STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335640	A. Building B. Wing	08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grand Rehabilitation & Nursing at Delaware Par	1205 Delaware Avenue 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 22485 Based on observation, interview, and record review conducted during Complaint investigations (#NY00336247 and #NY00319578) during a Standard survey completed on 8/9/24 the facility did not ensure that housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior were provided for one (Unit 3) of two resident units. Specifically, the facility roof was in disrepair and actively leaking resulting in stained and wet ceiling tiles. Additionally, there were walls and floors in disrepair, urine odors, a soiled privacy curtain and a broken window. The findings are: The policy and procedure titled Maintenance Service dated 1/24 documented that maintenance service shall be provided to all areas of the building, grounds, and equipment. a. Observation on the Third Floor on 8/5/24 at 6:40 PM revealed the walls of the shower stall in the [NAME] Shower Room were in disrepair. Further observation revealed the bottom of the plastic shower surround panels were soft and speckled with a brownish-black substance. There was no caulk or sealant between the walls and the shower floor. During an interview on 8/6/24 at 8:55 AM, the Director of Maintenance stated the bottom of the shower stall was caulked about three months ago, and it needed to be scrubbed and caulked again. b. During observations on 8/6/24 between 8:00 AM to 12:35 PM on Unit 3: Resident room [ROOM NUMBER] - a two foot by two-foot ceiling tile brown, bowed, and wet. Resident room [ROOM NUMBER] - urine smell in the room. Resident room [ROOM NUMBER] - urine smell in the room. Resident room [ROOM NUMBER] - wall across from bathroom with molding was removed, multiple gouges in the walls exposing drywall, and a wallpaper border at the top of the walls torn and in disrepair. Nurses Station - strong urine odor. (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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident room [ROOM NUMBER] - water actively dripping into a garbage can below. Further observation revealed two ceiling tiles were saturated and bowed downward. At the time of the observation, Maintenance Assistant #1 removed the saturated ceiling tiles from the ceiling which easily fell apart. Additional observation revealed three floor tiles below this area in the corridor were curled up on the edges. Resident room [ROOM NUMBER] - the wall at the head of the bed had a large piece of fabricated white material approximately two feet by two feet screwed to the wall all the way around. The corner seam adjacent to the closet was in disrepair from floor to ceiling with cracked chipped drywall. The floors in the room were sticky throughout and the room had a urine odor. During an interview on 8/6/24 at 8:07 AM, Resident #47 stated that sometimes the staff would put a bucket underneath a leaking ceiling tile to catch the water. They also stated that the ceiling was still leaking, and they wish it would stop. During a telephone interview on 8/6/24 at 8:12 AM, Resident's #76's representative they stated that the hallways smell like urine and feces when they visit the facility. During an interview on 8/6/24 at 9:10 AM, the Director of Maintenance stated Maintenance staff patched the roof with a silicone product at the end of summer or beginning of fall in 2023. The Director of Maintenance stated the patch held until spring 2024. They further stated this area actively leaked when it rained. Additionally, they stated the floor tiles in the area had already been replaced, but new water damage had occurred. During an interview on 8/8/24 at 9:48 AM with Housekeeping Aide #1 stated that housekeeping was responsible for cleaning resident rooms. During an interview on 8/9/24 at 10:21 AM, Resident #51 stated that the hallways smell like urine. During an interview on 8/8/24 at 3:20 PM, the Director of Maintenance stated there was an active leak from the roof above Resident room [ROOM NUMBER]. They stated they were told the roof was patched four years ago in this area. The patch held until about two weeks ago when it began to leak again. The Director of Maintenance stated Maintenance staff were keeping an eye on the area and changed ceiling tiles every time they showed brown rings, which meant they were wet. They also stated if there was a hard rain, they would likely have to move the resident out of the room. The Director of Maintenance further stated they were waiting for corporate personnel to go ahead with one of the five contractor's estimates that they submitted, and in the meantime, they did not think adding another layer of silicone patch would be effective, as the whole roof needed to be re-surfaced. Review of the Maintenance Work Order dated 7/31/24, it documented a roof leak in Resident room [ROOM NUMBER]. Review of additional Maintenance Work Orders dated 8/5/24 and 8/6/24, it documented a roof leak in Resident room [ROOM NUMBER]. c. During observations and interviews on 8/7/24 between 9:00 AM and 2:00 PM on Unit 3 revealed the following: Shower Room - black spots and debris along the bottom of the wall where the floor molding was missing; and rust stain dripping from a shower grab bar with a brownish substance on the shower wall. