STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335638	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buffalo Center for Rehabilitation and Nursing	1014 Delaware Ave Buffalo, NY 14209

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 36415 Based on interview and record review conducted during a Standard survey completed on 5/7/24, the facility did not ensure residents received treatment and care in accordance with professional standards of practice for one (Resident #63) of three residents reviewed for infection. Specifically, Resident #63 did not have weekly blood tests completed as recommended per the hospital discharge summary and the facility Medical Director. In addition, there was no care plan developed for the use of an intravenous midline catheter (tubing that is inserted into a vein for the delivery of medications and/or fluids). The findings are: The policy and procedure titled Physician Consultations dated 8/19 documented as appropriate, the attending physician would approve orders based on consultant recommendations and the attending physician would be responsible for following up on the effects of recommended medications and treatments. The policy and procedure titled Care Plans-Comprehensive with revised dated 10/19, documented the comprehensive person-centered care plan would include measurable objectives and time frames; describe services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; incorporate identified problem areas and risk factors; and reflect currently recognized standards of practice for problem areas and conditions. Resident #63 had diagnoses that included sepsis (infection in the blood), chronic pancreatitis (an inflammatory disorder of the pancreas) and dementia. The Minimum Data Set (a resident assessment tool) dated 4/2/24 documented the resident was understood, understands, and had severe cognitive impairment. The Minimum Data Set documented Resident #63 was administered intravenous medications during the assessment period. The Comprehensive Care Plan with date initiated 3/28/24, documented that Resident #63 had sepsis (a severe blood infection). Interventions included to administer medications and treatments as ordered, monitor for adverse reaction to medications, monitor for an increase in symptoms and obtain labs as ordered with results reported to the practitioner. The care plan did not include the use of an intravenous midline catheter. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335638	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/07/2024
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The hospital discharge summary dated 3/27/24 documented Resident #63 was to have weekly laboratory values obtained (CRP) c-reactive protein test and (ESR)erythrocyte sedimentation rate (blood tests that measure the amount of inflammation in the body)). The results were to be faxed to the infection control clinic at the hospital. The facility medical providers progress notes documented the following: 3/28/24 at 9:19 AM, The Medical Director documented that Resident #63 was to have a weekly c-reactive protein test and erythrocyte sedimentation rate obtained and the results were to be faxed to the infectious disease clinic. 4/1/24 at 6:08 PM and 4/5/24 at 7:37 PM, Physician Assistant #1 documented that Resident #63 was to have a weekly c-reactive protein test and erythrocyte sedimentation rate obtained. 4/11/24 at 2:31 PM, The Medical Director documented that they were awaiting labs for Resident #63 and that a weekly c-reactive protein test and erythrocyte sedimentation rate would need to be faxed to the infectious disease clinic. 4/18/24 at 5:49 PM, The Medical Director documented that Resident #63 needed inflammatory markers drawn on a weekly basis and was unclear if they had been drawn recently. It was further documented that a weekly c-reactive protein test and erythrocyte sedimentation rate would need to be faxed to the infectious disease clinic. Review of the order recap report dated 3/27/24-5/31/24, revealed Resident #63 had an order on 3/27/24 for Meropenem (a broad-spectrum antibiotic medication) Intravenous (IV) solution, 1 gram mixed with 100 milliliters of normal saline, to be administered intravenously three times a day for 56 days. There were no orders to obtain the weekly c-reactive protein test and erythrocyte sedimentation rate as recommended and