic and paper record, revealed they were admitted to the facility on [DATE]. There was no Level I Pre-admission Screening present in the medical record prior to the date of admission. Consequently, the resident was admitted without verification of whether a Level II assessment was required.During an interview on 05/21/2026 at 12:18 PM, the Social Worker stated they were unable to locate the Pre-admission Screening and Resident Review (PASSAR) for Resident #5. They stated the resident transferred from a facility that was no longer operating, and they were unable to contact them. The Social Worker stated resident #5 did have bipolar disorder diagnosis, but they were well controlled on their medication and had been followed by psychiatry. During an interview on 05/22/2026 at 8:45 AM, the Social Worker stated, at the time of Resident #5's admission, Former Administrator #2 reviewed the admission documents, and they should have noticed the screen was missing. They stated the screen was important because it alerted them if the resident required a higher level of care, mentally or cognitively. If they did require a level II referral, they would need to know what recommendations were made.2. Resident #32 had diagnoses including dementia with agitation, major depressive disorder and polyosteoarthritis (degenerative joint disease). The Minimum Data Set, dated [DATE], documented Resident #32 had moderate cognitive impairment. They were understood and understand others and had behavioral symptoms.Review of Resident #32's electronic medical record revealed that the resident was admitted to the facility on [DATE]. There was no evidence of a Level I Preadmission Screening form in the medical record prior to the date of admission.During an interview on 05/22/2026 at 9:09 AM, the Social Worker stated they did not have a Pre-admission Screening and Resident Review (PASRR) for Resident #32. They stated Resident #32 was transferred from another facility in 2021 and they were not part of the admissions process then. They stated Resident #32 should have a Preadmission Screening and Resident Review, so the facility had guidelines that were appropriate for the resident. During an interview on 05/26/2026 at 1:39 PM, the Administrator stated they would have expected the person that accepted admission paperwork to review it and make sure the screens were there. They stated the screen was important to know if residents required more services. 10 New York Codes, Rules and Regulations 415.11(e)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review conducted during survey the facility failed to ensure residents with pressure ulcers received necessary treatment and services consistent with professional standards of practice to promote healing for one (Resident #3) of two residents reviewed. Specifically, Resident #3's air/foam mattress pressure pump was disconnected from pump, and the pump was unplugged preventing air flow use with mattress.The findings include: The facility policy and procedure titled Documentation of Pressure Ulcer and Chronic Wounds) revised 6/23, documented that pressure ulcers and chronic wounds were monitored closely to monitor effectiveness of treatment and change in risk factors. Risk factors were identified and suggested interventions may be implemented or modified on an as needed basis. Review of undated Self-Adjusting Air/Foam Mattress with Optional Alternating Pressure Pump operation manual, documented the mattress was indicated for the prevention and treatment of any and all stage pressure ulcers when used in conjunction with a comprehensive pressure ulcer management plan. To use as an alternating system with pump, connect pump hoses extending from the mattress. Plug pump into a properly grounded wall outlet. Switch to the ON position, and air will begin to flow into mattress. Resident #3 had diagnoses that included osteomyelitis (infection and inflammation of the bone), pressure ulcer of sacral region-stage four (4) (damage to the skin and underlying soft tissue, involving full-thickness skin and tissue loss at the base of the spine), and spinal stenosis (narrowing of the spinal canal). The Minimum Data Set (a resident assessment tool) dated 12/12/2025 documented that Resident #3 was understood, understands, and was cognitively intact. Resident #3 required substantial assistance to dependent assistance with bed mobility. Resident #3 was at risk of developing pressure ulcers and had two (2) Stage 3 (full thickness tissue loss) pressure ulcers present on admission; and one (1) stage 4 (full thickness tissue loss) pressure ulcer present on admission. The undated Comprehensive Care Plan documented that the resident was at risk for impaired skin integrity related to impaired mobility, moisture and pressure injuries. Interventions included administer treatments as ordered, educate regarding making frequent small shifts in body weight, pressure reduction device for bed: air mattress to be set for 238 pounds. The Kardex (guide used by staff to provide care) dated as of 5/11/2026 documented the resident utilized a pressure reduction device for bed an air mattress to be set for 238 pounds. The Order Summary Report dated 05/27/2026 documented an order for every two (2) hour offloading while in bed for skin integrity and to document all refusals dated 03/27/2026. The Treatment Administration Records dated 01/01/2026 through 05/27/2026 revealed there was no documented