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident room [ROOM NUMBER] - Privacy curtain with brownish tan debris splattered on it and a cracked window. The resident in the room at the time of the observation stated the privacy curtain was disgusting and the window was broken. Corridor outside of Resident room [ROOM NUMBER] - two ceiling tiles in the corridor outside of Resident room [ROOM NUMBER] had brown water stains that appeared to be fresh. During an interview on 8/7/24 at 12:35 PM, the Director of Maintenance stated the ceiling tiles outside of Resident room [ROOM NUMBER] had been replaced this morning (8/7). They also stated it hadn't rained in twelve hours, but water puddled in this area of the roof and some water was still leaking through after the rain ended. During an interview on 8/8/24 at 3:12 PM, the Director of Maintenance stated they were not aware of a cracked windowpane in Resident room [ROOM NUMBER]. d. During an interview on 8/5/24 at 7:07 PM, Resident #42 stated they were moved to another room when the ceiling tiles fell because of the leaking roof. During an observation on the Third Floor on 8/8/24 at 10:10 AM revealed a drain hose ran from the ceiling into the sink in the bathroom of Resident room [ROOM NUMBER]. Further observation revealed a five foot long by five-foot-wide tarp was installed above the ceiling tiles, above the area of the door-side bed in Resident room [ROOM NUMBER]. The drain hose that was observed in the bathroom sink originated at the center of the tarp. During an interview on 8/8/24 at 10:10 AM, the Director of Maintenance stated there was an active roof leak in the area above the door-side bed in Resident room [ROOM NUMBER] and the tarp was added around March 2024 to control the leaking. They also stated every few days, and especially after rain, Maintenance staff checked the tarp in this room and cleared any water that may still be in the drain hose. During an interview on 8/9/24 at 9:55 AM, the Administrator stated that they expect housekeeping to clean the rooms according to the cleaning schedule and they expect the housekeeping supervisor to do clean room audits. The Administrator stated they were aware of the ceiling/roof issues, there were estimates for the repairs, and that they were waiting for corporate to approve the repair. Review of roof repair estimate dated 1/16/24 documented that a new roof flashing and a new roof membrane was needed to repair the roof. Review of a roof repair estimate dated 5/28/24 documented that a new roof was needed for the building. NYCRR 10 415.5(h)(2)

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22485 Based on observation, interview, and record review conducted during a complaint investigation (Complaint #NY00330109) during the Standard survey completed on 8/9/24, the facility did not ensure the resident's right to be free from abuse for one (Resident #72) of 7 residents reviewed for abuse. Specifically, Resident #72 wandered into Resident #61's room on two separate occasions where a resident-to-resident altercation occurred that resulted in minor injuries to Resident #72. Additionally, care plan interventions (stop signs in doorway) to keep Resident #72 out of the room, were not in place. The finding is: The policy and procedure titled Abuse Prohibition Protocol, Types of Abuse, Response/Reporting dated 1/24 documented every resident has the right to be free from abuse and the facility would do all that is in their control to prevent such occurrences. Physical abuse includes acts of violence like striking (with or without an object), hitting, and shoving. 