STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335577	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elderwood at Lancaster	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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43802 Based on interview and record review conducted during the Standard survey completed on 11/22/24, the facility did not ensure the resident has the right to exercise his or her rights as a resident of the facility and as a citizen of the United States. Specifically, two (Residents #19 and #49) of two reviewed for voting was not afforded the right to vote in the November 2024 Presidential Election. The findings are: The policy and procedure titled Voting Arrangements dated 7/13/2018 documented the Director of Activities, in cooperation with the Director of Social Services and the Board of Elections, will ensure that residents (who are registered and wish to participate) will have the opportunity to vote on the premises in local, county, state, and federal primaries and elections. The Director of Activities or designee assists the Director of Social Services in arranging for facility space for voting, notifying registered residents of the opportunity to vote, and encouraging residents to take advantage of this opportunity. The activities staff also assists with transport of the residents to the voting area. 1. Resident #19 had diagnoses including depression, diabetes, and hypertension (high blood pressure). The Minimum Data Set (a resident assessment tool) dated 10/9/24 documented Resident #19 was cognitively intact, was understood, and understands. The Minimum Data Set documented it was very important for Resident #19 to do their favorite activities. The comprehensive care plan revised on 11/6/24 documented Resident #19 to encourage Resident #19 to make decisions as able and preferred community programs involving resident council. The comprehensive care plan did not reflect Resident #19's voting preference. During interview on 11/18/24 at 10:06 AM, Resident #19 stated they were upset they never received an absentee ballot and did not vote in the presidential election on 11/5/24. The SNF (skilled nursing facility) Activities Evaluation form with an effective date of 9/29/24 revealed that Resident #19 did not participate in voting. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 11/20/24 at 1:47 PM Resident #19's family member stated the Presidential Election was very important to Resident #19 and had expressed their desire to vote. Resident #19 called their family member on 11/5/24 and requested to be taken out of the facility to cast their vote. Resident #19's family member thought the facility would have provided Resident #19 with an absentee ballot for this year's Presidential Election. 2. Resident #49 had diagnoses which included spinal stenosis- (narrowing of one or more areas in your spine most often in upper or lower back), hypertension, and dementia. The Minimum Data Set, dated dated dated [DATE] Resident #49 was cognitively intact, was understood, and understands. The Minimum Data Set documented it was somewhat important for Resident #49 to do their favorite activities. The comprehensive care plan revised 11/6/24 documented to encourage Resident #49 to make decisions as able. The comprehensive care plan did not reflect Resident #49's voting preference. The SNF (skilled nursing facility) Activities Evaluation form with the effective date of 8/5/24 documented that Resident #49 participated in voting. Review of the Resident Council Minutes from 5/1/24 through 10/23/24 revealed there were no documented discussions regarding the voting process for the November 2024 Presidential Election. During an interview during the Resident Council Meeting on 11/19/24 at 11:04 AM, Resident #49 (Resident Council President) stated no one had asked them to participate in the Presidential Election, they did not receive an absentee ballot, and would have liked to vote. Review of the voting log 2024 provided by Director of Activities #1 on 11/20/24 revealed Residents #19 & #49 were not included on the list for absentee ballot applications. During an interview on 11/20/24 at 9:19 AM, Director of Activities #1 stated every resident unless deemed incompetent by a judge had the right to vote in an election. Absentee ballots were sent from the Board of Elections based on the list of registered voters in their system and sent additional applications with ballots for those residents who wished to register. Since taking over for Director of Activities #2 on 11/18/24, Director of Activities #1 requested the list from the Board of Elections on 11/20/24. Residents #19 & #49 were not included on that list. There was no additional documented evidence of residents #19 and #49 being offered an application or absentee ballot for the November Presidential Election. Director of Activities #1 stated the process should have been discussed in Resident Council for those who expressed interest in voting for the November 2024 Presidential Election. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 11/21/24 at 9:23 AM, the Supervisor for absentee ballots with the Board of Elections stated there were six active voters at the facility. In July/August a list of registered voters, additional registration forms and absentee ballot applications with deadlines and instructions were sent through the mail to Director of Activities #3. The information was sent early so that every resident who wanted to vote could vote. The current contact person for the facility was Director of Activities #2 and had not received information back from them. Facilities typically provided the change in address during assisting residents with the voting process. Residents #19 and #49 were registered with their previous addresses in their system. The last time Resident #19 voted was in 2020 and Resident #49 was in 2022. It's the facility's responsibility to ask all residents whether they would like to vote, assist with registration process with the correct address, and ensured they received an absentee ballot. During a telephone interview on 11/22/24 at 9:28 AM, the Director of Social Work stated they collaborated with activities in early summer and assisted Director of Activities #3 in asking those residents who had interest in this year's presidential election. The Director of Social Work had no documented evidence of residents who requested to vote and stated the Director of Activities #3 kept tract of that. During an interview on 11/22/24 at 10:13 AM, the Administrator stated the Director of Activities #3 should have documented some kind of tracking system and pursed the voting process then forwarded the information to Director of Activities #2. Residents had a right to change their minds whether they wanted to vote and expected documentation that residents were interviewed annually. Depending on their answer we should do our part. 10NYCRR 415.3(d)(1)(i)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 43802 Based on observation, interview, and record review conducted during a Standard survey completed on 11/22/24, the facility did not ensure a resident was assessed by the interdisciplinary team to determine a resident's ability to safely administer their own medications if clinically appropriate for one (Resident #11) of one resident reviewed. Specifically, Resident #11 was observed with medications in their room and has stated they self-administered those medications without being evaluated as to whether they could safely do so. The finding is: The policy and procedure titled Self Administration of Medications, last revised 04/10/18, documented residents who desire to self-administer medication are permitted to do so upon review and approval by the inter-disciplinary care planning team members and with an order from the attending physician. Legend or over the counter medication will be stored in a locked drawer in the resident's room. The use of self-administered medication will be monitored by the licensed nursing staff. Each appropriate resident is offered the opportunity to self-administer their medications following assessment by the interdisciplinary team to determine cognitive, physical, and visual ability to perform the task. The request is then discussed with the attending physician. All appropriate information is recorded in the nursing progress notes. Additionally, a self-administration evaluation will be completed upon admission or verbalization of the preference to self-administer. The evaluation will be completed quarterly, annually, upon significant change or as needed. Daily, the licensed nurse determines the amount of medication that has been self-administered and records the information in the medication administration record. Resident #11 diagnoses included unspecified sequelae of cerebral infarction (an area of the brain tissue dies due to a lack of blood flow), unspecified atherosclerosis of native arteries of extremities (narrowing and hardening of the arteries that supply blood to the legs and feet) right leg, embolism, and thrombosis of iliac artery (blood clots form in the iliac artery in the pelvis), and chronic obstructive pulmonary disease (a respiratory disease). The Minimum Data Set (a resident assessment tool) dated 11/6/24 documented Resident #11 was understood, understands, and had no cognitive impairment. The comprehensive care plan, dated 08/05/24, documented Resident #11 was independent with decision making related to their care. Documented in the section titled customary routine stated resident was able to self-administer medications (inhaler) and likes to keep at bedside, dated 11/04/24. Review of Order Summary Report documented an active order dated 10/30/24 for Fluticasone Salmeterol 250-50 micrograms/activation (Advair), one inhalation orally every morning and at bedtime for COPD (Chronic Obstructive Pulmonary Disease). Additionally, mometasone-formoterol (Dulera) inhaler, a medication prescribed for patients with asthma (a respiratory disease) was present on the bedside tray table with a hospital label intact indicating two puffs twice a day. There was no active physician's order for Resident #11 to self-administer medications and that medications were to be left at the bedside. Additionally, there was no evidence of an active order for mometasone-formoterol (Dulera). (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of progress notes dated 08/22/24 to 11/22/24 documented no evidence that Resident #11 was assessed by the interdisciplinary team to self-administer medications. There was no documented evidence that self-administration of medication was monitored by the Licensed Nurse and there was no progress note after each self-administration medication by a Licensed Nurse per the facility policy. During an observation and interview on 11/18/24 at 9:22 AM, one inhalation diskus of opened Fluticasone-Salmetrol 250-50 Microgram/actuation aerosol inhaler (Advair) (used for Chronic Obstructive Pulmonary Disease, a respiratory disease) without a box or pharmacy label with resident's name and directions; and one opened inhaler of mometasone-formoterol (Dulera) (prescribed for asthma, a pulmonary diseases) observed with a hospital pharmacy label on tray table in room next to bed. Resident #11 stated they administer their inhalers to themselves. when they need it. During an interview on 11/18/24 at 12:13 PM, Registered Nurse #3, unit one cart nurse, identified medications on