per the Medical Director until 5/5/24. Review of Resident #63's laboratory results from 3/27/24-5/4/24 revealed there was no documented evidence that a c-reactive protein test and erythrocyte sedimentation rate was obtained weekly. During an interview and record review on 5/7/24 at 8:37 AM, Unit Clerk #1 stated they were responsible for filing out the laboratory sheets for the residents that were new admissions and who had weekly blood draws. Unit Clerk #1 stated Licensed Practical Nurse #2 would notify them which residents were to have weekly blood draws. Unit Clerk #1 stated that they were never told that Resident #63 was to have a weekly c-reactive protein test and erythrocyte sedimentation rate. Review of untitled documents that Unit Clerk #1 identified as their weekly laboratory blood draw logs dated 3/29/24, 4/5/24, 4/22/24, 4/26/24 revealed Resident #63 was handwritten on the logs to have a complete blood count and basic metabolic panel. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/7/24 at 9:07 AM, the Medical Director stated the unit manager or nurse doing the admission orders was to transcribe recommended laboratory orders that were on a discharge summary into the electronic medical record and then they would sign off the orders. The Medical Director stated their expectation was that a nurse would have ordered the weekly c-reactive protein test and erythrocyte sedimentation rate and sent the results to the infectious disease clinic as recommended on the hospital discharge summary. The Medical Director stated they documented in their progress notes the resident was to have the weekly blood tests and the results were to be sent to the infectious disease clinic. The Medical Director stated that they could not be positive if they ever gave a verbal order for Resident #63 to have the weekly blood work completed. The Medical Director stated the reason for Resident #63 was to have an erythrocyte sedimentation rate and c-reactive protein test weekly was because the laboratory test was a nonspecific inflammatory blood test, and the Infectious Disease Doctor requested it. During an interview on 5/7/24 at 9:18 AM, Licensed Practical Nurse #2 stated they had entered Resident #63 admission orders into the electronic medical record and per the hospital discharge summary the resident should have had weekly erythrocyte sedimentation rates and c-reactive protein blood tests obtained. Licensed Practical Nurse #2 stated that the Medical Director may have mentioned it but could not recall. Licensed Practical Nurse #2 stated on 5/5/24 they realized they had erroneously omitted the blood work recommendation and contacted Physician Assistant #2. Licensed Practical Nurse #2 stated they were responsible for updating a resident's care plan and Resident #63 did not have an intravenous catheter care plan in place and should have. During an interview on 5/7/24 at 12:26 PM, the Director of Nursing stated they expected all recommendations on a resident's hospital discharge summary to be carried out unless the primary Medical Doctor disagrees. The Director of Nursing stated they could not locate any erythrocyte sedimentation rates (ESR) and c-reactive protein (CRP) blood test results for Resident #63. The Director of Nursing stated there should have been a care plan developed for the resident's intravenous catheter. 10 NYCRR 415.20

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36415 Based on observation, interview, and record review conducted during the Standard survey completed on 5/7/24, the facility did not ensure that the residents' environment remained as free from accident hazards as possible. Specifically, four (First Floor, Second Floor, Third Floor, Fourth Floor) of four resident use floors had issues with water temperatures that exceeded 120 degrees Fahrenheit. The findings are: The undated policy and procedure titled Hot Water Temperature Policy documented that hot water temperature was maintained between 105 and 120 degrees Fahrenheit. Water temperatures were regularly monitored and tested at various points of use in resident care areas and records were maintained. If water temperatures deviated from recommended ranges, immediate corrective actions were taken. Facilities Management or designated personnel should address issues promptly. During observations on 5/6/24 between 11:30 AM and 11:54 AM, the following hot water