1. Resident #72 had diagnoses including dementia, hypothyroidism, and vitamin D deficiency. The Minimum Data Set (a resident assessment tool) dated 5/8/24 documented the resident had severe cognitive impairment and had wandering behaviors that significantly intruded on the privacy of others. The comprehensive care plan dated 12/20/23 documented the Resident #72 was at risk for being taken advantage of related to cognitive impairment and dementia. Interventions included a second stop sign was added to Resident #61's doorway to prevent Resident #72 from wandering into that room. Resident #61 had diagnoses including schizophrenia, major depressive disorder, and chronic pain. The Minimum Data Set, dated dated dated [DATE] documented the resident was cognitively intact and had verbal behaviors directed toward others. The comprehensive care plan dated 12/20/23 documented Resident #61 had a second stop sign added to their doorway. An undated Care Plan Detail report documented Resident #61 interventions/tasks included a second stop sign was added to their doorway. The Event Summary Resident report dated 12/18/23, completed by the Regional Clinical Director, documented that Resident #72 wandered into Resident #61's room. Resident #61 then hit Resident #72 in the head with a bed remote. Staff responded immediately when they head yelling and removed Resident #72 from Resident #61's room. Resident #72 had a small bump on the back of their head. Per staff Resident #72 sometimes removes the stop signs or goes under them to get into rooms. An intervention for a second, lower stop sign was to be placed on Resident #61's doorway. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an untitled, unsigned document dated 5/26/24, documented Resident #72 was found with two hematomas (collection of blood under the skin) on their head that were bleeding. The supervisor was directed to review camera footage which showed the Resident #72 entered Resident #61's room and was in there for five minutes. When Resident #72 exited the room, they were holding their head. Upon initial approach Resident #61 denied anything happened, but then admitted they hit Resident #72 with their television remote because the resident entered their room and started going through their things. The accident and incident report dated 5/26/24 at 9:48 PM documented interventions for the resident-to-resident altercation between Residents #72 and #61 were to place Resident #72 on 15-minute checks for 48 hours and a room change to promote safety. During an observation on 8/5/24 at 7:41 PM, 8/6/24 at 9:52 AM and 8/7/24 at 8:09 AM, there were no stop signs across Resident #61's doorway. There were no stop signs in the area at all. Resident #61 was lying in their bed. During an observation on 8/8/24 at 7:39 AM, two stop signs were hanging down the left side of Resident #61's doorway, they were not across the doorway, there were no staff in the room at this time. Resident #61 was lying in their bed. During an interview on 8/8/24 at 3:21 PM, Certified Nurse Aide #9 stated Resident #72 always wandered and staff would try to redirect them. There have been a couple incidents between Resident #72 and #61. The Certified Nurse Aide stated they put two stop signs up, but Resident #61's roommate takes them down when they go in and out of the room without putting them back up. Also, Resident #72 was known to take the stop signs down. During an interview on 8/8/24 at 3:36 PM, Certified Nurse Aide #10 stated they found Resident #72 walking down the hall holding their face and bleeding on 5/26/24. Certified Nurse Aide #10 stated Resident #72 tends to want to wander down that specific hallway more than the other hallways and the stop signs weren't working. Certified Nurse Aide #10 stated the incidents between the residents were considered physical abuse. During an interview on 8/8/24 at 4:22 PM, Licensed Practical Nurse #8 stated the incident in May was unwitnessed. They frequently checked placement of the stop signs but Resident #72 has taken them down in the past. Staff redirect the resident, but someone isn't with her one on one. During an interview on 8/9/24 at 8:50 AM, Registered Nurse Unit Manger #2 stated Resident #72 wanders, goes up and down the hallways and was easily redirected. Registered Nurse Unit Manager #2 stated they thought the stop signs were working and nobody had reported that Resident #72 had taken down the stop signs since they had started working in the facility two weeks ago, but they have heard this was something the resident has done in the past. The stop signs can be easily removed, they are a visual deterrent and not a barricade. Registered Nurse Unit Manager #2 stated they didn't know if the stop signs were up on Monday or Tuesday. There was no schedule for checking the stop signs. They just do it on rounds or when walking by the room because of the roommate taking them down. Registered Nurse Unit Manager #2 stated they wouldn't comment on whether the resident-to-resident incidents were considered abuse because they didn't work at the facility during those times. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/9/24 at 10:08 AM, the Director of Social Work stated in the instances of the resident-to-resident incidents involving Resident #72 and Resident #61, Resident #72 wandered into Resident #61's room and got into the resident's personal space. Resident #61 then lashed out. Resident #72 does seem to be drawn to that specific room, so stop signs were placed and black tape was placed in front of the doorway. The Director of Social Work stated they considered Resident #61 hitting Resident #72 to be abuse and the resident's right to be free from abuse was not maintained. They stated there were periods of time that the stop signs were successful and there were no incidents, then unsuccessful. They do ask staff their opinions for interventions because they were with the residents all the time, Resident #61 refused a move or bed change. During an interview on 8/9/24 at 10:58 AM, the Director of Nursing stated the supervisor called them the evening of 5/26/24 and reported the resident had some bleeding and they thought they fell . The Director of Nursing directed the supervisor to watch the camera footage with the security guard. When they watched footage the Resident #72 wandered into Resident #61's room and when they exited, they were holding their head. When they interviewed Resident #61 about it, they eventually admitted they hit Resident #72 with a television remote because they were messing with their things. They moved Resident #72's room down the opposite end of the unit. The Director of Nursing stated they didn't think this was an abuse situation because the residents don't really know what they were doing most of the time and Resident #61 had a psych disorder. During an interview on 8/9/24 at 12:42 PM, the Administrator stated they would consider the incidents that involved Resident #61 and Resident #72 to be abusive and that Resident #72 had the right to be free from abuse. 10 NYCRR 415.4(d)(1)(vii)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 22485 Based on observation, interview, and record review conducted during a Standard survey completed on 8/9/24, the facility did not ensure that when the use of a restraint was indicated, the facility used the least restrictive alternative for the least amount of time for one (Resident #76) of one resident reviewed. Specifically, the resident's seatbelt restraint was not released every two hours as ordered. The finding is: The policy and procedure titled Use of Restraints dated 1/24 documented a physical restraint was defined as any manual method or mechanical device attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement. The opportunity for motion and exercise is provided for a period of not less than 10 minutes during each two hours of restraint use. Resident #76 had diagnoses including cerebral palsy (abnormal brain development that affects ability to control muscles), seizures, and anxiety disorder. The Minimum Data Set (a resident assessment tool) dated 6/14/24 documented Resident #76 had severe cognitive impairment, and they used a physical restraint when in their chair. The Restraint Evaluation dated 7/29/24 documented Resident #76 used a wheelchair seat belt, the resident was unable to release it, and it was considered a restraint. Review of the Order Summary Report revealed a provider order dated 4/25/24 for a seatbelt in the resident's chair related to muscular weakness/cerebral palsy. Staff were to release the restraint every two hours and as needed for safety. The comprehensive care plan dated 6/3/24 documented Resident #76 used a physical restraint for positioning related to cerebral palsy. Interventions included to release the seatbelt every two hours for toileting or repositioning. The Bedside Kardex Report (a guide used by staff to provide care) dated 8/8/24 documented the seatbelt was supposed to be released every two hours for toileting or repositioning. During a continuous observation on 8/8/24 from 7:35 AM to 10:33 AM Resident #76 sat in their wheelchair with their seatbelt in place. The seat belt restraint was not released during this timeframe. During an interview on 8/8/24 at 10:47 AM, Certified Nurse Aide #7 stated they arrived to work at 9:00 AM, were told to stay with Resident #76 and that their seatbelt needed to be released at 11:00 AM. Certified Nurse Aide #7 stated restraints needed to be released every two hours and wasn't sure why. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/8/24 at 10:53 AM, Licensed Practical Nurse #1 stated the resident got up at 6:45 AM that morning and restraints were supposed to be released every two hours. The seatbelt was for positioning but was considered a restraint. During an interview on 8/8/24 at 12:29 PM, Certified Nurse Aide #8 stated they didn't release the seat belt that morning during breakfast because that was when Resident #76 was most grabby and jumpy and after that (meal) another aide was with the resident. During an interview on 8/9/24 at 8:47 AM, the Registered Nurse Unit Manager #2 stated the seatbelt wasn't considered a restraint and Resident #76 can reposition themselves in their chair. The Registered Nurse Unit Manager #2 stated the seatbelt was supposed to be released periodically, every two hours by the assigned Certified Nurse Aide. Staff know