tray table. Resident stated they like to use them as needed. Registered Nurse #3 stated the inhalers should not be left on the tray table and they would check on the facilities process for self-administration of medications. Medications removed from room taken to cart to review orders. Diskus medication placed into medication cart by Registered Nurse #3. Registered Nurse #3 reviewed physician orders, no order found for mometasone-formoterol (Dulera) inhaler. Registered Nurse #3 Continued to state an order was important to ensure it is administered. The resident needed to be monitored for possible overuse, and the nurse couldn't document use if it is left in the room. Additionally, they stated there was a potential for other residents to use them if not locked in medication cart. Registered Nurse #3 stated Resident #11's inhalers should be kept in drawer because they didn't see an order for self-administration. During an interview on 11/18/24 at 2:25 PM, Registered Nurse Unit Manager #1 stated residents were allowed to administer their own medications if they were alert and oriented and could rationalize the medication. They stated there was no formal evaluation and it would just be documented in the residents' care plan that they could self-administer. Registered Nurse Unit Manager #1 stated it was in Resident #11's care plan that they could self-administer inhaler. Additionally, they stated Resident #11 should not have the Dulera inhaler; they would call the physician and determine if it should be used or if it was being substituted for a different inhaler. During an interview on 11/20/24 at 12:57 PM, Director of Nursing #1 stated before a resident self-administers medication there should be a self-administration assessment completed in PCC (Point Click Care, an electronic medical record), followed by resident education, demonstration, and evaluation. They stated it should be documented in the progress notes that instruction was given and that the resident is able to demonstrate self-administration of the medication safety. Director of Nursing #1 stated there should be an order for all medications that are being self-administered and may keep the medication at bedside, and the medication nurse will sign on the Medication Administration Record indicating they observed the resident administering the medication. Additionally, Director of Nursing #1 stated that all medications needed to be stored out of reach of other residents; example was in a locked drawer, or kept on the resident in their pocket. 10 NYCRR 415.3 (f)(1)(vi)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 43802 Based on interview and record review conducted during the Recertification survey completed on 11/22/24, the facility did not ensure the resident's representative was notified immediately when the residents mental and psychological condition changed requiring a change in treatment. Specifically, for one (Resident #71) of one resident reviewed the facility did not notify Resident #71's responsible when there was need to alter their treatment and a new psychotropic medication was initiated. The finding is: The policy and procedure titled Notification of Resident Changes dated 5/31/18 documented the facility will immediately notify the resident's legal representative when there is: a need to alter treatment significantly (a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment). Resident #71 had diagnoses that included dementia with other behavioral disturbances, Wernicke's encephalopathy (degenerative brain disorder) and repeated falls. The Minimum Data Set (a resident assessment tool) dated 10/2/24 documented Resident #71 was severely cognitively impaired, sometimes understood and rarely/never understands. There were no behaviors documented and antipsychotics were received on a routine basis. The comprehensive care plan documented on 3/29/24 that Resident #71 had been ordered psychotropic medications related to dementia with associated psychotic and/or agitated behaviors. Interventions included to discuss necessity, risks, and benefits of psychotropic drug use with resident and responsible party. Review of Order Summary Report printed 11/22/24 revealed an order dated 10/21/24 for Rexulti (antipsychotic medication) 0.5 milligrams, give 1 tablet by mouth in the morning (10/22/24-11/4/24). The Rexulti was then increased to 1 milligram every day from 11/5/24-11/15/24. Review of nursing progress notes dated 10/21/24 through 11/5/24 revealed there was no documented evidence that responsible party was notified of order to start Rexulti. The Progress note dated 11/6/24 at 2:19 PM documented Resident #71's responsible party called with concerns about a new medication, Rexulti regarding the co-pay and the need for another medication in the same drug class as other medications, Seroquel. Review of Interdisciplinary Care Team Psychoactive Medication Review dated 10/22/24 completed by Social Worker #1 at 9:58 AM documented recommendation for gradual dose reduction of Seroquel (antipsychotic). Additionally, the form documented that Resident #71's representative has been educated on the risk and benefits of medication use and agrees with the plan of care. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of medical professionals' late entry progress note dated 10/21/24 at 9:13 PM, Physician Assistant #1 documented Seroquel will be reduced to 25 milligrams twice daily and to start Rexulti 0.5 milligrams every morning with intension to titrate to effect, with a target dose 2 to 3 milligrams. Additionally, on 11/4/24 at 11:10 AM, Physician Assistant #1 documented to increase Rexulti to 1 milligram every day. There was no documented evidence the responsible party was notified of initiation of the new medication or the increased dose. Review of Grievance/Concern/Compliment Log Form dated 11/13/24 responsible party called regarding Resident #71's Rexulti medication expense and request for Rexulti to be discontinued. The Director of Nursing concluded on 11/14/24 that Rexulti would be discontinued. Communication of resolution was given to the responsible party on 11/15/24. During a telephone interview on 11/18/24 at 1:14 PM, Resident #71's responsible party stated they were not notified that Resident #71 was started on Rexulti, until they received a bill for six hundred dollars at the beginning of November. During an interview on 11/22/24 at 11:27 AM, Licensed Practical Nurse #4 stated they can notify responsible party of resident changes but usually the nursing supervisor or unit managers completed the notifications of changes. They stated they did not update the responsible party regarding the Rexulti but stated when they do notify the responsible party of changes, they document who they spoke with and the conversation. Licensed Practical Nurse #4 stated it was important for the responsible party to be involved in the resident's care and be included in medical decisions. They stated the responsible party should be notified prior to ordering new medication or as soon as possible. During an interview on 11/22/24 at 12:11 PM, Social Worker #1 stated they do not update, or call responsible parties regarding medication changes. They stated those conversations go through the medical provider or nursing staff. Social Worker #1 stated they were responsible to complete the Interdisciplinary Care Team Psychoactive Medication Review form. They stated during the Interdisciplinary Care Team meeting the nursing staff indicates they will update the responsible party. They stated they document on the form who should be notified but that it was not confirming the responsible party had been updated on the changes. Additionally, they stated the responsible party should be aware of medication changes because medication changes could have a positive or negative effect on residents. During an interview on 11/22/24 at 12:25 PM, Director of Nursing #1 stated they expected residents and/or responsible party to be notified of changes right away. The nurse who took the order, or the unit manager should provide and document the notifications, but any nurse could do it. Director of Nursing #1 stated they were covering as the Unit Manager for Resident #71's unit in October and November, and they did not notify the responsible party of the new order for Rexulti. During a telephone interview on 11/22/24 at 3:28 PM, Physician Assistant #1 stated they did not notify Resident #71's responsible party of the new order for Rexulti and were not sure who notifies the responsible party of changes discussed at the Interdisciplinary Care Team meeting. They stated they assumed the responsible parties were being notified by the nursing staff. 10 NYCRR 415.3 (f)(1)(iv)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36415 Based on observation, interview, and record review during the Standard survey completed on 11/22/24, the facility did not provide housekeeping and maintenance services necessary to maintain a safe, clean, comfortable, and homelike environment. The issues included an active roof leak, foul odors in a shower room, and a shower chair with sharp edges from a broken footrest. Additionally, oxygen concentrator filters were dust-laden and were not cleaned according to manufacturer's recommendations. This affected one (Unit 2) of two resident units. The findings are: 1. The policy and procedure titled Working Surfaces and Fall Prevention Protection, dated 5/8/18, documented all operations must be performed in a manner which will prevent any undesirable effects to our employees, assets, the community, and the environment. Observation on Unit 2 on 11/21/24 at 9:00 AM revealed the following areas that appeared to have wet ceiling tiles: one ceiling tile in the corridor between Resident room [ROOM NUMBER] and #219, two ceiling tiles in the corridor outside of Resident room [ROOM NUMBER]; three ceiling tiles outside of Resident room [ROOM NUMBER]; one ceiling tile in the corridor between Resident room [ROOM NUMBER] and #227; and three ceiling tiles in the corridor outside of Resident room [ROOM NUMBER]. During an interview at the time of the observation, the Director of Facilities stated the roof had leaked from the heavy rains last night. The roof leaks in the Unit 2 portion of the building were an on-going issue. The ceiling tiles in this area of the building were made of a special absorbent material, to reduce the likelihood that water would drip onto the carpeted floor below. On 11/21/24 at 10:00 AM, the Director of Facilities stated there was a roof top unit above Unit 2 and when it rained, water would leak from around the edge of the roof top unit. Roofing contractors had replaced the curb around the roof top unit, but it needed to be looked at again. Observation on Unit 2 on 11/22/24 at 8:20 AM revealed the following areas had wet ceiling tiles: in the corridor outside of Resident room [ROOM NUMBER]; one ceiling tile in the corridor between Resident room [ROOM NUMBER] and #221, two ceiling tiles outside of Resident room [ROOM NUMBER], and one ceiling tile in the corridor between Resident room [ROOM NUMBER] and #227. Additional observation revealed the carpet in the corridor outside of Resident room [ROOM NUMBER] felt wet. Observation on Unit 2 on 11/22/24 at 12:55 PM revealed water was actively dripping from the ceiling onto the carpet in the corridor outside of Resident room [ROOM NUMBER]. Additionally, two ceiling tiles in the corridor between the Unit 2 Nurses' Station and the Beauty Shop appeared wet. During an interview on 11/22/4 at 12:55 PM, the Director of Facilities stated it was raining outside and there was nothing the roofers could do while it was raining, but maintenance staff had been changing out the absorbent ceiling tiles as they got wet and extracting the water from the carpet. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/21/24 at 11:12 AM, the Administrator stated the section of roof above Unit 2 had been patched a few times and there had been discussions for a while about replacing the whole roof above Unit 2 versus repairing it in sections. These discussions were ongoing. The Administrator further stated according to the roofing contractor, water settled in small clay membranes on the roof and residual water penetrated down through the multiple membranes. They stated they had been tracking that section for a while, having small pieces repaired at a time. The Administrator stated in the past three years, they had observed water leaking in the corridors, but not in resident rooms. During interviews on 11/21/24 between 3:40 PM and 4:02 PM, Licensed Practical Nurse #4, Unit Clerk #2, Certified Nurse Aide #11 and Housekeeping Aide #1 stated over the past year when it rained hard the roof leaked on Unit 2 in the corridors, and buckets would be placed to catch the water. Review of the roofing contractor's Work Authorization and Service Summary dated 8/19/24 revealed it stated emergency leaks were reported in kitchens, and active leak was coming from box, roof was dry on underdeck. Review of the roofing contractor's Work Authorization and Service Summary dated 8/22/24 revealed it stated multiple leaks were reported, drains on roof were clogged with natural debris, the drain basket was cleaned, and a failed patch was repaired. 2. During observations on 11/18/24 at 12:21 PM, Unit 2 shower room, across from Resident room [ROOM NUMBER] had strong urine and fecal odors. In an adjacent shower stall with an opened hinged door there were two grey garbage totes (one short and one tall) on caster wheelbases. The tall grey garbage tote was unlined and was full of resident's personal laundry spilling over top. The short grey tote was lined with a clear plastic bag and had paper sign that read Please do not remove from shower room. TENA's Only and the with lid off and full of fecal soiled linens, soiled briefs, and garbage. Two small black flying insects were observed in the room. Additionally, there was a hard plastic (PVC - polyvinyl chloride tubing) shower chair with a footrest that was in disrepair (cracked with sharp jagged edges on both corners). The footrest was secured in the up position by a strap. During an observation on 11/20/24 at 11:56 AM, Unit 2 shower room, across from Resident room [ROOM NUMBER], still had a strong foul odor of urine and feces. A grey garbage tote was observed in the shower stall, with opened hinged door, uncovered with visible soiled briefs with brown fecal matter. The shower chair in the adjacent shower stall had sharp jagged corners on the footrest that was in the upright position against the seat of the chair. During an observation on 11/21/24 at 5:56 AM, the Unit 2 shower room across from Resident room [ROOM NUMBER], still had a strong foul odor. A short grey garbage tote did not have a lid and contained soiled garbage. During an interview on 11/21/24 at 8:33 AM, the Director of Facilities stated typically, a bin of soiled linen and a bin of soiled briefs were stored in the stall on the left of the Unit 2 shower room. They stated the location of the bins was decided by nursing staff, for their convenience. During a continuous observation on 11/21/24 from 11:11 AM to 11:27 AM, Resident #71 was sitting in the shower chair that was in disrepair (footrest cracked with sharp edges) the footrest was in the upright position and positioned just under Resident #71's thigh that extended past the edge of the shower chair seat. The resident was being assisted by Certified Nurse Aide #11. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/21/24 at 11:28 AM, Certified Nurse Aide #11 stated they did not notice the cracked sharp edges of the footrest and should have. They stated residents could be injured. Certified Nurse Aide #11 stated the shower room had an odor and smelled muggy. They stated garbage and linens should be removed for infection control and odor control. During an observation and interview on 11/21/24 at 11:33 AM, Registered Nurse Unit Manager #2 stated the shower room smelled of fecal matter and the odor was offensive. They stated they expected nursing staff to remove garbage totes when full and clean the shower area after each use for infection control, sanitation, and odor control. Additionally, Registered Nurse Unit Manager #2 stated the footrest of the shower chair was broken and should have been tagged, not to use, due to the jagged edges. During an interview on 11/21/24 at 1:25 PM, the Director of Facilities stated the shower chair was composed of PVC (polyvinyl chloride) piping, had no mechanical or electrical components, and no preventative maintenance was performed by maintenance staff on this type of shower chair. The Director of Facilities stated they did not have an owner's manual for this type of shower chair. During an interview on 11/22/24 at 12:36 PM, Director of Nursing #1 stated they expected nursing staff to clean up after themselves between residents. They stated soiled linen and garbage should be removed from the shower room and placed in the soiled utility room so it can be picked up by housekeeping staff. Director of Nursing #1 stated lids should be on all garbage totes to contain odors. 3. The policy and procedure titled Oxygen Therapy dated 3/27/2018 documented appropriately trained Licensed Nurses/Therapists Therapy Assistants will set up and monitor the use of equipment. Residents, families, and staff will be educated as indicated regarding safety/manufacturer precautions for concentrator use. Steps of procedure required for infection control: Check filter to ensure that it is clean and positioned properly; periodically maintain equipment and supplies as follows: Pull the air intake filter out from back of unit and wash in warm soapy water and rinse weekly. The Patient Manual for the Brand A oxygen concentrator documented at least one time each week, wash the air intake gross particle filter, which is in the back of the unit. The equipment provider may advise you to clean it more often, depending upon your operating conditions. The filter is cleaned by removing, washing it in a warm solution of soap and water, rinsing it, and ensuring the filter is dry before replacing it. The Service Manual for Brand B oxygen concentrator documented to ensure accurate output and efficient operation of the unit, the air intake gross particle filter must be cleaned. The filter must be cleaned weekly by removing the filter, washing it in warm soapy water, rinsing it, and removing excess water. During observations on 11/18/24 at 9:59 AM, 11/19/24 at 9:02 AM, and 11/20/24 at 9:12 AM, Resident #7 was receiving supplemental oxygen from an oxygen concentrator. The oxygen concentrator was Brand B and had a filter on the back of the unit which had thick grey debris present. Resident #7 had an order to always wear oxygen at 2 liters dated 9/10/24. During an observation on 11/20/24 at 8:45 AM, an oxygen concentrator was providing supplemental oxygen to an resident in Resident room [ROOM NUMBER]. This oxygen concentrator was Brand A and had a filter on the back of the unit with thick grey debris. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elderwood at Lancaster	1818 Como Park Blvd Lancaster, NY 14086

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/20/24 at 8:45 AM, the Director of Facilities stated maintenance staff replaced oxygen concentrator filters monthly and the condition of the filter depended on the amount of concentrator usage. Maintenance staff did not wash the filters. Review of the preventative maintenance and work order tracking system task titled Oxygen Concentrators: In-House Maintenance revealed it was most recently done 11/13/24 and the task titled Oxygen Concentrators: Change Filters was most recently done 10/18/24. During an interview on 11/22/24 at 2:34 PM, Licensed Practical Nurse #4 stated until this week they were not aware that nursing was supposed to change or clean the filters on the oxygen concentrators. They stated filters can accumulate dust, bacteria that could cause infection. 10 NYCRR 415.29

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43802 Based on observation, interview, and record review conducted during a Standard survey completed on 11/22/24, the facility did not ensure that residents who were unable to carry out activities of daily living received the necessary services to maintain good grooming and personal hygiene for two (Resident #16 and #79) of four residents reviewed. Specifically, Resident #16 was not provided with timely incontinence care and Resident #79 had long dirty fingernails. The findings are: The policy and procedure titled Hygiene and Grooming dated 2/7/24 documented that designated nursing staff will ensure that residents are cleaned and appropriately groomed at all times. Residents will be provided with care to maintain or improve abilities to perform hygiene and grooming tasks, as needed. The day shift morning (AM) and daily care is given to all residents in preparation for breakfast and the daily routine. Morning care includes oral hygiene; a partial bath; perineal care (as necessary/ordered) and any specific hygiene care on days when no shower/bath is scheduled. Hygiene care is repeated before and after meals and throughout the days as needed. The policy documented that nails are cleaned and trimmed as part of the bath/shower routine and whenever needed. The policy and procedure titled Perineal, Incontinence Care dated 5/3/18 documented perineal care will be provided with morning and HS care (hour of sleep), and when residents are incontinent or cannot provide such care for themselves. Perineal care will be given to cleanse the genital area, to prevent infection and to eliminate odors. Nursing Assistants will perform perineal care for residents. The policy and procedure titled Hand and Nail Care dated 1/17/19 documented residents will receive nail care for cleanliness and to prevent infection. Appropriately trained nursing assistants will provide nail care for all residents except those with diabetes mellitus or severe peripheral vascular disease (decreased blood circulation in extremities). 