temperatures were obtained using digital stem-type thermometers: First Floor: Sink in Main Lobby Public Bathroom - 126.6 degrees Fahrenheit. Second Floor: Resident room [ROOM NUMBER] - 134.5 degrees Fahrenheit Resident room [ROOM NUMBER] - 134.6 degrees Fahrenheit Resident room [ROOM NUMBER] - 130.0 degrees Fahrenheit Resident room [ROOM NUMBER] - 134.4 degrees Fahrenheit Resident room [ROOM NUMBER] - 135.7 degrees Fahrenheit Resident room [ROOM NUMBER] - 131.7 degrees Fahrenheit Third Floor: Sink in 3D Shower Room - 132.0 degrees Fahrenheit. Shower head 3B Shower Room - 129.0 degrees Fahrenheit Shower head 3C Shower Room - 128.0 degrees Fahrenheit Resident room [ROOM NUMBER] - 134.6 degrees Fahrenheit (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident room [ROOM NUMBER] - 133.9 degrees Fahrenheit Resident room [ROOM NUMBER] - 134.1 degrees Fahrenheit Resident room [ROOM NUMBER] - 129.0 degrees Fahrenheit Resident room [ROOM NUMBER] - 134.3 degrees Fahrenheit Resident room [ROOM NUMBER] - 129.0 degrees Fahrenheit Resident room [ROOM NUMBER] - 133.6 degrees Fahrenheit Fourth Floor: Resident room [ROOM NUMBER] - 133.4 degrees Fahrenheit Resident room [ROOM NUMBER] - 135.0 degrees Fahrenheit Resident room [ROOM NUMBER] - 132.8 degrees Fahrenheit Resident room [ROOM NUMBER] - 132.5 degrees Fahrenheit Resident room [ROOM NUMBER] - 134.0 degrees Fahrenheit Resident room [ROOM NUMBER] - 134.0 degrees Fahrenheit During an interview on 5/6/24 at 11:40 AM, Resident #456's family member stated the water from the bathroom faucet felt hot. and needed to add cold water to adjust the temperature. During an interview on 5/6/24 at 11:43 AM, Resident #351 stated the water was too hot. and they had to add cold water to adjust the water temperature from being too hot. During an interview on 5/6/24 at 11:50 AM, Resident #99 stated they noticed the hot water was hotter than usual starting last night (5/5/24) and added cold water to adjust the temperature. During an interview on 5/6/24 at 11:58 AM, Resident #97 stated, You couldn't even touch the water the past few days, it would get so hot. Resident #97 stated the aides did not give showers due to the temperature of the hot water. During observations on 5/6/24 at 12:15 PM, hot water temperatures were obtained in the presence of the Maintenance Director, using the Surveyor's digital stem-type thermometer and the facility's infrared thermometer. To obtain the temperatures, the Surveyor's thermometer stem was placed in the hot water stream and the facility's infrared thermometer was pointed at the bottom of the sink with the hot water running. In the bathroom sink of Resident room [ROOM NUMBER], the digital stem-type thermometer read 132.6 degrees Fahrenheit, and the infrared thermometer read 132.0 degrees Fahrenheit. In the bathroom sink of Resident room [ROOM NUMBER], the digital stem-type thermometer read 132.0 degrees Fahrenheit, and the infrared thermometer read 130.8 degrees Fahrenheit. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/6/24 at 12:15 PM at the time of the observation, the Maintenance Director stated hot water should be between 110 and 115 degrees Fahrenheit and the water temperatures obtained from Resident rooms [ROOM NUMBERS] were too hot. They further stated about ten days ago, the facility replaced a pump, which improved the circulation of hot water, and they had been playing with the hot water system's thermostat since then. The Maintenance Director stated they usually checked the facility's hot water system thermostat and hot water holding tank first thing in the morning, and this morning around 8:00 AM. The thermometer on the hot water holding tank read 110 degrees Fahrenheit, which they thought was low, and they raised the thermostat. During an observation and interview inside the Boiler Room on 5/6/24 at 12:25 PM revealed the hot water system thermostat was set for 122 degrees Fahrenheit and the thermometer on the hot water holding tank read 132 degrees Fahrenheit. The Maintenance Director stated the facility had one single hot water system with no mixing valve. The Director stated they personally recorded the temperature of the hot water holding tank every day that they worked, and the last time they did it was on 4/30/24. The Maintenance Director stated they personally recorded temperatures of hot water at various points throughout the facility and the last