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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335573	A. Building B. Wing	06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lockport Rehab & Health Care Center	909 Lincoln Ave Lockport, NY 14094

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34587 Based on observation, record review and interview conducted during the Standard survey completed on 6/4/24 the facility did not ensure residents had the right to choose activities, schedules, and health care consistent with their interests, assessments, and plan of care for one (Resident #9) of two residents reviewed for choices. Specifically, Resident #9 was provided with a shower once a week in the evening instead of twice a week during the day as care planned and preferred. The finding is: The policy and procedure titled Resident Rights reviewed 5/24 documented each resident was ensured the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. The policy and procedure titled Quality of Life dated 4/92 documented the resident has the right to choose activities, schedules, and health care consistent with their interests, assessments and plans of care and the right to make choices about aspects of their life in the facility that are significant to the resident. Resident #9 had diagnoses including depression, anxiety, and diabetes mellitus. The Minimum Data Set (MDS- a resident assessment tool) dated 3/9/24 documented Resident #9 always understood, always understands, and was cognitively intact. The Minimum Data Set documented, Resident #9 required partial/moderate assistance for showering and there were no refusals of care. The Minimum Data Set, dated dated dated [DATE] documented it was very important for Resident #9 to choose between a tub bath, shower, bed bath or sponge bath. The comprehensive care plan dated 2/27/24, documented Resident #9 had an activity of daily living self-care performance deficit. Interventions included supervision for bathing, baths on Tuesday and Friday between 6AM-2PM. Review of the kardex (a guide used by staff to provide care) dated 6/3/24 documented Resident #9's bathing was on Tuesday and Friday between 6AM-2PM. Review of the 6-2 PM Shower Schedule dated 5/24/24 located at the nurse's station, lacked documented evidence of Resident #9's care planned shower schedule. (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: 335573	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2024

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F 0561

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Review of the 2-10 PM Shower Schedule dated 5/24/24, documented Resident #9 was to receive a shower on Tuesday between 2-10 PM.

During an observation and interview on 5/29/24 at 9:20 AM, Resident #9 stated they always got a shower at about 8:30 PM and then they went straight to bed. Resident #9 stated because their shower was given at that time, they were unable to watch their television shows before bed and that was upsetting for them. Resident #9 stated they had told the certified nursing aides that they would like a shower twice a week and during the day shift, but nothing was ever done about it. Resident #9 stated they were told they were only allowed one shower per week, and they wanted another shower during the week so they could feel clean.

During an interview on 6/3/24 at 10:29 AM, Resident #9 stated they never were offered nor received a shower on 5/31/24 (Friday).

During an observation and interview on 6/3/24 at 10:45 AM, Certified Nursing Aide #1 stated they knew when a resident was due for a shower because it would show up on the electronic charting program and there was a book on the unit with the shower schedule in it. Certified Nursing Aide #1 stated the showers would show up on the kardex too, but they used the electronic charting program to let them know if a resident was scheduled for a shower that shift. Certified Nursing Aide #1 demonstrated on the electronic charting program and showed that the bathing task would not show up if the resident was not scheduled for a shower that shift. Certified Nursing Aide #1 demonstrated how to access the kardex using their electronic device. Certified Nursing Aide #1 stated the kardex showed that Resident #9 should have a shower on Tuesdays and Fridays between 6 AM and 2 PM. Certified Nursing Aide #1 opened the book with the shower schedule and stated the shower schedule did not match the kardex. Certified Nursing Aide #1 stated the nurses were responsible for updating the care plan, kardex, and shower schedule. Certified Nursing Aide #1 stated the staff should treat all residents the way they wanted to be treated because it was their dignity.

During an interview on 6/3/24 at 10:55 AM, Certified Nursing Aide #2 stated there was a bath schedule in the book at the nurses' station and in the residents' kardex. Certified Nursing Aide #2 stated they usually looked at the book with the bath schedule in it to know if a resident was scheduled for a shower. Certified Nursing Aide #2 stated the bath schedule and the kardex should probably match, and it would be the unit manager who changed that. Certified Nursing Aide #2 stated Resident #9 should get their shower when they preferred because it was their right.

During an interview on 6/3/24 at 11:05 AM, Licensed Practical Nurse #1 stated the care plan and the shower schedule in the book should both match and since it was in the care plan, it was possible that someone knew Resident #9's wishes to have a shower twice a week during the day shift.