evidence regarding the use or monitoring of the air/foam mattress's function and settings. Review of Wound Care Assessment/Consultation dated 05/12/2026 completed by Wound Consultant documented Sacrum/Coccyx Stage 4 (four) pressure ulcer measured 8.0 centimeters in length, 9.0 centimeters in width and 2.5 centimeters in depth. Left Buttocks Stage 3 (three) pressure ulcer measured 7.5 centimeters in length, 4.5 centimeters in width and 0.1 centimeters in depth. Right Buttock Stage 3 (three) pressure ulcer measured 3.0 centimeters in length, 1.5 centimeters in width and 0.1 centimeters in depth. The healing status of all the pressure ulcers was documented as plateau/stalled. Recommendations/Interventions documented the use of pressure redistribution device. Review of Nursing Weekly Skin Status Documentation completed by the Director of Nursing #1 on 05/20/2026 documented Sacrum/Coccyx Stage 4 (four) pressure ulcer measured 9.5 centimeters in length, 8.5 centimeters in width and 2.5 centimeters in depth. Left Buttocks Stage 3 (three) pressure ulcer measured 8.5 centimeters in length, 8 centimeters in width and 0.1 centimeters in depth. Right Buttock Stage 3 (three) pressure ulcer measured 3.0 centimeters in length, 2 centimeters in width and 0.1 centimeters in depth. During intermittent observations on 05/20/2026 at 11:09 AM, 05/21/2026 at 9:56 AM and 12:33 PM, 05/22/2026 at 8:27 AM, and 05/26/2026 at 7:00 AM, 7:33 AM, and 1:46 PM, Resident #3 was in bed the air mattress hose was disconnected from pump, and the pump was unplugged hanging from foot board of bed. During an (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	observation on 05/26/2026 at 8:37 AM, Licensed Practical Nurse #2 and Licensed Practical Nurse #3 Resident Care Coordinator, provided pressure ulcer care to Resident #3's pressure ulcers located on the resident's coccyx/sacrum, right buttock and the left buttock. Licensed Practical Nurse #2 completed treatments to all of the pressure ulcers as ordered. The air mattress pump was not connected or functioning during the observation. During an observation and interview on 05/26/2026 at 1:46 PM, Certified Nurse Aide #1 stated Resident #3 had pressure ulcers on their tailbone, and both buttocks. Certified Nurse Aide #1 reviewed the Kardex from the resident's closet, dated as of 05/11/2026 and stated Resident #3 should have an air mattress on their bed and that it did not look like they did. They stated the air mattress would be blowing air and that it was not. During an interview on 05/26/2026 at 1:57 PM, Licensed Practical Nurse #2 stated they did not know why Resident #3's air mattress was not functioning. They stated Resident #3 was planned to have an air mattress to assist with offloading, to help prevent further deterioration of their pressure ulcers. During an interview on 05/26/2026 at 2:05 PM and 2:19 PM, Licensed Practical Nurse #3 Resident Care Coordinator stated they were not aware that Resident #3's air mattress was not functioning properly or that the pump was disconnected. They stated it was important for Resident #3 to have an air mattress to prevent continuous pressure on their pressure ulcers, to help prevent worsening of pressure ulcers. They stated the nursing aides and nurses were responsible to ensure the air mattress was on and to notify maintenance of any function issues. Licensed Practical Nurse #3 Resident Care Coordinator stated Resident #3 had a room change on 05/03/2026. During an observation and interview on 05/26/2026 at 2:11 PM, the Director of Maintenance stated Resident #3 mattress was a Dual Mattress that will not collapse if the air pump if off. They identified that the air hose for the air mattress portion of the mattress was not connected to the pump and that the pump was not plugged in. They located the air hose from the mattress and connected it to the air mattress pump at the foot end of the bed, plugged the air pump in and then turned on the air pump. The Director of Maintenance stated they were not part of the room swap (change) on 05/03/2026. During a telephone interview on 05/27/2026 at 8:57 AM, Director of Nursing #1 stated they were not aware that Resident #3's air mattress was not functioning. They stated they would expect nursing staff to check air mattresses to ensure they were functioning properly and to notify them or the maintenance department if they were not. They stated air mattresses were important in relieving direct pressure and promoting healing. During an interview on 05/27/2026 at 11:18 AM, the Director of Maintenance stated Resident #3's mattress needed to be plugged in and connected to ensure proper inflation of the air mattress component. They stated they would expect the mattress to be inflated for proper use. They stated maintenance was not notified of any issues pertaining to Resident #3's air mattress through their electronic record system. During a telephone interview on 05/27/2026 at 11:42 AM, the Wound Consultant stated the expectation was that Resident #3 was being encouraged to offload by turning and positioning in bed and that their air mattress was operational for offloading to prevent wound deterioration and promote wound healing. They stated because Resident #3's mattress was not completely deflated; they did not feel the lack of the air pump was detrimental to their pressure ulcers. During a telephone interview on 05/27/2026 at 12:17 PM, Registered Nurse Supervisor #1 stated Resident #3's mattress was moved during a room change on 05/03/2026. They stated nursing and housekeeping staff moved Resident #3's air mattress only and not the bed frame. Registered Nurse Supervisor #1 stated they did not see Resident #3's air mattress set up after it was moved, and could not say if the mattress was plugged in. They stated it would be important for the air mattress to be set up correctly to promote pressure reduction and that the care plan was followed. During an interview on 05/27/2026 at 12:34 PM and 1:49 PM, the Corporate Clinical Director stated they would expect nursing staff to check that the air mattresses were operating every shift. 