time they did was on 4/29/24, which was the day the pump was replaced. The Maintenance Director stated they were out of town starting on 5/1/24 and did not think any of the Maintenance department staff would've checked hot water temperatures while they were out, and they had no documentation of any hot water temperatures recorded between 4/30/24 and present. During an interview on 5/6/24 at 1:14 PM, the Maintenance Director stated the hot water system consisted of two boilers that supplied water to the hot water holding tank and the pump heated the water between the boilers and the holding tank. If the water was too hot, lowering the thermostat would cut off heat to the water, but would not be able to add cold water into the tank. They further stated the thermometer they used to take hot water temperatures was the infrared thermometer, which was new about two months ago and had not been calibrated. At 2:40 PM, the Maintenance Director stated no one from the Maintenance department worked on the weekends and they were not contacted about any hot water concerns while they were out of town. During an interview on 5/6/24 at 12:45 PM, the Assistant Maintenance Director and the Maintenance Technician stated they did not take any hot water temperatures in the facility, and they did not touch the hot water system's thermostat. At this time, the Assistant Maintenance Director stated if the Maintenance Director was out of the building and someone had an issue with hot water, they would call an outside vendor for repairs and not attempt repairs by themselves. During an interview on 5/6/24 at 12:54 PM, Housekeeper #1 stated they noticed the water was hotter than usual today and they did not notify anyone. During an interview on 5/6/24 at 12:59 PM, Certified Nurse Aide #2 stated the hot water was hotter than usual today and they had to adjust the water temperature by adding more cold water. During an interview on 5/6/24 at 12:59 PM, Certified Nurse Aide #3 stated the hot water was hotter than usual today and they were still able to shower their residents by adjusting the temperature. During an interview on 5/6/24 at 1:02 PM, Certified Nurse Aide #1 stated the water was steaming hot last week and they notified Maintenance right away. They also stated that if the water was really hot, they would notify their manager or Maintenance right away. They stated they would mix it with cold water so a resident would not get scalded by hot water. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/6/24 at 1:04 PM, Licensed Practical Nurse Unit Manager #1 stated there was a group chat that indicated there was hot water temperatures in the building. They stated that they expected staff to report any hot water temperatures to themselves, the Administrator, and Maintenance right away. They also stated that they expect their staff not to use showers if the water was too hot, to mix the hot water with cold water, or to use wipes to clean residents instead of very hot water. During interview on 5/6/24 at 1:08 PM, Certified Nursing Assistant #3 stated they first noticed the hot water was hotter than usual and added cold water during the night shift from 5/5/24 - 5/6/24. During an interview on 5/6/24 at 1:12 PM, Licensed Practical Nurse #9 stated they noticed the hot water was too hot when they washed their hands at lunch time today (5/6/24). and they added cold water to adjust the temperature. Review of the maintenance log titled Facility Maintenance Daily AM Rounds revealed hot water temperatures were recorded each weekday from the two boilers and the hot water holding tank. Additionally, hot water temperatures were recorded from six resident rooms on most weekdays. The most recent entry was dated 4/30/24 and documented the hot water holding tank was at 120 degrees Fahrenheit. The most recent entry that included hot water temperatures inside resident rooms was dated 4/29/24 and it documented the hot water holding tank was at 90 degrees and the hot water in the resident rooms ranged from 72 to 81 degrees Fahrenheit. During an interview on 5/7/24 at 2:00 PM, the Administrator stated the expectation was that Maintenance department staff should check hot water temperatures daily if the Maintenance Director was not here. 10 NYCRR 415.12 (h)(1)

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F 0755

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.