to do this because it was on the care plan, and it was important to release it to make sure the resident could move freely and for safety. During an interview on 8/9/24 at 10:54 AM, the Director of Nursing stated the seatbelt was supposed to be released every two hours when the resident was out of bed, and it was used for positioning in their chair. Either the assigned certified nurse aide or the nurse could remove it. 10 NYCRR 415.4(a)(5)(i)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22485 Based on observation, interview, and record review conducted during a Complaint investigation (NY00345819) during a Standard survey completed on 8/9/24, it was determined the facility did not ensure that the resident's person-centered care plan was implemented to meet the resident's medical and nursing needs for two (Residents #61 and #63) of nine residents reviewed. Specifically, the residents did not have a stop sign/s across their doorway to deter other residents from entering their room as planned. The finding is: The policy and procedure titled Care Plan, Comprehensive Person-Centered dated 1/24 documented that a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. Resident #63 was admitted to the facility with diagnoses of schizoaffective disorder and bipolar disorder (mental health conditions.) The Minimum Data Set (MDS - a resident assessment tool) dated 4/25/24 documented the resident was understood, understands and was cognitively intact. The comprehensive care plan with a revision date of 6/18/24 documented there were safety concerns related to Resident #63's impulsive behaviors at times and involvement with resident-to-resident altercations. Interventions included Resident #63 was to have a stop sign across doorway of their room. The Kardex (a guide used by staff to provide care) dated 6/19/24 documented Resident #63 was to have a stop sign across their doorway. During an observation on 8/5/24 at 8:16 PM, Resident #63's doorway did not have stop sign in place across their door. During an observation on 8/6/24 at 9:01 AM, Resident #63 was sitting up in bed, there was no stop sign in place across their doorway of Resident #63's room. During an observation on 8/7/24 at 8:43 AM, Resident #63 was not in room and there was no stop sign in place across their doorway. During an observation and interview on 8/8/24 at 9:43 AM, Resident #63 was observed in their room, and there was no stop sign across their doorway. Resident #63 stated they had never had a stop sign on their doorway. During an interview on 8/8/24 at 9:55 AM, Certified Nursing Assistant #3 stated they were not aware if Resident #63 had a stop sign for their doorway and if it was on the Kardex. They stated the nurses would communicate to them what residents had stop signs. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/8/24 at 3:44 PM, Licensed Practical Nurse #6 could not recall if a stop sign had been implemented for Resident #63 after a resident-to-resident altercation. During an interview on 8/9/24 at 9:15 AM, Certified Nursing Assistant #6, stated they had not seen a stop sign on Resident #63's door. During an interview on 8/9/24 at 9:35 AM, Registered Nurse Supervisor #1 stated they placed a stop sign on Resident #63's doorway 6/18/24 after a resident-to-resident altercation to prevent other resident's from entering Resident #63's room. They stated they updated the care plan and documented the intervention in the electronic medical record. Registered Nurse Supervisor #1 stated they were not aware if Resident #63's still had the stop sign in place. During an interview on 8/9/24 at 9:46 AM, the Director of Nursing stated that stop signs were used to deter other residents from entering another resident's rooms. They stated stops signs should be documented on both the care plan and Kardex. The Director of Nursing stated that if a resident's stop sign was not in place, they would expect staff to report it to the Nurse Manager, Supervisor, or the Director of Nursing and have it replaced. 2. Resident #61 had diagnoses including schizophrenia, major depressive disorder, and chronic pain. The Minimum Data Set, dated dated dated [DATE] documented the resident was cognitively intact and had verbal behaviors directed toward others. The comprehensive care plan dated 12/20/23 documented Resident #61 had a second stop sign added to their doorway. An undated Care Plan Detail report documented Resident #61 interventions/tasks included a second stop sign was added to their doorway. During an observation on 8/5/24 at 7:41 PM, 8/6/24 at 9:52 AM and 8/7/24 at 8:09 AM, there were no stop signs across Resident #61's doorway. There were no stop signs in the area at all. Resident #61 was lying in their bed. During an observation on 8/8/24 at 7:39 AM, two stop signs were hanging down the left side of Resident #61's doorway, they were