1. Resident #16 had diagnoses including dementia, hypertension, and congestive heart failure. The Minimum Data Set, dated dated dated [DATE] documented Resident #16 had moderate cognitive impairment, was understood, and usually understands. Resident #16 was always incontinent of bowel and bladder and required maximal assist for toileting hygiene. The comprehensive care plan dated 11/05/24, documented Resident #16 had cognitive impairments, an activities of daily living function/mobility deficit and was incontinent of bowel and bladder. Interventions included that resident required a maximal assist of one person for toileting hygiene and was to receive prompt incontinent care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a continuous observation on 11/20/24 from 8:42 AM until 10:37 AM, At 8:42 AM, Resident #16 was in bed wearing a night gown and there was a smell of body odor noted in the room, a wash cloth and towel were at the foot of the bed. At this time the resident stated they had not been provided any care yet that morning. At 10:37 AM Certified Nurse Aide #6 entered Resident #16's room and began morning care. Certified Nurse Aide #6 pulled back Resident #16's covers to provide peri care and a strong smell of urine was noted. Resident #16 was saturated with urine, their gown and bed linens were visibly wet to the mattress. Resident #16 stated three times during care that they were soaked from urine. After Resident #16 was place into their wheelchair, the mattress needed to be cleaned with a disinfectant spray along with a full bed change. During an interview on 11/20/24 after morning care was completed, Certified Nurse Aide #6 stated they had not arrived to work until 8:30 AM. They stated there was no staff member assigned to Resident #16 from 6:00 AM until when they arrived at work. They stated Resident #16 was always incontinent of urine when they were in bed and probably the last time Resident #16 was provided incontinent care was on the previous shifts last round around 5:00 AM. Certified Nurse Aide #6 stated that if incontinent care was provided to Resident #16 between 6:00 AM and 8:30 AM they would have not been so saturated with urine. During interviews on 11/20/24 between 11:15 AM - 11:34 AM, Certified Nurse Aide #10, Certified Nurse Aide #11, and Register Nurse #1 all stated they had not provided any care to Resident #16 on the morning of 11/20/24. During an interview on 11/20/24 at 1:53 PM, Certified Nurse Aide #12 stated when they arrived at work that morning they started on their assignment and not provide any care to Resident #16. During an interview on 11/20/24 at 3:25 PM, the Director of Therapy Services stated at approximately 7:30 AM Unit manager #2 requested help to get residents out of bed for breakfast that morning. They stated Occupational Therapist #1 also assisted Unit Two with morning duties, but they had not provided any care to Resident #16. During an interview on 11/22/24 at 9:08 AM, Registered Nurse Unit Manager #2 stated when they arrived at work on 11/20/24 at approximately 7:00 AM there were only two Certified Nurse Aides on the unit. Director of Nursing #1 and the Director of Therapy and themselves were assisting residents out of bed for breakfast. Registered Nurse Unit Manager #2 stated they did not provide any care to Resident #16. They stated that Resident #16 was incontinent and should be checked upon every 2-4 hours to see if incontinent care was needed. Registered Nurse Unit Manager #2 stated that Resident #16 should have not been saturated with urine through their gown, bed linens down to the mattress. In an interview at 9:25 AM, Registered Nurse Unit Manager #2 reviewed the assignment sheets for 11/20/24 and stated there was no Certified Nurse Aide assigned to Resident #16 until Certified Nurse Aide #6 arrived to work at 8:30 AM. During an interview on 11/22/24 at 9:26 AM, Director of Nursing #1 stated on 11/20/24 they assisted in providing morning care to residents on Unit Two because two Certified Nurse Aides were late for their shifts. They stated they did not provide any care to Resident #16. The Director of Nursing stated that morning care being provided to Resident #16 at 10:30 AM would not have been considered timely and they should have been checked for incontinence when Certified Nurse Aide #6 arrived to work. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #79 had diagnoses that included metabolic encephalopathy (disease of the brain), pneumonia (respiratory infection), and dysphagia (difficulty swallowing). The Minimum Data Set (a resident assessment tool) dated 10/20/24 documented Resident #79 was understood, understands, was moderately cognitively impaired, had no refusals of care and preferred a bed bath. Resident #79 required partial/moderate assistance for personal hygiene. The comprehensive care plan dated 10/21/24 documented Resident #79 required substantial or maximal assist of one person for personal hygiene and was to receive showers two days a week. There was no documentation related to nail care. The Visual/Bedside Kardex (guide used for staff providing care) dated 11/22/24 documented Resident #79 was a substantial/maximal assist for personal hygiene. Review of the Treatment Administration Records dated 10/15/24 - 11/22/24, documented that skin examinations were completed every Tuesday and Friday evening shift on 10/15/24,10/18/24, 10/22/24, 10/29/24, 11/08/24, 11/12/24, and 11/19/24. There was no documentation related to nail care. Review of the Documentation Survey Report (certified nurse aide task documentation) dated from 10/15/24 - 11/22/24 revealed Resident #79 received personal hygiene care sporadically and was either dependent or required substantial/maximum assistance with care. There were no documented care refusals. Review of nursing progress notes dated from 10/15/24 - 11/22/24 revealed there were no documented refusals of nail care. During an observation on 11/18/24 at 9:48 AM, Resident #79 was lying in bed, sleeping. The nails on both their hands were visible and had multiple fingernails of various lengths with dark brown debris packed under the nails. During a follow up observation and interview on 11/19/24 at 8:57 AM, Resident #79 was sitting up in bed with their breakfast tray in front of them over the bed. The packed dark brown debris remained under their fingernails on both hands, nails were of medium uneven length. Resident #79 stated staff have not offered to clean under their nails and they would like them cleaned. The resident stated they did not mind the length. During an observation and interview on 11/20/24 at 1:56 PM, Certified Nurse Aide #16 stated they were assigned to Resident #79's that morning. They stated morning care involved oral care, cleaning the body, shaving and nail care if needed. Certified Nurse Aide #16 stated they had provided morning care to Resident #79 this morning but did not have time to provide nail care due to being short staffed. They stated their workload was heavy and they didn't have enough time to provide care the way they wanted to. Certified Nurse Aide #16 walked into Resident #79's room and observed their nails and stated Resident #79 could use some cleaning under their nails. They stated nails should be cleaned on shower days and whenever they were dirty for infection control reasons, it is unsanitary. (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 11/21/24 at 1:17 PM, Registered Nurse Unit Manager #1 stated nail care was supposed to be completed on shower days and as needed. They stated there is an order for skin and nail checks on shower days and they expected them to be completed per the physicians' orders. Registered Nurse Unit Manager #1 stated they expected staff to clean Resident #79's nails whenever they were noticed to be dirty. If they couldn't, let the nurse know. Registered Nurse Unit Manager #1 stated Resident #79's nails should be cleaned for infection control and dignity reasons. Additionally, they stated they were responsible for ensuring nail care was completed on all residents on the unit. During an interview on 11/22/24 at 10:48 AM, Director of Nursing #1 stated they expected nail care to be provided to residents on shower days and anytime they were noticed to be dirty. They stated the nursing staff on the unit were responsible for ensuring nail care was completed on residents and it was important for infection control and dignity reasons. Director of Nursing #1 stated they expected Resident #79's nail care to be completed as soon as someone noticed they were dirty. Additionally, Director of Nursing #1 stated they felt as though the lack of daily care provided to the residents had a lot to do with the lack of staffing in the facility at that time. They stated, staff just had a tough time finding time to get to the little things like nail care, hair, and shaving when they are running ragged. 10NYCRR 415.12(a)(3)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43802 Based on observation, interview, and record review conducted during a Complaint investigation (#NY00360394, NY00317661) during the Standard survey completed on 11/22/24, the facility did not ensure that there was sufficient nursing staff on a 24-hour basis to provide care to all residents. Specifically, one of one facility reviewed for sufficient staffing the facility did not meet their assessed minimum staffing levels for Certified Nurse Aides to meet the needs of each resident. The findings are: Refer to F 677 Activities of daily living care for dependent residents. The undated policy and procedure titled Emergency Staffing Plan documented in the event of extreme staffing available internal float pool and 3rd party agency nursing staff and Certified Nurse Aides will be utilized. The administrator and/or designee will reach out to other facilities to try and secure available staff to assist. All department managers/supervisors and all other available staff will be available for any non-nursing duties assigned by the supervisor. All non-scheduled staff will be called to see if they are available to come into work and assist. Review of facility provided document titled Your Rights as A Nursing Home Resident In New York State documented as a resident in the facility they have the right to be valued as an individual and be treated with consideration, dignity, and respect in full recognition of their self-worth. The right to be cared for in a manner that enhances their quality of life and receive services with reasonable accommodations for individual needs and preferences. The right to receive adequate and appropriate care. The facility assessment dated [DATE] documented hand-written minimum staffing levels for Certified Nurse Aides were 2 aides on the day shift (6:00 AM to 2:00 PM), 2 aides on the evening shift (2:00 PM to 10:00 PM), and 2 aides on the night shift (10:00 PM to 6:00 AM) for a facility census of 80-88 residents. The facility census report for October 2024 and November 2024 documented the following resident census:10/26/24 = 84; 11/3/24 = 85; 11/8/24 = 88; 11/11/24 = 86; 11/12/34 = 87; 11/15/24 = 84; 11/17/24 =83; and 11/18/24 = 84. The facility nursing daily staffing sheets documented the following: 10/26/24 - 2 Certified Nurse Aides for the night shift (down 2). 11/03/24 - 2 Certified Nurse Aides for the night shift (down 2). 11/08/24 - 1 Certified Nurse Aides for the night shift (down 3). 11/11/24 - 2 Certified Nurse Aides for the night shift (down 2). (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	11/12/24 - 2 Certified Nurse Aides for the night shift (down 2). 11/15/24 - 2 Certified Nurse Aides for the night shift (down 2). 11/17/24 - 2 Certified Nurse Aides for the night shift (down 2). 