36415

Based on observation, interview and record review conducted during the Standard survey completed on 5/7/24, the facility did not obtain the services of a licensed pharmacist that was involved with all aspects of the provision of pharmacy services in the facility; the facility did not establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; did not determine that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled for one (discontinued narcotic storage closet) of three medication storage rooms and five (second floor A and B wings, third floor A and B wings, and fourth floor C wing) of eight narcotic reconciliation books reviewed. Specifically, the discontinued narcotic storage closet located in the Assistant Director of Nursing office did not have accountability records for narcotics awaiting destruction. Additionally, the narcotic reconciliation drug records on the second floor A and B wings, third floor A and B wings, and the fourth floor C wing shift to shift counts were not consistently signed off as completed. Furthermore, the Pharmacist Consultant stated they were not involved with the controlled substance processes in the facility.

The finding is:

1.The policy and procedure titled Narcotic Destruction, revised 3/20 documented that the keys to the narcotic destruction cabinet would be held by two people and when they became aware of a medication being discontinued, they were both to go together to the unit and receive the discontinued medication from the responsible nurse on the unit. The key holders would both verify the count of the discontinued narcotic, sign the page, along with the responsible nurse, in the bound book that the medication had been removed from. The policy and procedure documented that the appropriate page from the book was to be copied, the two key holders would take the medication and together lock it up in the narcotic boxes for destruction. The policy and procedure documented that the copy of the narcotic book would be stored in a separate place from the narcotic cabinet. The policy and procedure documented that when the list was compiled to be submitted to the Bureau of Narcotic Enforcement for destruction, both key holders would complete the list together. The pages that correspond to each medication must be matched to the narcotics for destruction to help ensure that all the medications are accounted for.

During an observation on 5/2/24 at 4:01 PM, in the presence of the Director of Nursing and the Assistant Director of Nursing, the discontinued narcotic medications were observed to be stored in the Assistant Director of Nursing's office closet. The closet door contained a double lock and upon opening there was noted to be an excessive number of narcotics stored. The following was observed inside the discontinued closet:

- a locked safe approximately 4 feet by 3 feet with three shelves of narcotic blister packs (carded plastic packaging used to dispense individual doses of medication). There was a stack of individual narcotic count sheets along with some narcotic count sheets wrapped around the blister packs.

-four cardboard medical supply boxes on top of the safe filled with liquid narcotics. Three of the boxes contained an account log that matched the narcotics in the box and one box had a log form that did not match the narcotics in the box.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-One green colored bag filled with narcotic blister packs. There was no account log for the narcotics in the bag. -Eight banker sized boxes (heavy duty cardboard boxes the height and width of a file folder and approximately 24 inches long) filled with narcotics with no account log for what was in the boxes. -Stacks of narcotics in rubber bands on top of a metal filing cabinet that did not contain an account log. -A few random blister packs on the floor of the closet. During an interview at the time of observation on 5/2/24 at 4:01 PM, the Assistant Director of Nursing stated they started working at the facility in October of 2023. The Assistant Director of Nursing stated they had accepted the keys for the discontinued narcotic closet from the Director of Nursing and they were the only key holder. The Assistant Director of Nursing stated at that time of the key exchange they could not account for what was in the destruction closet. The Assistant Director of Nursing stated that the closet was full upon key exchange, and they continued to collect discontinued narcotics so that they did not pile up on the units. The Assistant Director of Nursing stated that the process they used for picking up discontinued narcotics was the unit nurse would bring down the narcotic to their office along with the narcotic reconciliation medication book. Both would verify the count, stamp the reconciliation sheet closed and sign and date the reconciliation sheet. The Assistant Director of Nursing stated they then placed the narcotic into the closet. The Assistant Director of Nursing stated that they did not copy any narcotic count sheets nor fill out a log when the narcotic was placed into