During an interview on 6/3/24 at 11:09 AM, Registered Nurse Supervisor #1 stated if Resident #9 had told someone they wanted their shower twice a week during the day shift and it was in the care plan, it was possible that someone knew that was what Resident #9 wanted. Registered Nurse Supervisor #1 stated if Resident #9 had switched rooms and the care plan was not updated, someone should have still asked them what their preference was for bathing. Registered Nurse Supervisor #1 stated this was Resident #9's home and they should receive their shower when they would like it. Registered Nurse Supervisor #1 stated the Director of Nursing had updated the shower scheduled on 5/24/24. Registered Nurse Supervisor #1 stated the Director of Nursing, Supervisor, and/or Unit Manager had access to update the bathing schedule.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/4/24 at 8:25 AM, the Director of Nursing stated if a resident had indicated to staff they were not happy with the schedule, then the schedule should have been changed to accommodate their request. The Director of Nursing stated that when Resident #9 was on the rehabilitation unit, their shower schedule was twice a week during the day shift and when they moved to their current unit, their shower schedule went down to once a week. The Director of Nursing stated the shower schedule should have been discussed during a care plan meeting. The Director of Nursing stated Resident #9's shower schedule should have been discussed with Resident #9 when they transferred from one unit to the other because it was their preference. During an interview on 6/4/24 at 8:48 AM, the Administrator stated it was expected that the nursing staff involved in the transfer of Resident #9 from one unit to the other would have had a conversation with Resident #9 about their preferences. The Administrator stated when Resident #9 had spoken to the certified nursing aide about their shower, the certified nursing aide should have told the licensed practical nurse. The Administrator stated this was important for Resident #9's comfort and their preferences should have been honored. 10 NYCRR 415.5 (b) (1,3)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 34587 Based on observation, interview, and record review conducted during a Standard survey completed on 6/4/24, the facility did not ensure that each resident who was unable to carry out activities of daily living received the necessary services to maintain grooming and personal hygiene for one (Resident #29) of three residents reviewed. Specifically, Resident #29 had long thick jagged fingernails with dark brown debris underneath on their left contracted (loss of joint mobility) hand, and long jagged fingernails with chipped polish and dark brown debris underneath on their right hand. The finding is: The policy and procedure titled Nail Care dated 2/23, documented the facility will provide appropriate nail care to all residents. Nails would be observed daily by staff providing direct AM care, would be trimmed weekly on bath day, and residents with special needs (diabetic and residents on blood thinners) will have nails trimmed by the nurse weekly. 1. Resident #29 had diagnoses including vascular dementia, obstructive hydrocephalus (excessive accumulation of cerebral spinal fluid on the brain), and history of multiple pulmonary emboli (blood clots in the lungs). The Minimum Data Set (a resident assessment tool), dated 4/12/24, documented the resident was severely cognitively impaired, was always understood and always understands, exhibited no behaviors, such as, rejection of care, and was a substantial/maximum assistance for personal hygiene. The comprehensive care plan revised on 4/24/24, documented Resident #39 had an activities of daily living self-care performance deficit, had contractures of the left hand, was a partial/moderate assistance for personal hygiene, and substantial/maximum assistance for bathing. The care plan also documented that Resident #29 was on blood thinners. Review of the treatment administration records from 3/1/24-5/31/24 revealed no documentation related to nail care. Review of the certified nurse aide task documentation from 4/1/24- 5/31/24 revealed Resident #29 received personal hygiene care daily and was either dependent or required substantial/maximum assistance with care. There were no documented care refusals. During an observation on 5/29/24 at 11:56 AM, Resident # 29 was sitting in their wheelchair in the dining room. The nails on their right hand were long and jagged, had chipped nail polish and dark brown debris underneath. Their left hand was contracted, with the left thumb nail long, thick, and dark yellow, curled upward. During an observation and interview on 5/31/24 at 7:59 AM, Resident #29 was sitting in their wheelchair in the dining room. The nails on their left hand were all thick, yellow, and jagged with chipped polish. The left thumb nail was long, thick, and dark yellow, curled upward. Nails on the right hand were long with chipped polish. The right thumb nail was cracked and jagged. Resident #29 stated they did not recall when someone last cleaned or trimmed their nails. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/31/24 at 10:34 AM, Certified Nurse Aide #2 stated that nails were usually checked for cleanliness during morning care every day and they were trimmed on shower/bath days. They stated that the aides were responsible for cleaning and trimming nails, but the nurse had to trim nails for residents that were on blood thinners. During an interview on 5/31/24 at 2:35 PM, Licensed Practical Nurse #3 stated that it was the responsibility of the nurse to trim Resident #39's fingernails because they were on a blood thinner, and that nails should be trimmed on the resident's shower/bath day. They stated that they were aware of the thick, long nails on the resident's left hand. Licensed Practical Nurse #3 stated that Resident #29 did not like their nails trimmed so they would try distraction when they attempted to trim them. They stated that it was important to keep resident's nails trimmed and clean to prevent them from injuring themselves and to prevent bacteria from growing underneath, especially because Resident #29's left hand was contracted. During an interview and observation on 5/31/24 at 2:39 PM, Registered Nurse #1 stated it was the responsibility of the nurse to trim the nails of residents that were on blood thinners. Nails should be checked daily and trimmed on shower/bath days. They stated it was important to keep resident's nails trimmed to prevent infection and/or injuries to themselves, especially a resident with a contracted hand because their nails could dig into their hand and cause a wound. Registered Nurse #1 observed Resident #29's nails and stated they were very thick, too long and should be trimmed, especially their left hand because it was contracted. During an interview on 6/3/24 at 10:56 AM, the Director of Nursing stated that they expected staff to check/clean resident's nails daily with morning care and to trim nails on their shower/bath day. Nail care was important because unkempt nails could be a source of infection or cause injury. It was also a dignity issue for residents that can't speak for themselves. The Director of Nursing stated it was especially important to keep nails clean and trimmed when the hand was contracted because it could lead to a pressure area and infection. 10 NYCRR 415.12 (a)(3)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34587 Based on record review and interview conducted during a Complaint investigation (Complaint #NY00323467) during the Standard survey completed on 6/4/24, the facility did not ensure that a resident who was fed by enteral means (method of feeding that uses the gastrointestinal (GI) tract to deliver part or all a person's caloric requirements) received the appropriate treatment and services to prevent possible complications for one (Resident #127) of one resident reviewed for feeding tubes. Specifically, the facility did not provide the tube feed formula as per the hospital discharge summary. The finding is: The policy and procedure titled Enteral Feeding/Gastrostomy (a tube that passes through the abdominal wall into the stomach) - Jtube (jejunostomy tube- a tube placed through the abdominal wall into the small intestine)- Nasogastric Tube (tube inserted through the nose into the stomach) - Duodenal Feeding Tube (a tube inserted into the small intestine) reviewed 05/23 documented the purpose was to provide adequate prescribed nutritional intake by way of a Gastrostomy Tube. The policy and procedure titled Physician Orders reviewed 03/24 documented a system is established and maintained for transcription and advisement of all physician orders by a licensed nurse and the purpose is to assure accurate and timely implementation of orders. Resident #127 admitted with diagnoses of malignant neoplasm (malignant tumor that tends to spread to other parts of the body) of the tonsil and right lung, diabetes mellitus, and dysphagia (difficulty swallowing). Review of the Speech and Language Pathologist progress note dated 9/7/23 documented Resident #127 was alert and oriented and within normal limits cognitive communicative functions. The Base Line Care Plan dated 9/6/23 documented Resident #127 had nutritional needs related to enteral feeding. The goals listed included Resident #127 would tolerate tube feedings without complications. Interventions included: provide tube feeding and water flushes as ordered. The diet order was nothing by mouth. Additionally, the Base Line Care Plan documented, Resident #127 was at risk for signs and symptoms of hypoglycemia (low blood sugar) related to diabetes mellitus. Interventions included monitor blood sugars and to provide diet as ordered. Review of the hospital discharge summary dated 9/6/23 documented Resident #127 was to continue feeds/formula: Glucerna 1.2 at 70 cubic centimeters per hour and free water flush 150 cc (cubic centimeters) every four hours. Additionally, the hospital discharge summary documented Resident #127 had a diagnosis of diabetes mellitus and should be reevaluated for initiation of therapy now that feeds were going well. The hospital discharge summary documented Resident #127 had a barium swallow study that showed Resident #127 had a nonfunctional swallow. Review of the Order Summary Report documented an order on 9/6/23 nothing by mouth (NPO) diet. There were no orders to continue the feed/formula as per the discharge summary. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the nursing progress note dated 9/6/23 at 4:55 PM, Licensed Practical Nurse Supervisor #1 documented peg tube placement was verified via stethoscope and Resident #127 had no complaints of pain, nausea, or abdominal distension. Review of the nursing progress note dated 9/6/23 at 5:28 PM, Licensed Practical Nurse Supervisor #1 documented Resident #127 arrived at the facility at 4:55 PM and the on call made aware. Review of the nursing progress note dated 9/6/23 at 7:28 PM, Licensed Practical Nurse Supervisor #1 documented new order from Nurse Practitioner #1 Humalog (a type of insulin) sliding scale for diabetes mellitus. Finger Sticks three times a day before meals. Review of the nursing progress note dated 9/6/23 at 11:38 PM, Licensed Practical Nurse #2 documented they spoke with Nurse Practitioner #1 regarding Resident #127 having a peg tube, no orders for feeds and no formula/feed. A new order was received to check blood sugars every four hours and give glucagon if blood sugar falls below 70. Continue 150 cubic centimeter water flush every four hours to maintain patency. As per discharge instructions from hospital, this writer did 150 cubic centimeter water flush at night with nightly meds. Admission orders to be clarified in AM. Review of the Nutritional assessment dated [DATE] documented Resident #127 was dependent upon enteral feeding due to highly unsafe swallow/dysphagia caused by underlying malignancy; multiple co-morbidities including diabetes. Additionally, the Nutritional Assessment documented a suggestion of Glucerna 1.2 at 30 cubic centimeters per hour increasing by 10 cubic centimeters every eight hours for a total goal of 70 cubic centimeters per hour. Review of the Medication Administration Record dated 9/1/23 through 9/30/23 documented Glucerna 1.2 at 70 cubic centimeters via peg tube began at 8:00 AM on 9/7/23. Review of the Medication Discrepancy Form dated 9/7/23 documented the date of the error was 9/6/23 by Licensed Practical Nurse Supervisor #1. It was documented, Resident #127 arrived at the facility at 4:55 PM, was nothing by mouth with continuous G-tube feeding of Glucerna 1.2 at 70 cubic centimeters per hour. The Medication Discrepancy Form documented the possible harmful effects to Resident #127 included failure to provide adequate hydration and nutrition. During an interview on 5/31/24 at 7:17 AM, Licensed Practical Nurse #2 stated there were no orders for the feed/formula in the electronic medical record. At about 11:30 PM they noticed it was missing and they contacted the Nurse Practitioner. The Supervisor (LPN #1) should have contacted the Nurse Practitioner or the Physician earlier. License Practical Nurse #2 stated Resident #127 should have had a feed given to them soon after admission because it was ordered from the hospital as a continuous feed. During a telephone interview on 5/31/24 at 9:58 AM, License Practical Nurse Supervisor #1 stated the hospital was supposed to send a supply of tube feed/formula with Resident #127. License Practical Nurse Supervisor #1 stated they called and left a voicemail for the on-call provider stating Resident #127 arrived without any feed supply from the hospital. License Practical Nurse Supervisor #1 stated the on-call provider never returned their phone call. License Practical Nurse Supervisor #1 stated they did not attempt to notify the Director of Nursing, pharmacy, or hospital that the feed was not available and should have. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 5/31/24 at 10:18 AM, the Nurse Practitioner stated they expected the nursing staff to follow orders, attempt to obtain the feed ordered, and notify them soon rather than later regarding missing feed. During a telephone interview on 5/31/24 at 10:58 AM, the Registered Dietitian stated sometimes the hospital would supply some of the feed for enteral feeds, but that agreement needed to be very definite. The Registered Dietitian stated the facility was usually aware of new admissions around noon and that would be adequate time for the facility to obtain feed/formula. The Registered Dietitian stated the facility had different options for feed already at the facility. The Registered Dietitian stated if they were not at the facility when a new admission with an enteral feed admitted , then the nursing staff could call them for recommendations, especially if the specific feed was not available. The Registered Dietitian stated for Resident #127 to go 15 hours without their continuous enteral feed was concerning. The Registered Dietitian stated Resident #127 should have been given an appropriate substitute for their feed and water flushes would not be considered an appropriate substitute. During an interview on 6/4/24 at 8:30 AM, the Director of Nursing stated they were alerted that Resident #127 was admitting to the facility with a peg tube and the hospital was supposed to send the feed. The Director of Nursing stated there were other types of feed that were on hand at the facility that could have been used. They stated, Licensed Practical Nurse Supervisor #1 was under the impression that the feed was coming from the pharmacy around 9:00 PM but it never came in. The Director of Nursing stated Licensed Practical Nurse Supervisor #1 should have called them or the Registered Nurse on call. The Director of Nursing stated they would have reached out to the Registered Dietitian for recommendations of rates and dilutions. 10 NYCRR 415.12(g)(2)