11/18/24 - 2 Certified Nurse Aides for the night shift (down 2). During an interview on 11/18/24 at 9:11 AM, Resident #14 stated there have been a few times, including the night prior where there was only one Certified Nurse Aide on the unit. Resident #14 stated they have had to wait over half an hour for their call light to be answered during these times. During an interview on 11/18/24 at 9:22 AM, Resident #11 stated sometimes they wait half an hour before anyone comes to answer their call light during the day. They stated in the middle of the night they wait a little longer than half an hour. Resident #11 stated often on the overnight shift a Certified Nurse Aide would come answer the light, turn it off, and say they will be back but does not come back for an hour or so. During an interview on 11/18/24 at 10:12 AM, Resident #45 stated there was not enough staff, and call bell wait times were longer than 15 minutes. During an interview on 11/18/24 at 10:28 AM, Resident #16 stated they had to wait long periods to be changed during the night, the bed gets wet, and it doesn't feel nice. During an interview on 11/18/24 at 11:56 AM, Resident #10 along with their Health Care Proxy, stated it would take a while for their call bell to be answered when they press it to be toileted. They stated there was longer call light waits especially on the weekends. A strong smell of urine was noted in the room at that time. Resident #10's Health Care Proxy stated they noted the urine odor and have noticed the odor at other times during their visits. During an interview on 11/18/24 at 2:50 PM, Resident #53 stated they had to wait a long time when they put their call light on to be changed out of their BM (bowel movement) soiled brief. They stated it was all shifts, on all days of the week but even worse on the weekends. During an interview on 11/19/24 at 3:30 PM, the Administrator stated the staffing minimum handwritten in by them was what we were to follow for their staffing minimum numbers. The Administrator stated the Nursing Supervisors would pick up a cart if there was a nurse hole and to consider them as part of one of the staff members giving direct patient care. During an interview on 11/21/24 at 5:33 AM, Certified Nurse Aide #1 stated they work the overnight shift and has had to work twice by themselves on a unit in the past 3 months. During an interview on 11/21/24 at 5:33 AM, Certified Nurse Aide #2 stated they work the overnight shift and has worked as the only aide on the unit 4 to 5 times in the past 5 months. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 11/21/24 at 5:40 AM, Certified Nurse Aide #3 stated that 3 to 4 times a week they work with no other Certified Nurse Aides on unit one. They stated they cannot complete all their work duties such as emptying foley catheter bags and checking residents every two hours for incontinent care. They stated they also pick up hours at 8:00 PM and usually work with just one other aide. Certified Nurse Aide #3 stated they when that happens, they are still putting residents to bed after 10:00 PM. During an interview on 11/21/24 at 5:45 AM, Licensed Practical Nurse #1 stated sometimes there was only 1 nurse and 1 aide when they worked the overnight shifts. During an interview on 11/21/24 at 5:45 AM, Certified Nurse Aide #4 stated they work the 2:00 PM till 10:00 PM and they on average work with two to three aides. They stated they are unable to complete all their duties and at times to do not have enough time to do showers. Certified Nurse Aide #4 stated the call lights ring for a while and residents must wait for incontinent care to be completed due to staffing. They stated that they tell their nurses and management where aware of the staffing challenges but staff just come and go. During an interview on 11/21/24 at 5:50 AM, Registered Nurse Nursing Supervisor #1 stated they were scheduled as the Nursing Supervisor on duty but often must take a nurse cart as well. Registered Nurse #1 stated normal overnight staffing is anywhere from 2 to 4 people for the whole building, and the nurse must round with the aide. They stated they felt as though they were not able to give the residents the quality of care they should be giving. During an interview on 11/21/24 at 10:32 AM, the Clinical Scheduling Specialist stated staffing levels were based on resident census and the census was reviewed daily. The Clinical Scheduling Specialist stated residents' acuity and needs were considered, but ultimately corporate gives them their minimum numbers to go by. They stated call offs were always a problem, and they would attempt to have staff pick up as soon as a call off came in. They stated on the off hours, the Nursing Supervisor was responsible for handling call offs but could reach out to them if they needed to. The Clinical Scheduling Specialist stated there was a facility agency float pool that can be accessed if staffing minimums need to be met. The Clinical Scheduling Specialist reviewed the minimum staffing numbers provided and the identified 8 days on the staffing schedule that the facility fell below the minimum staffing levels and stated the minimums are 1 nurse and 2 aides to each unit across the board. The Clinical Scheduling Specialist stated it's written in black and white. There were times when units worked with 1 nurse and 1 aide. During an interview on 11/21/24 at 12:03 PM, Registered Nurse Unit Manager #1 stated the facility often asks them to work overtime due to staff call ins, staff were over worked, constantly working short staffed, and it's caused a lot of staff to walk out. Registered Nurse Unit Manager #1 stated they have brought their concerns to upper management, but they were ignored. They stated other staff constantly tell them they were unable to complete their work and documentation was not being completed. Registered Nurse Unit Manager #1 stated their nursing license was on the line because the care was not there. During an interview on 11/21/24 at 1:17 PM, Certified Nurse Aide #8 stated when they work 2:00 PM till 8:00 PM, with only two Certified Nurse Aide's they cannot get all their work completed. Certified Nurse Aide #7 stated that when they have 20 residents on their assignment, they cannot provide incontinent care every two to four hours as per the residents plan of care. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 11/21/24 at 4:35 PM, Director of Nursing #1 stated they were not aware the facility had not met their minimum staffing requirements in the last 30 days. During a telephone interview on 11/22/24 at 10:21 AM, Certified Nurse Aide #5 stated they worked the overnight shift and there were plenty of nights they were working as the only aide on the unit with 1 nurse. They stated they would both be extremely busy and sometimes the nurse was unable to assist them with completing rounds. Certified Nurse Aide #5 stated they struggled to provide timely incontinent care to residents when they were the only aide on the unit. Residents were sitting in their urine for extended periods of time because they were the only aide to care for them. They stated there were times they were changing an incontinent resident for the first time at the end of the shift. During an interview on 11/22/24 at 10:40 AM, Director of Nursing #1 stated the Nursing Supervisor often must work on a cart; pass medication, and do treatments, as well as supervise the building. During an interview on 11/22/24 at 11:06 AM, Licensed Practical Nurse #2 stated they are frequently the only nurse working the overnight shift with 1 aide on the unit. Licensed Practical Nurse #2 stated they have spoken with staffing and upper management about their concerns. During a telephone interview on 11/22/24 at 12:07 PM, Certified Nurse Aide #7 stated they work unit two 10:00 PM to 6:00 AM and times work the shift by themselves. Certified Nurse Aide #7 stated they would attempt to provided incontinent care to all the residents to keep them dry but usually could only provide one incontinent round. Certified Nurse Aide #7 stated that call lights ring often or they had to sit with residents who would attempt to get out of bed on unit two. They stated that even when a certified nursing aide came to assist them from unit one, they still could not complete all their work duties. During an interview on 11/22/24 at 12:48 PM, the Administrator stated there have been resident complaints of long call light times that were brought up in resident council, and the facility does their best to monitor long call wait times. 10NYCRR 415.13(a) (1) (i-iii)

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Elderwood at Lancaster	1818 Como Park Blvd Lancaster, NY 14086

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	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. 43802 Based on observation, interview, and record review conducted during a Standard survey completed on 11/22/24, the facility did not ensure the Director of Nursing served as a charge nurse/Supervisor, only when the facility has an average daily occupancy of 60 or fewer residents. Specifically, the Director of Nursing worked as a charge nurse when the facility had a daily average census of greater than 60. The finding is: Review of a facility provided document titled Director of Nursing, last revised 2/2024, revealed the Director of Nursing ensures the health and well-being of our residents by being responsible for oversight and operations of the nursing department and its staff including staffing, training, and development, and management of personnel. The Director of Nursing is responsible for upholding and following state, local, and federal regulations, and best practices within their scope of practice. Additionally, the Director of Nursing, in conjunction with the scheduler, monitors the master staffing plan for the department and approves the schedule. The State Operational Manual dated 11/21/22 documented a charge nurse is 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. Review of the facility provided document titled Nursing Supervisor, last revised 4/2021, revealed the Nursing Supervisor ensures the health and well-being of our residents by being responsible for nursing care rendered at the facility during the assigned shift, supervision of nursing personnel of each unit, and other additional duties assigned by the Director of Nursing Services. Review of the facility provided document titled Licensed Practical Nurse/ Team Leader, last revised 10/2024, revealed the Team Leaders assist in ensuring the general health and well-being of our residents by providing direct nursing care. Direct nursing care of residents encompasses planning, developing, organizing, implementing, and evaluating the care of residents to ensure that the highest degree of quality care and regulatory compliance is maintained. Licensed Practical Nurses in charge capacity are to exercise supervisory authority even at times that Registered Nurses are on duty and must exercise discretion and independent judgement to ensure proper discipline and productivity. The facility census at the time of survey entrance on 11/18/24 at 8:30 AM was 83 out of 95 available beds. The untitled facility resident census reports for October and November 2024 documented the following: 10/20/24 the census was 84. 10/28/24 and 11/3/24 the census was 85. (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	11/04/24 the census was 87. 11/06/24 the census was 85. 11/09/24 the census was 87. 11/11/24 the census was 86. 11/12/24 the census was 87. 11/13/24 the census was 85. 11/16/24 the census was 84. 11/17/24 the census was 83. 11/19/24 the census was 86. 