not across the doorway, there were no staff in the room at this time. Resident #61 was lying in their bed. During an interview on 8/8/24 at 3:21 PM, Certified Nurse Aide #9 stated they put two stop signs up, but Resident #61's roommate takes them down when they go in and out of the room without putting them back up. Also, other residents may take them down. During an interview on 8/8/24 at 4:22 PM, Licensed Practical Nurse #8 they frequently checked placement of the stop signs, but residents take them down. During an interview on 8/9/24 at 8:50 AM, Registered Nurse Unit Manger #2 stated the stop signs can be easily removed, they are a visual deterrent and not a barricade. Registered Nurse Unit Manager #2 stated they didn't know if the stop signs were up on Monday or Tuesday. There was no schedule for checking the stop signs. They just do it on rounds or when walking by the room. (continued on next page)

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	335640	A. Building B. Wing	08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grand Rehabilitation & Nursing at Delaware Par	1205 Delaware Avenue 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NYCRR10 415. 11 (c) (1)

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 22485 Based on observation, interview, and record review conducted during a Standard survey completed on 8/9/24, the facility did not ensure residents with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing for one (Resident #49) of one resident reviewed. Specifically, the Physician Wound Consultants recommendations for an air mattress were not implemented. The finding is: The facility policy and procedure titled Consultations, last revised 1/24, documented the facility is responsible to provide consultation services for any residents as needed. The facility assumes responsibility for obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility, and the timeliness of the services. Nursing will notify physician of consultation and any recommendations if physician is not at facility. Physician will approve any orders he/she agrees with on consult. Physician will document if he/she agrees on consult. The facility policy and procedure titled Weekly Wound Assessment/Rounds, last revised on 1/24, documented the physician will help staff review and modify the care plan as appropriate, especially when wounds are not healing as anticipated or new wounds develop. The physician will authorize pertinent orders related to wound treatments. If the resident is not responding to established regimen, the nurse/medical professionals shall evaluate need for treatment change or reassess need for interdisciplinary services. Resident #49 had diagnoses that included chronic obstructive pulmonary disease (COPD, lung disease), type 2 diabetes mellitus, and peripheral vascular disease (poor circulation of lower extremities). The Minimum Data Set (a resident assessment tool) dated 6/26/24 documented Resident #49 was cognitively intact, was understood and understands. Additionally, the Minimum Data Set documented that Resident #49 had three Stage 3 pressure ulcers (full thickness tissue loss). The comprehensive care plan (identified as current) dated 7/21/2020 with a revision date of 8/9/24 documented Resident #49 had a pressure ulcer to right thigh with a goal that ulcer will heal prior to next review. The care plan documented the resident had a history of being verbally aggressive towards staff and refusing treatment recommendations. The comprehensive care plan did not include the use of an air mattress as recommended. Review of wound assessment and plan dated 5/31/24 revealed Resident #49 had a Stage 3 pressure ulcer on the left posterior (back) thigh that required additional preventative treatment. An air mattress was recommended by Physician Wound Consultant. Review of additional Wound Consults dated 7/7/24, 7/12/24, 7/19/24, 7/28/24 and 8/2/24 revealed an air mattress continued to be recommended. The 7/12/24 note documented the pressure ulcer on the left thigh was healing and decreased in size. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician Progress Note dated 6/10/24 at 1:16 PM completed by Physician Assistant #1 documented they were asked to review Resident #49's wound team evaluation and recommendations. Physician Assistant #1 documented they agree with current wound team comprehensive evaluation and recommendations. Physician Wound Consultants input is greatly appreciated, wounds evaluated and treated appropriately per Physician Wound Consultants recommendations. There were no follow up physician or nursing progress notes that documented the recommendation was carried out. During intermittent observations made on 8/7/24 at 8:24 AM and 1:36 PM, and 8/8/24 at 11:07 AM, Resident #49 was in bed and there was no air mattress present on bed. During an observation