10 New York Code Rules Regulations 415.12 (c) (1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335533	A. Building B. Wing	05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Absolut Center for Nursing and Rehabilitation at G	4540 Lincoln Drive Gasport, NY 14067

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 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 the survey, the facility failed to ensure they established and maintained 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 for one (1) (Resident #2) of four (4) residents reviewed for enhanced barrier precautions (interventions designed to reduce transmission of multi-drug-resistant organisms including gown and glove use during high contact resident care activities) and one (1) of one (1) facility legionella program. Specifically, staff did not wear appropriate personal protective equipment during wound care for Resident #2 and the facility's Legionella Water Management Plan was not reviewed or revised annually. The findings include:The policy titled Policy on Disease-Specific Isolation/Precautions last revised 12/19/24 documented enhanced barrier precautions referred to an infection control intervention designed to reduce the transmission of multidrug resistant organisms that employs targeted gown and glove use during high contact resident care activities. Enhanced barrier precautions are used in conjunction with standard precautions and expand the use of personal protective equipment to donning (putting on) gowns and gloves during high contact resident care activities that provide opportunities for transfer on the multidrug resistant organisms to staff hands and clothing. Enhanced barrier precautions may be recommended for residents with wounds, generally chronic wounds.Review of the Enhanced Barrier Precaution signage (a sign used by the facility to indicate a resident required enhanced barrier precautions) documented that everyone must wear gloves and a gown for the following high-contact resident care activities: dressing, bathing/showering, transferring, providing hygiene, changing briefs or assisting with toileting, device care or use; and wound care (any skin opening requiring a dressing).1.Resident #2 had diagnoses including diabetes, ulceration of the left leg, and peripheral vascular disease (narrowing of arteries that reduce blood flood to limbs). The Minimum Data Set (a resident assessment tool) dated 04/03/2026 documented Resident #2 was cognitively intact, understood and understands. Resident #2 had one (1) Stage III (3) pressure ulcer (an open area on the skin caused by prolonged pressure characterized by full thickness tissue loss, visible subcutaneous fat, but no visible muscle, tendon, or bone)The comprehensive care plan dated 05/22/2026 documented Resident #2 was at risk for infection related to wounds with interventions including enhanced barrier precautions and to observe/report signs of infection.The Kardex Report (a guide used by staff to provide care) dated 04/30/2026 documented Resident #2 was on enhanced barrier precautions.Review of the Order Recap Report dated 05/01/2026 - 05/31/2026 document Resident #2 had the following active medical provider orders:-cleanse open area on buttocks with normal saline, pat dry and apply honey hydrogel (a medical-grade honey with an acrylic gel) and cover with dry clean dressing daily for wound care. The start date was 04/22/2026.-gentamicin (antibiotic) to left pinky toe topically and cover with alginate dressing (a high absorbency dressing) daily for vascular ulcer (an opening in the skin from impaired blood circulation). The start date was 05/22/2026.Review of the Wound Care Assessment/Consultation note dated 05/12/2026, the Wound Consultant documented Resident #2 had a stage III (3) pressure ulcer to the left buttocks measuring 0.8 centimeters (length) x (by) 0.4 centimeters (width) x 0.1 centimeters (depth). The wound had a pink/red/healthy wound bed with excoriated (red or bleeding partial-thickness skin loss)/denuded (moist) wound edges. The Wound Consultant documented Resident #2 had a left great toe vascular wound measuring 1.0 centimeters (length) x1.0 centimeters (width) x 0.1 centimeters (depth) with minimal bleeding and there was slough (yellow/white dead tissue) along with pink/red/healthy tissue to the wound bed.During a wound care observation and interview on 05/26/2026 at 1:18 PM, Resident #2 was observed to have an enhanced barrier precaution signage on the wall/door frame prior to entering their room. Written in black ink on the sign was the room number, D (door) and W (window). Licensed Practical Nurse #1 donned gloves and completed the treatments to Resident #2's left buttock (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pressure ulcer