11/21/24 the census was 86. The facility Daily Staffing Sheets documented the following: - 10/20/24, the Director of Nursing served as the Nursing Supervisor from 7:00 AM to 3:00 PM. - 10/28/24, the Director of Nursing assigned as a Licensed Practical Nurse from 2:00 PM to 5:00 PM. - 11/03/24, the Director of Nursing served as the Nursing Supervisor from 7:00 AM to 2:00 PM and was also assigned as a Licensed Practical Nurse (Cart). - 11/04/24, the Director of Nursing assigned as a Licensed Practical Nurse from 2:00 PM to 5:00 PM. - 11/06/24, the Director of Nursing assigned as a Licensed Practical Nurse from 2:00 PM to 10:00 PM. - 11/09/24, the Director of Nursing served as the Nursing Supervisor from 6:00 AM to 11:30 AM. - 11/11/24, the Director of Nursing assigned as a Licensed Practical Nurse from 2:00 PM to 5:00 PM. - 11/12/24, the Director of Nursing assigned as a Licensed Practical Nurse from 2:00 PM to 10:00 PM. - 11/13/24, the Director of Nursing served as the Nursing Supervisor from 2:00 PM to 10:00 PM and was also assigned to a Licensed Practical Nurse Cart. - 11/16/24, the Director of Nursing assigned as a Licensed Practical Nurse from 2:00 PM to 10:00 PM. (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	- 11/17/24, the Director of Nursing served as the Nursing Supervisor from 2:00 PM to 8:00 PM. - 11/19/24, the Director of Nursing assigned as a Licensed Practical Nurse from 2:00 PM to 10:00 PM. - 11/21/24, the Director of Nursing assigned as a Licensed Practical Nurse from 4:00 PM to 7:00 PM. During an interview on 11/20/24 at 12:57 PM, the Director of Nursing stated they work 20 hours of overtime a week to accommodate nursing staffing shortages. They stated they have been working on the nurse carts recently, but also supervises the building when needed (passing medications, doing treatments, admitting new residents, providing hands on care with activities of daily living). During an interview on 11/21/24 at 10/32 AM, the Clinical Scheduling Specialist stated call offs were always problem, and they would reach out to other staff to come in first. If they were unable to find someone else, they reach out to Director of Nursing #1 to fill in, especially for supervision and on the weekends. The Clinical Scheduling Specialist stated Director of Nursing #1 has worked as a Charge Nurse 4 to 5 times in the last 30 days due to call offs and staff shortages. During an observation on 11/21/24 at 4:25 PM, Director of Nursing #1 was observed standing at the nurse's station with a manilla folder and narcotic keys in their hand. They were overheard stating to a surveyor that they were working on the nurse's cart that evening) and may be a little late the next day due to being at the facility so late. During an interview on 11/21/24 at 4:35 PM, Director of Nursing #1 stated they were working on the nurses' cart that evening on Unit 1. They stated they had an admission that just arrived and gestured towards the manilla folder in their hand. Director of Nursing #1 stated there have been plenty of days in the last month they have stayed and worked on a cart, which involved passing medication and completing new admissions and treatments, or supervised the building, or both at times due to short staffing. During an observation on 11/22/24 at 9:15 AM, Director of Nursing #1 was overheard stating to the Clinical Educator, I've worked 27 days in a row, I hope I don't have to come in tomorrow. During a telephone interview on 11/22/24 at 10:27 AM, Registered Nurse Nursing Supervisor #2 stated the Nursing Supervisor position consisted of them supervising the buildings residents and staff and ensuring their safety and well-being, doing periodic rounds of facility, and managing staffing issues when they arose. They stated the Licensed Practical Nurse/Team Leader position consisted of passing medications, rounding the unit, providing treatments, doing admissions, and assisting with hands on care to residents. During an interview on 11/22/24 at 10:40 AM, the Director of Nursing stated they often supervise and work the cart on the weekends when staffing numbers were low. Director of Nursing #1 stated it was hard for them do their job duties and then be on a cart during the week, but they do what needs to be done to fill the holes in the schedule. During an interview on 11/22/24 at 12:48 PM, the Administrator stated Director of Nursing #1 has had to work on a nurse's cart recently due to call offs and short staffing. (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	During the exit interview on 11/22/24 at 1:40 PM, the Administrator and Director of Nursing #1 stated they were unaware of the regulation that the Director of Nursing was unable to serve as charge nurse when the facility occupancy was over 60 residents, and it has been happening more since the pandemic. 10NYCRR 415.13(b)(1)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 43802 Based on observation, interview, and record review conducted the Standard survey completed on 11/22/24, the facility did not ensure that drugs and biologicals were securely stored in accordance with State and Federal laws for one (Unit 2) of two units reviewed for medication storage. Specifically, medications were signed as administered and left unattended at Resident #66's bedside. The finding is: The policy and procedure titled Medications Administration Methods dated 1/25/24 documented a Licensed Nurse will be responsible for passing medications according to techniques and procedures that meet current practice standards in compliance with State Codes, Rules, and Regulations and other applicable state and federal laws. A medication must never be left at bedside or be out of sight of the nurse administering the medication. The nurse must watch each resident take the medication, and ensure the medication is swallowed, unless the resident has an order for self-administration of medications. Medication administration is recorded on the Medication Administration Record after administration. Resident #66 had diagnoses which included dementia, psychotic disturbance, and depression. The Minimum Data Set (a resident assessment tool) dated 9/18/24 documented Resident #66 had moderate impaired cognition, was understood, and understands. The comprehensive care plan revised 9/19/24 documented Resident #66 had dementia and lacked decision making capacity. The certified nurse aide care guide (guided used by staff to provide care) dated as of 11/18/24 documented Resident #66 experienced periods of confusion. The Order Summary Report dated 11/18/24 documented active physician's orders for Folic Acid (supplement)1 milligram by mouth daily, Lactulose Solution (laxative) 10 gram/15 milliliters by mouth daily for high ammonia levels, Sertraline (antidepressant) 25 milligrams by mouth daily, and Vitamin B-1 (supplement) 100 milligrams by mouth daily. There was no physician's order for Resident #66 to self-administer medications. During observation and interview on 11/18/24 at 9:36 AM, Resident #66 was lying in bed, there was one green oblong tablet, one yellow round tablet, and one white round tablet in a medication cup on the over the bed table with a four-ounce plastic drinking cup with 15 milliliters of yellowish clear liquid. Resident #66 stated at 9:38 AM, the nurse left them earlier this morning and would think about taking their medication. Review of the Medication Administration Record on 11/18/24 at 11:21 AM, revealed Licensed Practical Nurse #3 initialed that they had administered Folic Acid, Sertraline, Vitamin B-1, and Lactulose Solution between the scheduled time frame of 7:00 AM - 10:00 AM. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 11:49 AM, Certified Nurse Aide #9 delivered Resident #66's lunch tray and observed the medications on the over the bed table and stated the pills shouldn't have been left there and was unsafe. The nurse should have made sure the resident took them. During observation and interview on 11/18/24 at 11:52 AM, Licensed Practical Nurse #3 identified the pills as Folic Acid, Sertraline, Vitamin B-1, and Lactulose Solution 15 milliliters and stated they left the medications at 6:30 AM and assumed Resident #66 would take them and they left the medications all the time. I'd expect them to have taken the pills. Staying with the resident until medications were swallowed was important so they don't choke or drop them. During an interview on 11/18/24 at 12:00 PM, Registered Nurse, Unit Manager #2 stated nurses were expected to watch residents swallow their medications to ensure they can be monitored effectively for adverse effects or behaviors. Medications left at the bedside required a physician's order. Resident #66 was incapable of self-administering medications due to dementia. Licensed Practical Nurse #3 should have ensured that Resident #66 swallowed their medications and if the resident refused would have expected Licensed Practical Nurse #3 to hold the medications and reapproach later. During an interview on 11/18/24 at 12:13 PM, Director of Nursing #1 stated Licensed Practical Nurse #3 should have made sure Resident #66 took the medications before leaving the room, and then signed for them. Resident #66 had a history for medication refusals, but we certainly do not leave the medications on the table for anyone to access, and was a safety risk. During an interview on 11/22/24 at 10:10 AM, the Administrator stated leaving the medications at the bedside posed a safety risk. Licensed Practical Nurse #3 should have watched Resident #66 take their medications, and then signed them as administered. 10 NYCRR 415.18(d)(e) (1-4)

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. 36415 Based on interview and record review during the Standard survey completed on 11/22/24, the facility did not employ a qualified professional to furnish a specific service to be provided by the facility and the facility did not have that service furnished to residents by a person or agency outside the facility under an arrangement. Specifically, the facility did not have a dentist on their staff and did not have dental services provided by an outside person or agency under an arrangement. This involved Resident #23 and has the potential to affect 83 of 83 residents. The finding is: The facility document titled Dental Care Requirements, dated 9/18, documented the dentist (or designee) must complete an oral exam within fourteen days of admission and document dental status in the medical record. Whenever a resident requires assessment/ treatment related to routine care or provision of complete and partial dentures, the cleaning, repair and restoration of dentures/ teeth, surgery and periodontal therapy, the dentist (or designee) must visit the resident and document the care and treatment in the medical record. Twelve months after the last full dental assessment, the dentist (or designee) must complete a dental examination and update the medical record. These requirements for the attending/ consultant dentist are based upon the State Health Code, Rules and Regulations and federal Medicaid and Medicare guidelines for residential health care facilities, and policies established by the facility Quality Assessment and Review Committee. Additionally, when the attending/ consultant dentist is not available to provide care, the facility will arrange timely dental as appropriate. Review of the Facility Survey Report (Form DOH-1550), signed by the Administrator on 11/19/24, revealed the facility was currently seeking external services available to service our patients. The questions: Are routine dental services provided within your facility, Does your facility have a cooperative agreement with an outside dental service, and Does your facility obtain emergency dental services from an outside resource were all answered No. During an interview on 11/19/24 at 8:45 AM, Resident #23 stated they had not seen a dentist since admission and would like to see one for some peace of mind. Review of Resident #23 medical records documented the resident signed a consent form on 2/23/24 to receive dental examinations and treatments. There was no documented evidence that Resident #23 had seen a dentist since admission. During an interview on 11/22/24 at 8:42 AM, Licensed Practical Nurse #4 stated the facility did not have an in-house dentist. They were not sure of the last time a dentist came to the facility, and some residents went out to their own private dentists. Licensed Practical Nurse #4 stated all residents could use a dentist for annual visits or more frequently as needed. (continued on next page)