the closet. During an interview at the time of observation on 5/2/24 at 4:01 PM, the Director of Nursing stated they received the discontinued narcotic keys from the Former Director of Nursing in April 2022 and that the discontinued narcotic closet was full of narcotics. The Director of Nursing stated there was no accountability for the narcotics that were in the closet at the time of the key exchange from the Former Director of Nursing. The Director of Nursing stated that they had performed one destruction since receiving the keys and emptied about 75% of the narcotics in the closet at that time. The Director of Nursing stated presently, there were narcotics that remained in the safe that were discontinued in 2021. The Director of Nursing stated that the facility started using the bonded narcotic reconciliation book in April of 2022 and prior to that there was no accountability for what was in the narcotic closet. They stated the process they used prior to the bonded narcotic reconciliation books was they would wrap the reconciliation sheet around the narcotic and then place it in the discontinued narcotic cabinet closet but did not have any accountability log for those narcotics. The Director of Nursing stated the purpose of keeping a log was it would help identify if narcotic diversion took place. The Director of Nursing reviewed the facility policy and procedure and stated they were not following the steps outlined in the policy and if they did follow the policy there would be accountability for the discontinued narcotics. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on 5/3/24 at 8:41 AM, the Former Director of Nursing stated that they would use the safe in the Assistant Director of Nursing office to store discontinued narcotics. They stated once the safe started to get filled and then had a double lock placed onto the closet door and then started to store the discontinued narcotics in boxes. The Former Director of Nursing stated the process they used to collect discontinued narcotics was that themselves along with another registered nurse reconciled the narcotic along with the count sheet, put it into the narcotic closet along with the reconciliation sheet and then log the narcotic on the Department of Health log sheets. The Former Director of Nursing stated the log forms were stored in a binder that was either in the Director of Nursing's office or Assistant Director of Nursing's office. The Former Director of Nursing stated they stopped working in the facility around March of 2022 and showed the current Director of Nursing where everything was. During a telephone interview on 5/3/24 at 3:53 PM, the Regional Director of Clinical Services from the facility's dispensing pharmacy, stated neither they or the pharmacy were involved with the facility's controlled substance destruction process, or the narcotic processes and that the facility's pharmacy consultant should be checking their processes frequently. Facility staff should be following their corporate policies. During a telephone interview on 5/3/24 at 4:07 PM, the Pharmacist Consultant stated that that they did not participate in the review or development of the narcotic storage or narcotic destruction policy at the facility. The Pharmacist Consultant stated that they have never observed the discontinued narcotic closet, the unit medication carts nor the narcotic cabinets on the units. The Pharmacist Consultant stated that there should be an inventory log for what was stored in the narcotic cabinets for accountability. 2. The policy and procedure titled Narcotic Count dated 8/18 documented that to ensure controlled substances are properly accounted for the on-coming and the off-going nurses assigned to the medication cart would be responsible for ensuring the accuracy of the controlled drug count. The two nurses would look at each medication, verify the number of the medication matches the number on the declining inventory on each identified page. The policy and procedure documented that once the nurse has accepted the count, signed off on the controlled medication count acknowledgement page in the back of the book and accepts the keys it is then the nurse's responsibility if the count was not correct at the next shift change. The policy and procedure documented in the event of a need to change the nurse assigned to the narcotic during times other than at routine shift change, two nurses will count using the above process. During an observation and interview with Licensed Practical Nurse #11 on 5/3/24 at 12:59 PM, the Third Floor B Wing narcotics reconciliation book Shift Count sheet revealed the 4/30/24 count at 3:00 PM going off duty was the last signature, identified as Licensed Practical Nurse #10. Licensed Practical Nurse #11 stated they counted the controlled substance medications for B Wing that morning (5/3/24) with the night shift nurse (Licensed Practical Nurse #10) at 7:15 AM and neither nurse signed the Shift Count sheet. Licensed Practical Nurse #11 stated each time the controlled substance control keys were exchanged between nurses the controlled medications should be counted and the Shift Count sheet should be signed by the nurse taking responsibility of the medications in the coming on duty column and the nurse going off duty should sign indicating they were no longer responsible for the controlled substances. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335638	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/07/2024