and left pinky toe vascular ulcer per medical provider orders. Licensed Practical Nurse #1 did not wear a gown during the wound care treatments. During an interview after the treatments were completed, Licensed Practical Nurse #1 stated they did not have to wear a gown for Resident #2's treatments because the enhanced barrier precaution signage on the door was for Resident #2's roommate not Resident #2. After reviewing the signage on the door, Licensed Practical Nurse #1 stated the sign did say to utilize enhanced barrier precautions while providing care for both residents in that room. They stated they did not wear a gown but should have. Licensed Practical Nurse #1 stated the purpose of utilizing enhance barrier precautions during wound care treatments were, so they did not pass infection to each other or themselves.During an interview on 05/27/2026 at 11:34 AM, Registered Nurse #1 Resident Care Coordinator stated the last time they assessed Resident #2's wounds were on 05/22/2026 and the resident had a pressure ulcer to their left buttock and a macerated (breakdown of skin due to moisture) pinky toe and both areas were chronic. Registered Nurse #1 Resident Care Coordinator stated there was scant (small) amount of drainage at that observation from Resident #2's left buttock wound. They stated that every resident that had a wound was to be on enhanced barrier precautions and staff were to wear gowns when preforming wound care so that staff did not cause an infection or transmit anything to each other. Registered Nurse #1 Resident Care Coordinator stated they were not aware that Licensed Practical Nurse #1 did not wear a gown during Resident #2's wound care observation on 05/26/2026 but Licensed Practical Nurse #1 should have.During a telephone interview on 05/27/2026 at 11:57 AM, the Wound Consultant stated they were familiar with the enhanced barrier precautions regulations but did not have any expectations for grown use during wound treatment care but would expect staff to follow the facilities policy. They stated they were providing wound consult visits for Resident #2 due to the resident having a pressure ulcer to their buttock and vascular wounds to their left foot. The Wound Consultant stated Resident #2's buttock wound was usually moist when they assessed their wound, and they would wear gowns during their rounds because it was just safer to do so. The Wound Consultant stated the purpose of enhanced barrier precautions was to prevent infection not only from person to person but also from wound to wound.During an interview on 05/27/2026 at 12:13 PM, the Corporate Clinical Director stated that if staff were providing care to any residents that had any additional open areas such as foley catheters or wounds, staff were expected to wear gloves, gowns and masks. They stated they were not familiar with Resident #2 but if the resident did have any wounds, then the resident would be on enhanced barrier precautions to protect the resident from staff bring germs to the resident. 2. Review of the facility's collection of Legionella documents revealed it contained Form DOH (Department of Health)-5222, Environmental Assessment of Water Systems in Healthcare Settings, dated 07/07/2025, completed by the Director of Maintenance and the Sampling and Management Plan for Healthcare Facilities: Guidance and Template, effective 10/31/2023, completed by Former Administrator #1.Review of the Sampling and Management Plan for Healthcare Facilities: Guidance and Template, effective 10/31/2023, revealed the Point of Contact was listed as Former Administrator #1, along with their contact information. Former Director of Nursing/ Infection Preventionist #1 was listed as the team member responsible for infection control.During an interview on 05/21/2026 at 9:45 AM, the Director of Maintenance stated Former Administrator #1 reviewed and updated the facility's Legionella Water Management Plan in 2023 due to a potential Legionella concern at that time. They stated they did not know if the plan had been reviewed or revised since then. Additionally, on 05/26/2026 at 3:13 PM, the Director of Maintenance stated the Environmental Assessment of Water Systems and the Legionella Water Management Plan should be reviewed annually. They stated they personally reviewed the Environmental Assessment of Water Systems every year, and in the past, the Administrator had reviewed the Legionella Water Management Plan.During an interview on 05/21/2026 at 9:55 AM, Director of Nursing #1 stated they were not sure if the Legionella Water Management Plan had been reviewed or revised since 2023 and they needed to look into it further. On 05/21/2026 at 11:00 AM, Director of Nursing #1 submitted a written note that (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated the 2023 document was the most recent version.During an interview on 05/26/2026 at 2:30 PM, the Administrator stated they had become the facility's Administrator in May 2026, they had not yet personally reviewed the facility's Legionella Water Management Plan, and it should be reviewed annually. Additionally, on 05/26/2026 at 3:35 PM, the Administrator stated they had also checked with Former Administrator #2 but were unable to locate any documentation that showed the Legionella Water Management Plan had been reviewed or revised since October 2023.10 New York Codes Rules Regulations 415.19(a)(2)New York Codes Rules Regulations Title 10 4-24-2.4(c)