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 11/22/24 at 8:49 AM, Registered Nurse Unit Manager #2 stated there used to be a dentist who came to the facility, and they were not sure when the dentist last visited the facility. They stated if a resident had a dental issue, they would inform the resident's primary care physician, to possibly have them examine the resident. They stated if a resident had a dental emergency, they would find out which dentists would work with that resident's insurance and look into all options. During an interview on 11/22/24 at 8:55 AM, the Medical Records Specialist stated currently there were no dental services being provided in-house. They stated if a resident had a dental emergency, facility nursing staff would assess for urgency, and the resident would be sent to (the County Medical Center) if appropriate, but they had not had a need to do so yet. Residents would normally see a dentist for an annual checkup, the facility had not been providing annual checkups, but were asking residents' families if they still wanted that. They stated a few family members had asked about dental services, and because there was still no in-house dentist, they had helped to set up appointments with a community dentist. The Medical Records Specialist stated they found a dentist in the local community who accepted Medicaid and they had been referring residents' families to that dentist. They stated the facility did not take the resident to a community dentist, but families could pursue it, depending on their insurance. According to their records, the dentist previously came to the facility every other week, the last time the dentist came to the facility was 4/18/24. During an interview on 11/22/24 at 9:15 AM, Registered Nurse Unit Manager #1 stated the facility currently waived dental services for some residents and new admissions understood that dental services were not included. A dentist did not come to the facility to provide services. Registered Nurse Unit Manager #1 stated if a resident had a dental problem, they must arrange for private dental services. They also stated a resident (unidentified) who was recently admitted to the facility for short-term rehabilitation had a cracked tooth and was experiencing mouth pain. The resident's pain was managed with pain medication and saltwater rinses. Registered Nurse Unit Manager #1 stated this resident did sign a dental services waiver and will follow-up with their own dental provider after they leave this facility. Registered Nurse Unit Manager #1 stated if a resident was experiencing intolerable pain, they would be sent to the hospital. They added that the ADA (American Dental Association - a professional organization that supports the dental profession and public health) recommended tooth cleanings and checkups every six months to a year, and that should be followed. During an interview on 11/22/24 at 9:15 AM, Unit Clerk #1 stated there were no dental services provided in the facility since about April 2024. They stated (a County Medical Center) would be an option for emergency dental services, but it was difficult to get same-day transportation. They added the medical center had a dental clinic that was only open on Wednesdays, and they were not taking any new patients Some residents had their own dentists, and their families could take them to dental appointments. Unit Clerk #1 stated when the dentist was coming into the facility, they came every other week, and saw residents for routine and emergency dental services, as well as cleanings. Review of the dental services log at the Unit 1 Nurses' Station revealed the latest entry was dated 4/18/24. (continued on next page)

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 11/22/24 at 10:00 AM, Director of Nursing #1 stated they had had not seen a dentist in the facility. Director of Nursing #1 stated the facility assisted residents' families in setting up dental appointments with dentists in the community. They stated they were not sure who would provide transportation to and from those dental appointments. They stated to their knowledge, no residents have needed emergency dental services in the last two months. Director of Nursing #1 also stated a resident should be offered the opportunity to see a dentist at least every year. During an interview on 11/22/24 at 10:25 AM, the Administrator stated the dentist that was under contract with the facility used to come in twice a month, and as needed, and last came to the facility in April 2024. The Administrator stated they utilized the dental clinic at a (County Medical Center). Facility staff told residents' families that dental services were not currently being provided in the facility, and if they preferred to see their own dentist, facility staff would assist in making the appointment and assist in transportation to and from the appointment. The Administrator stated the Medical Records Specialist and Unit Clerks tracked when residents were due for routine checkups and cleanings and told them personally when dental visits were needed. Facility staff would arrange for a dental cleaning, as it was the facility's responsibility. If a resident did not have family members involved in their care, Social Workers and the Medical Records Specialist got involved in arranging dental services. Additionally, the Administrator stated the corporate-level team was actively working to find a new dentist to provide services at this facility. During a telephone interview on 11/22/24 at 11:40 AM, the Chief Business Development Officer for Skilled Nursing Facilities and Assisted Living Facilities stated the facility did not currently have a contract with a dentist to provide in-house dental services. Previously, the facility had a contracted dentist who serviced the residents of this facility through April 2024. They stated initially when the contracted dentist left, the facility had to jump through hoops to get their residents into the (County Medical Center) dental clinic because the former contracted dentist did not end their own contract with the county and the county medical center had told the facility that the former dentist must schedule the appointments, not the facility. The Chief Business Development Officer for Skilled Nursing Facilities and Assisted Living Facilities stated this issue had been resolved and the facility had been using the county dental clinic for its residents. They stated, in a dental emergency, the facility would send the resident to the count medical center and provide transportation or send them to any dentist in the local community who would accept the resident, and the facility would pay the bill. With Medicaid residents (all long-term residents), the facility would use the county dental clinic, as the facility pays for dental services for Medicaid residents. If a sub-acute resident (short-term resident) had a dentist in the community, the facility would use that dentist. If a sub-acute resident had no community dentist, the facility would assist in getting an appointment and transportation with a local dentist. 10NYCRR 415.26(e)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43802 Based on observation, interview and record review conducted during a Standard survey completed 11/22/24, the facility did not maintain an infection prevention and control program designed to provide a safe, sanitary, and a comfortable environment, to help prevent the development and transmission of communicable diseases and infections for two (Residents #2, #11) of two residents reviewed. Specifically, staff did not maintain proper infection control measures after completing foley catheter (tube inserted into bladder to drain urine) care prior to touching high contact areas, and the resident's catheter tubing was observed directly on the floor (#2); staff did not wear appropriate personal protective equipment (PPE) for residents on enhanced barrier precautions while providing care (#2); and there was a lack of signage to alert staff that Resident #11 required enhanced barrier precautions. Additionally, the facility's written processes did not include the staffs practice of a blue diamond identification system for residents on enhanced barrier precautions. The findings are: The policy and procedure titled, Catheter, Daily Care revised on 11/23/2022, documented residents with indwelling catheters will have daily cleaning of the catheter tubing and perineal area for the purpose of preventing urinary tract infections. Explain procedure to resident, wash hands thoroughly and apply gloves required for infection control, take equipment to bedside, provide privacy, cleanse perineal area, dry area thoroughly with clean towel. Discard gloves and wash hands thoroughly. The policy and procedure titled Transmission Based Precaution Levels, last modified on 6/6/24, documented Enhanced barrier precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with multi drug resistant organisms as well as those at increased risk of multi drug resistant organisms' acquisition (residents with chronic wounds or indwelling medical devices including urinary catheters). Hand washing, gloves and gowns were required during direct resident contact such as dressing, transferring, device care or use, and wound care. The Infection Preventionist of designee will review reports regarding sign and symptoms of infections and determine most appropriate precautions and implement them accordingly. The Unit Manager is responsible for placing signage on the resident door to instruct staff and visitors to see nurse prior to entering room. The policy documented the precaution set-up includes a drawer/cart maintained outside the door of the resident rooms containing necessary supplies for persons entering or leaving the room of a resident on precautions. This may include, but is not limited to gloves, disposable gowns, masks, precaution bags, and goggles. The policy did not include a process or guidance related to a blue diamond next to resident's name plate. 1. Resident #2 had diagnoses that included a urinary tract infection, chronic kidney disease and neurogenic bladder (muscles and the nerves are not connecting to the brain causing voiding difficulties). The Minimum Data Set (a resident assessment tool) dated 9/26/24 documented Resident #2 was cognitively intact. Resident #2 was dependent on staff for perineal hygiene and toileting hygiene. Resident #2 had an indwelling catheter. