

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335577	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/18/2024
NAME OF PROVIDER OR SUPPLIER  Elderwood at Lancaster		STREET ADDRESS, CITY, STATE, ZIP CODE  1818 Como Park Blvd Lancaster, NY 14086	

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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43802</p> <p>Based on observation, interview, and record review during an Abbreviated survey (Complaint # NY00323906) completed on 10/18/24, the facility did not ensure that the resident's person-centered care plan was implemented to meet the resident's medical and nursing needs for one (Resident #1) of three residents reviewed for care plan implementation. Specifically, the resident was not provided with posey boots (therapeutic footwear that help prevent and treat heel ulcers) at all times as ordered and care planned.</p> <p>The finding is:</p> <p>The policy and procedure titled Pressure Ulcer, Pressure Injury and Other Skin Conditions: Initial Assessment, Care Planning, Ongoing Evaluation and Management last modified 2/27/2023, documented residents with pressure ulcers, injuries or skin conditions will receive evaluation, treatment, and services to promote healing and prevent new conditions from developing. Pressure Ulcer, Pressure Injuries and Other Skin Condition Care Plan Guidelines documented additional considerations will be made for residents with a present pressure ulcer/injury which included use of specialized cushions/devices for pressure reducing/reduction.</p> <p>Review of policy and procedure titled Skin Care Program dated 5/8/2018 documented designated nursing staff will monitor the skin condition and ensure proper skin care of each resident on an ongoing basis. The need for individual inter-disciplinary approaches to skin care will be reported and initiated.</p> <p>Resident #1 had diagnoses that included unspecified dementia, epilepsy (seizure disorder-nerve cell activity in the brain is disturbed) and generalized osteoarthritis. The Minimum Data Set (a resident assessment tool) dated 9/18/24 documented Resident #1 was severely cognitively impaired, usually understands others, and was usually understood. Resident #1 was dependent with activities of daily living and had a Stage 3 (full thickness tissue loss) pressure ulcer.</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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The comprehensive care plan for pressure ulcer revised on 10/1/24, documented the resident had the presence of an unstageable (obscured full-thickness skin and tissue loss) pressure ulcer on their right heel. Interventions initiated on 9/30/24 included to apply treatment per medical provider order. The comprehensive care plan for skin integrity revised on 9/30/24 documented the resident was at risk for impaired skin integrity and had actual skin alterations. Interventions initiated 12/13/2022 included implement pressure ulcer prevention/skin interventions as care planned and posey boots at all times.</p> <p>Review of the Kardex (a guide for resident care) dated 10/17/24 documented Resident #1 was to always have posey boots.</p> <p>Review of Order Summary Report printed 10/17/24 documented an active order, dated 7/16/24, for heel booties at all times every shift. An active order for posey boots at all times was dated 11/9/2023.</p> <p>Review of Treatment Administration Record for October 2024 documented posey boots at all times every shift and heel booties at all times every shift was signed for by nurses every shift, except on 10/6/24 and 10/8/24 night shifts.</p> <p>The skilled nursing facility skin assessment dated [DATE] documented Resident #1 had a right heel pressure ulcer Stage 3, acquired in house on 7/15/24. The wound was not resolved and the resident was being seen by the Wound Consultant.</p> <p>The Wound Assessment and Plan completed by the Wound Consultant, Medical Doctor, dated 9/27/24, 10/4/24 and 10/11/24 documented Resident #1 had a right heel pressure ulcer that was unstageable (depth obscured). Documented comments included to offload pressure-either with heels up or offload with heel booties. The 10/11/24 assessment documented healing status of the wound was the same/stable, the wound bed had 100% eschar (tan, brown or black wound bed).