NAME OF PROVIDER OR SUPPLIER: Buffalo Center for Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE: 1014 Delaware Ave Buffalo, NY 14209	

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview with Licensed Practical Nurse #12 on 5/3/24 at 1:31 PM, the Third Floor A Wing narcotics reconciliation book Shift Count sheet revealed multiple sporadic blanks for coming on duty and going off duty. Licensed Practical Nurse #12 stated they did not know why the other nurses were not signing the Shift Count sheet and they should be. They stated the purpose of the Shift Count sheet was to indicate who was responsible for the controlled medications for accountability and there should not be any blanks for past dates. They stated they had not reported the blanks to their Unit Manager, Assistant Director of Nursing or Director of Nursing and they should have. During an observation and interview on 5/3/24 at 2:06 PM, the Second Floor B wing narcotics reconciliation book had one blank space on the shift count sheet for the AM shift on 5/3/24. Licensed Practical Nurse #4 stated that the previous nurse must have left without signing. They stated they counted the narcotics that morning, but both forgot to sign the book. Licensed Practical Nurse #4 stated that the count should be done every shift and the book should have been signed. They stated that it was important to keep track of the narcotics between shifts in case something went missing, so they would know which person had the keys at the time the medication went missing. During an observation and interview on 5/3/24 at 2:06 PM, the Second Floor A wing shift count sheet was not signed in or signed out for the 7:00 AM-3:00 PM shift for 5/3/24. Licensed Practical Nurse #5 stated that at times they didn't sign the shift count sheet because they got interrupted, distracted, or were rushing. Licensed Practical Nurse #5 stated that they never left their shift without counting and if the oncoming nurse was not available, they would count with the supervisor. They stated the purpose of signing the shift count sheet was that they were accepting responsibility for the medications and everything that was in the cabinet. Review of the Shift Count (Narcotic Count Reconciliation Records) from 4/22/24-5/3/24, revealed the following lacked documented evidence that narcotic reconciliation was completed by the oncoming and outgoing nurses: -Second Floor A wing cart had 21 shifts -Second Floor B wing cart had 9 shifts -Third Floor A wing cart had 26 shifts -Third Floor B wing cart had 49 shifts -Fourth Floor C wing cart had 23 shifts During an interview on 5/6/24 at 7:50 AM Licensed Practical Nurse #10 stated they don't always sign the shift count sheet because they were busy, and they should always sign in the appropriate column to indicate if they were coming on duty or going off duty to indicate accountability for the controlled substances. Licensed Practical Nurse #10 stated they were not aware the last signature on the shift count sheet for Third Floor B wing book was theirs and dated 4/30/24. They stated the shift count sheet was to be signed each time the controlled substance keys were exchanged between nurses to indicate the controlled substance count was accurate and who was responsible for the controlled substances for that date/shift. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/7/24 at 7:22 AM, Licensed Practical Nurse #13 stated they often do not sign the shift count sheet because they were too busy. They stated the shift count sheet should be signed each time they counted the controlled medications with the other nurse upon coming on duty and going off duty to indicate the controlled substance count was accurate and who was responsible for the controlled substances for that date/shift. During a telephone interview on 5/7/24 at 8:18 AM, Licensed Practical Nurse #7 stated that at times they've had to do narcotic count by themselves because the off going nurse left their shift and the narcotic cabinet keys were left in the reconciliation book. Licensed Practical Nurse #7 stated that they have never left their shift without counting out the narcotics. Licensed Practical Nurse #7 stated they were usually pretty good at signing in/out for the narcotics but at times may have forgotten. Licensed Practical Nurse #7 stated by signing in/out of the shift count log they were taking responsibility for the narcotics and an accurate account for them. During an interview on 5/7/24 at 9:02 AM, Licensed Practical Nurse #2 (unit manager of the second floor) stated that the oncoming and off going nurses should be doing medication reconciliation narcotic count at shift change and