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The comprehensive care plan dated 10/11/2024 documented Resident #2 had an alteration in bladder/bowel elimination related to the aging process and history of urinary tract infections. Interventions included: monitor for urinary complications assess for changes in elimination pattern, provide prompt incontinent care, monitor for signs and symptoms of urinary tract infection. The Visual/Bedside Kardex report (a guide used by staff to provide care) dated 11/22/24, documented under bowel and bladder Resident #2 had an indwelling catheter foley. During an observation on 11/18/24 at 10:02 AM Resident #2 was lying in bed and their urinary catheter tubing was on the floor. During an observation on 11/19/24 11:04 AM Resident #2's urinary catheter bag was hanging beneath their wheelchair and the urinary tubing was on the floor. During an observation on 11/20/24 at 9:16 AM, outside Resident #2's room an enhanced barrier precautions sign was posted. Certified Nurse Aide #13 and Certified Nurse Aide #14 prepared Resident #2 for a transfer by attaching a sling to the mechanical lift while the resident was sitting on the side of their bed. They transferred Resident #2 using the mechanical lift from the bed side to a recliner chair next to the bed. Certified Nurse Aide #14 held onto Resident #2's urinary catheter bag with their gloved hand during the transfer and placed it into the black privacy bag attached to the side of the recliner. Neither Certified Nurse Aide had on an protective gown. Review of the Enhanced Barrier Precautions sign posted outside Resident #2's Room documented providers and staff must wear gloves and a gown for the following high contact resident care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs, or assisting with toileting; Device care or use: central line, urinary catheter, feeding tube, tracheostomy; Wound care: any skin opening requiring a dressing. During an interview on 11/20/24 at 9:19 AM, Certified Nurse Aide #13 stated they were aware Resident #2 was on enhanced barrier precautions because of their urinary catheter and there was a sign posted outside the resident's door. Certified Nurse Aide #13 stated there would be a blue diamond next to the resident's name that was on enhanced barrier precautions, and Resident #2 had a blue diamond next to their name. Certified Nurse Aide #13 stated they were not wearing the personal protective equipment while providing care to Resident #2 and they should have. They stated without wearing it, there was a possibility to spread infection or cause cross contamination. Certified Nurse Aide #13 stated they were responsible to ensure they wear personal protective equipment when necessary. Certified Nurse Aide #13 stated they were training Certified Nurse Aide #14. During an interview on 11/20/24 at 9:22 AM, Certified Nurse Aide #14 stated they saw the sign posted outside of Resident #2's door and understood they were on enhanced barrier precautions. Certified Nurse Aide #14 stated they should have had more personal protective equipment (gown) on while providing hands on care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335577	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elderwood at Lancaster	1818 Como Park Blvd Lancaster, NY 14086

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/20/24 at 9:23 AM, Registered Nurse Unit Manager #1 stated there would be a blue diamond next to the resident's name, a sign posted outside of the door, and they would have an order in the computer indicating they are on enhanced barrier precautions. Registered Nurse Unit Manager #1 stated staff were supposed to wear gloves and a gown when providing any sort of hands-on care to a resident that was on enhanced barrier precautions. They stated they would have expected Certified Nurse Aides #13 and #14 to have been wearing gowns and gloves when providing care to Resident #2, especially if they were touching their urinary catheter. Registered Nurse Unit Manager #1 stated wearing personal protective equipment is important to stop the spread of infection. During an observation on 11/22/24 at 7:26 AM, Certified Nurse Aide #15 and Certified Nurse Aide #11 washed their hands, applied personal protective equipment (gloves, a gown, and a face shield) prior to providing urinary catheter care for Resident #2. After completing peri care/foley care and without changing their gloves: Certified Nurse Aide #15 proceeded to put on a clean brief and dress the resident, touched the resident's oxygen tubing, transferred the resident via mechanical lift, retrieved a comb from the dresser and combed the resident's hair, and handed the resident a tissue, re-positioned the resident's wheelchair and moved the tray table closer to the resident. Resident #2's catheter bag was hung on their wheelchair and the tubing was directly on the floor. During an interview on 11/22/24 at 8:04 AM, Certified Nurse Aide #15 stated they should have changed their gloves after providing urinary catheter care, peri care and prior to getting the resident groomed and dressed, touching the mechanical lift, tissues, tray table and oxygen tubing. They stated it was important to change gloves after perineal care and apply clean gloves to ensure there was no cross contamination. During an observation on 11/22/24 at 8:45 AM, Resident #2 was being wheeled down the hall in their wheelchair, leaving out on pass with a family member for an appointment, and the urinary catheter tubing was dragging on the floor. During an interview on 11/22/24 at 11:22 AM, the Clinical Educator/Infection Control Nurse stated if the tubing was on the floor the Certified Nurse Aide should replace the bag with a new one. During an interview on 11/22/24 1:17 PM, Assistant Director of Nursing in the presence of Director of Nurses #1 stated Certified Nursing Aide #15 should have removed their gloves, washed their hands, and put on new gloves, before touching any surface areas for infection control purposes. The tubing should not have dragged on the floor because the floor was filthy, and this was not good infection control measures. During an interview on 11/22/24 at 1:17 PM, Director of Nursing #1 stated staff where to wear personal protective equipment during daily catheter care because Resident #2 had an indwelling urinary catheter and was on enhanced barrier precautions. They stated that Certified Nursing Aide #15 should have removed their soiled gloves and washed their hands after performing peri care and prior to touching anything else including high contact surfaces. They stated urinary catheter tubing should never touch the floor if it did the catheter bag should have been replaced with a new one. They stated staff should take all measures to decrease that risk. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335577	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elderwood at Lancaster	1818 Como Park Blvd Lancaster, NY 14086

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #11 had diagnoses that included chronic obstructive pulmonary disease (COPD), embolism and thrombosis of iliac artery (blood clots form in the iliac artery in the pelvis), and peripheral vascular angioplasty status with implants and grafts (invasive intervention to expand a narrowing of an artery with placement of a stent) The Minimum Data Set, dated dated dated [DATE] documented Resident #11 was cognitively intact. The Minimum Data Set documented Resident #11 had two venous and arterial ulcers. The Visual/Bedside Kardex Report dated 11/22/24 documented Resident #11 required enhanced barrier precautions to be in place. The comprehensive care plan dated 10/30/24 and revised on 11/08/24 documented Resident #11 was at risk for infections related to wounds with an intervention to have enhanced barrier precautions in place and to monitor for signs and symptoms of infection. Additionally, the comprehensive care plan documented Resident #11 had an alteration in skin integrity related to right heel ulcer and right great toe ulcer with an intervention to apply treatment per physician's orders. The Order Summary Report, dated 11/22/24, documented an active order (initiated 11/08/24) to implement and maintain enhanced barrier precautions related to right heel ulcer. During an observation on 11/19/24 at 10:00 AM, there was no enhanced barrier precaution signage outside of Resident #11's room, there was no blue diamond next to Resident #11's name, and no personal protective equipment outside or inside of their room. During an observation on 11/20/24 at 9:55 AM, there was no enhanced barrier precaution signage outside of Resident #11's room, no blue diamond next to Resident #11's name, and no personal protective equipment outside or inside of their room. During an interview and observation on 11/20/24 at 9:56 AM, Registered Nurse Unit Manager #1 stated Resident #11 had a chronic wound to their heal and required enhanced barrier precautions. Registered Nurse Unit Manager #1 walked down to Resident #11's room and stated there was no sign posted outside of the room to indicate they were on enhanced barrier precautions and there should be. Also they should have the blue diamond by their name plate. Registered Nurse Unit Manager #1 stated important to wear PPE to prevent the spread of infection from one patient to another Additionally, Registered Nurse Unit Manager #1 stated they were responsible for ensuring enhanced barrier precautions were in place for Resident #11. (continued on next page)

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	335577	A. Building B. Wing	11/22/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/20/24 at 1:10 PM, Director of Nursing #1 stated enhanced barrier precautions were put in place for residents who had open wounds and urinary catheters. Implementation would be started based on diagnosis; a blue diamond would be placed next to the resident's name and a sign near their door indicating they're on enhanced barrier precautions. Personal Protective equipment would be placed in the resident's room. Director of Nursing #1 stated any staff member providing hands on care or in close proximity of the resident should be wearing personal protective equipment (gowns, gloves, masks). They stated enhanced barrier precautions were in place for residents to help prevent the spread of infection, protect the patient, and protect other residents and staff. Director of Nursing #1 stated Resident #11 had a chronic heal wound and was immunocompromised. They stated Resident #11 required enhanced barrier precautions; there should be personal protective equipment in their room, and staff should be wearing it when providing care. Director of Nursing #1 stated Resident #2 required enhanced barrier precautions because they have a urinary catheter and staff should have been wearing personal protective equipment when providing care to them. Additionally, they stated all nurses were responsible for ensuring staff were wearing personal protective equipment when necessary. Director of Nursing #1 stated the blue diamond system was it was implemented by the previous Director of Nursing. During an interview on 11/22/24 at 8:55 AM, the Clinical Educator/Infection Preventionist stated they expected staff to wear all appropriate personal protective equipment when providing hands on care to residents on enhanced barrier precautions. They stated staff must wear gowns and gloves when providing any sort of care that involves direct patient contact. The Clinical Educator/Infection Preventionist stated Resident #11 should have enhanced barrier precautions in place, including signage posted outside their door. They stated staff should have been wearing gowns and gloves when providing care to Resident #2. NYCRR 415.19 (b)(1)