</p> <p>During intermittent observations on 10/15/24 at 9:19 AM and 3:46 PM; 10/16/24 at 9:39 AM, 11:21 AM, 12:58 PM, and 2:06 PM; and 10/17/24 at 8:08 AM and 12:13 PM, Resident #1 was sitting in their wheelchair, wearing non skid socks, with their legs positioned in a leg cradle (a device that helps position the legs and feet). On 10/16/24 at 8:49 AM, the resident was in bed with their heels resting directly on the mattress. During these observations, the resident's heels were not elevated to offload pressure while in bed and they were not wearing heel booties and/or posey boots as ordered and care planned.</p> <p>During an observation on 10/17/24 at 12:47 PM, Resident #1's right heel pressure ulcer was observed to be dry with a yellow/tan wound bed with the presence of two small areas of black eschar within the yellow/tan wound bed. The pressure ulcer was approximately the size of a quarter.</p> <p>During an interview on 10/17/24 at 12:36 PM, Certified Nurse Aide #4 assigned to Resident #1 stated Resident #1 should have heel booties on per their Kardex. Certified Nurse Aide #4 stated they reported to someone in therapy a week ago that Resident #1 did not have their heel booties. Certified Nurse Aide #4 stated the heel booties were used to protect Resident #1's heels and they should have them on.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/17/24 at 12:58 PM, Licensed Practical Nurse #2 stated Resident #1 had their heel booties on today. They stated the heel booties were listed on Resident #1's plan of care and on the treatment administration record. Licensed Practical Nurse #2 stated heel booties should be on to prevent further skin breakdown or deterioration of skin. Licensed Practical Nurse #2 stated they weren't aware that Resident #1 didn't have their heel booties on today and the nursing staff, aides and nurses were responsible to put them on.</p> <p>During an interview on 10/17/24 at 1:09 PM, Registered Nurse #1, Nurse Manager, stated the team leaders, nurses, and the Certified Nurse Aides were responsible for applying Resident #1's posey boots per the care plan. They stated they believed Resident #1 was supposed to wear their posey boots at all times due to history of pressure ulcers on their heels. Registered Nurse #1 stated they expected if Resident #1 didn't have posey boots, nursing staff should report it, go to laundry, therapy and/or find something to use in the interim if they got soiled.</p> <p>During an interview on 10/17/24 at 1:24 PM, the interim Director of Nursing #1 stated they expected heel booties/posey boots to be worn at all times to off load pressure on Resident #1's heels and to prevent further breakdown as ordered.</p> <p>During a telephone interview on 10/17/24 at 2:15 PM, Licensed Practical Nurse #3 stated they coded a 9 on the treatment administration record on 10/6/24 and 10/8/24 for posey boots, at all times because Resident #1 did not have any to apply. Licensed Practical Nurse #3 stated they looked on both units for boots and notified the oncoming shift of not having boots for Resident #1. Licensed Practical Nurse #3 stated they were unaware if Resident #1 had any skin breakdown at this time, but that Resident #1 was not supposed to be without the heel booties per the order. They stated the boots were to prevent skin breakdown.</p> <p>During an interview on 10/17/24 at 5:02 PM, Certified Nurse Aide #1 stated they knew Resident #1 used to wear heel booties, but their wound healed. They stated if a resident was supposed to wear heel booties, then they should be in the resident's room. They stated Resident #1 did not have heel booties in their room on 10/15/24 and 10/16/24 to be put on. Certified Nurse Aide #1 stated they did not check residents' Kardex's everyday, but if a resident's plan of care tells them a resident should wear heel booties, then the resident should have them available.</p> <p>During a telephone interview on 10/17/24 at 5:10 PM, the Wound Consultant, Medical Doctor stated a wound that presented with necrotic (dead) tissue and the bottom of the wound was unable to be seen, would be an unstageable pressure ulcer. Offloading pressure to a pressure injury was used as an intervention with treatment. They stated prevention, treatment of pressure ulcers was multi-factorial and not using heel booties could be a possible contributing factor to healing if staff were not compliant with interventions.</p> <p>During a telephone interview on 10/18/24 at 12:14 PM, the interim Director of Nursing stated posey boots and heel booties were different. They stated Resident #1 should not have an order for both posey boots and heel botties. Additionally, they stated nurses should not be signing for orders that they didn't verify were done.</p> <p>10NYCRR 415.12(c)(2)</p>		