signing at the back of the narcotic book for accountability. Licensed Practical Nurse #2 stated after it was brought to the facility's attention the process of signing for shift-to-shift narcotic count not always being completed they usually tried to do audits of the narcotic reconciliation book for signatures, but they must have missed them. Licensed Practical Nurse #2 stated that there were times they've had to count with a nurse when they were leaving their shift prior to the oncoming nurse arriving at the building and sometimes they signed the shift count log but sometimes they got side-tracked and did not. Licensed Practical Nurse #8 stated that the importance of signing the shift count log was it verified the narcotic count was accurate and all accounted for. During a telephone interview on 5/7/24 at 9:49 AM, Licensed Practical Nurse #8 stated that the process for narcotic key exchange was the outgoing nurse, and the oncoming nurse reconciled the narcotics along with the narcotic logbook at the change of shift. Licensed Practical Nurse #8 stated that at times they had the narcotic cabinet keys left for them in the narcotic reconciliation book and then they would make a nursing supervisor count with them. Licensed Practical Nurse #8 stated if they did not have a nurse replacement when they needed to leave the building, they would have the nursing supervisor count with them. During an interview on 5/7/24 at 11:45 AM, the Regional Director of Clinical Services stated the process for collecting discontinued medications would be that either the Director of Nursing or the Assistant Director of Nursing would along with another nurse verify the count of the narcotic, place them into the discontinued closet and log then on the Bureau of Narcotic Enforcement log. They stated then the log was to be kept in a binder. The Regional Director of Clinical Services stated they were unable to locate the binder from the Former Director of Nursing to account for the narcotics that remained in the discontinued closet and therefore they could not ensure that diversion of narcotics did not take place. The Regional Director of Clinical Services stated the process for narcotic cabinet key exchange on the units would be that the oncoming nurse, along with the off going nurse counted the narcotics, ensured that the count was correct and signed the shift count log. They stated the purpose of signing count sheet logs was the key holder was ensuring the narcotic count was correct and that the last nurse to sign the book was responsible for all of the narcotics in the cabinet. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on 5/7/24 at 12:15 PM, the Pharmacist Consultant stated the purpose of the key exchange process was that the oncoming nurse and the off going nurse verified the narcotic count was reconciled. The Pharmacist Consultant stated they were unsure if a signature was needed at the time of key exchange, but some type of documentation of inventory was needed from one staff member to the other. The Pharmacist Consultant added they do not oversee the narcotic processes in the building. During further interview on 5/7/24 at 12:35 PM, the Director of Nursing stated that they were unable to locate any discontinued narcotic logs or a binder from the Former Director of Nursing. The Director of Nursing stated that when they took responsibility for the discontinued narcotic cabinet, they started some logs for the discontinued narcotics and then failed to follow through with the logging process. The Director of Nursing stated that the purpose of maintaining a log for the discontinued narcotics was to be able to identify what is in the cabinet and to also identify if narcotic diversion could have occurred. The Director of Nursing stated their expectation for narcotic cabinet key exchange on the units was that the oncoming nurse needs to perform a narcotic reconciliation with the outgoing nurse, and they exchanged the keys. The Director of Nursing stated that when a nurse must leave their shift early or leave the building then the unit manager or the nursing supervisor were expected receive the keys and ensure the count was correct. The Director of Nursing stated that with key exchange the shift count sheets needed to be signed by each nurse for narcotic accountability. The Director of Nursing stated they were unaware of any incidence where narcotic keys were left by any off going nurse. During an interview on 5/7/24 at 12:43 PM, the Administrator stated that they expected the Pharmacist Consultant to review the narcotic policies as they are part of the Quality Assurance and Performance Improvement Committee. The Administrator stated they expected that the narcotics were reconciled and signed for at key exchange. The Administrator stated they expected all staff to follow the policy and procedures for narcotics to ensure that all narcotics were kept safe and were there when they are needed for the resident. They expected the management team would oversee that the policies were being followed by staff. 10 NYCRR 415.18(a)(b)(1)(2)(3)