on 8/7/24 at 1:40 PM Licensed Practical Nurse #5 provided pressure ulcer care to Resident #49's pressure ulcers. At this time, there was no air mattress present on the bed. Resident #49 was observed a quarter sized open area on their left posterior thigh. During an interview on 8/8/24 at 12:10 PM, Certified Nurse Aide #5 stated Resident #49 did not have an air mattress on their bed and was not aware that they may have needed one. During an interview on 8/8/24 at 12:11 PM, Registered Nurse Unit Manager #3 stated were aware of Resident #49's pressure ulcer. Registered Nurse Unit Manager #1 reviewed the wound consults and stated they could not say why the recommendations made by the Physician Wound Consultant were not followed. During an interview on 8/8/24 at 12:17 PM, Licensed Practical Nurse #5 stated they were aware Resident #49 had a pressure ulcer and were unaware of the recommendation for an air mattress for Resident #49's bed. During an interview on 8/8/24 at 2:00 PM, the Director of Nursing stated when recommendations for wound care were made, the consults were placed in the providers mailbox by the nurse. The provider comes in and reviews the consults and carries out (writes order) any recommendations made. During an interview on 8/9/24 at 10:24 AM, the Physician Wound Consultant stated they recommended an air mattress for Resident #49 on 5/31/24. The Physician Wound Consultant stated they had not noticed and was not aware the air mattress was not placed on Resident #49's bed. Physician Wound Consultant stated Resident #49 would benefit from having the air mattress. During an interview on 8/9/24 at 11:13 AM, the Director of Nursing stated that if a recommendation was made by the wound consultant, they would expect the facility provider to be updated by the Unit Manager and the recommendation to be carried out. 10NYCRR 415.12 (c) (1)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 22485 Based on observation, interview, and record review conducted during the Standard survey completed on 8/9/24, the facility did not ensure that a resident with limited range of motion received the appropriate treatment and services to prevent further decrease in range of motion for one (Resident #5) of one resident reviewed for positioning and mobility. Specifically, Resident #5 had a contracture (loss of joint mobility) and was not provided a device to prevent further contracture. The finding is: The facility policy and procedure titled Contracture Management, last revised on 1/24, documented the facility will engage residents as appropriate in contracture management interventions to improve, maintain and prevent the deterioration of mobility of joints, flexion (bending of a joint) and extension of extremities. A joint contracture is characterized by chronically reduced range of motion secondary to structural changes in non-bony tissues, including muscle, tendons, ligaments, and skin. Prolonged immobilization of joints or trauma are the most common causes of joint contractures. Additionally, all residents will be assessed for range of motion of resident joints and muscles. Upon examination, recommendations are made to the medical professional for treatments and/or orthotics as appropriate. Resident #5 had diagnoses that include hemiplegia (paralysis on one side of body) and hemiparesis (weakness of one side of body) following cerebral infarction (stroke). The Minimum Data Set (a resident assessment tool), dated 6/12/24, documented Resident #5 had severe cognitive impairment, rarely/never understood, and sometimes understands. The Minimum Data Set documented that Resident #5 and was totally dependent on staff for all activities of daily living and had functional limitation in range of motion of both upper extremities. The comprehensive care plan dated 8/6/2020, with a revision date of 6/23/24, documented Resident #5 was at risk for impaired skin integrity related to decreased mobility with an intervention added on 3/2/21, to prevent resident from scratching and keep hands and body parts from excessive moisture, keep fingernails short. There was no rolled washcloth to left hand documented on comprehensive care plan. Review of a physician progress note dated 3/12/19 revealed Resident #5 had an admitting diagnosis of contracture of the left side of the body. The Task List Report (guide for staff) for Resident #5 dated 8/9/24 at 9:26 AM, documented Resident #5 had an intervention in place to have rolled washcloth in left palm to be worn at all times except for hygiene and report any abnormal observations to the nurse initiated on 12/30/21 and cancelled on 11/1/22. Review of Certified Nurse Aide task schedule for August 2024, dated 8/9/24 at 9:30 AM, documented Resident #5 had a task for a rolled washcloth in left palm to be worn at all times. This task was grayed out indicating it was not active and there were Xs in the boxes indicating staff did not complete this task. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Occupational Therapy note dated 10/17/23, documented Resident #5 was referred for skilled therapy evaluation for potential improvement with grooming/hygiene and to address bilateral upper extremity hand contractures. There was no functional limitation due to contractures. An Occupational Therapy Discharge Summary, dated 11/16/23, documented long-term goal met on 11/16/23 that Resident #5 will tolerate 15 minutes of passive range of motion to reduce risk of worsening contractures. An Occupational Therapy note dated 6/11/24, documented Resident #5 was referred to therapy by nursing to manage bilateral hand contractures and positioning for hand range of motion and comfort to prevent worsening of contractures and skin breakdown. There was a functional limitation present due to contractures in bilateral hands, worse on left side. Recommendations were documented as splint/orthotic recommendations: to be determined. Risk factors were documented that Resident #5 was at risk for muscle atrophy (the partial or complete wasting away of a body part or tissue). An Occupational Therapy Discharge Summary, dated 7/9/24, documented Resident #5 met long-term goal that occupational therapy would determine appropriate orthotic device that promotes neutral wrist and digit positioning for bilateral hand placement and positioning to prevent contractures. Rolled washcloth because this provides patient with most hygienic and optimal hand positioning. The discharge recommendations documented to follow care plan as directed and reach out to therapy with questions or concerns. During intermittent observations on 8/7/24 at 8:29 AM, 11:56 AM, 1:36 PM, and 8/8/24 at 7:58 AM and 1:22 PM, Resident #5 was lying in bed with no rolled washcloth present to left hand. During an interview on 8/8/24 at 9:23 AM, Certified Nurse Aide #4 stated they have seen rolled washcloths in Resident #5's hands prior but was not sure if they were supposed to have them. During an interview on 88/24 at 9:43 AM, Licensed Practical Nurse #5 stated they were not aware of any rolled washcloth order to Resident #5's left hand. During an interview on 8/8/24 at 9:54 AM, Rehab Aide stated they thought Resident #5 had a palm guard or rolled washcloth in place to their left hand. During an interview on 8/8/24 at 9:57 AM, Occupational Therapist stated they worked with Resident #5 recently and noticed that Resident #5's left hand was contracted. Occupational Therapist stated that if there wasn't a washcloth in place to Resident #5's left hand then there should be. Resident #5 had used the rolled washcloth in the past and it had been effective for them. If the rolled washcloth wasn't in place it could lead to worsening contractures, skin break down, and pain. Occupational Therapist stated they were going to add a rolled washcloth to Resident #5's Certified Nurse Aide tasks for Resident #5. During an interview on 8/8/24 at 10:35 AM, Occupational Therapist stated they made a clerical error after Resident #5's evaluation in June and forgot to add the rolled washcloth as a task for the Certified Nurse Aide to apply. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 8/8/24 at 10:57 AM, Occupational Therapist measured the flexion (bending of a joint) and extension (opening of joint) of Resident #5's upper extremity joints. Occupational Therapist stated according to the measurements, Resident #5 has a contracture in the proximal (closer to the point of attachment to the body) joint of left hand. During this observation, Occupational Therapist opened Resident #5's left hand and there were 3 indentations from the fingers in the palm of the hand. Occupational Therapist stated moisture and bacteria could build up and cause infection. During an interview on 8/8/24 at 12:07 PM, Certified Nurse Aide #3 stated they have seen rolled washcloths in Resident #5's hand before and they were used so that their hand does not get contracted and to keep it clean. During an interview on 8/8/24 at 12:16 PM, Certified Nurse Aide #5 stated sometimes Resident #5 had rolled washcloths in their hand but does not know why. During an interview on 8/8/24 at 2:01 PM, Occupational Therapist stated when there were changes made to a resident's plan of care after an evaluation the therapist will place an order for the change, enter a progress note and verbally communicate to nursing staff the change. During an interview on 8/8/24 at 2:08 PM, the Director of Nursing stated they would expect therapy to care plan any interventions for residents if new ones were added or one was continued and update nursing staff on the intervention. During an interview on 8/9/24 at 8:42 AM, Director of Therapy stated Resident #5 had a rolled washcloth in place in the past as an intervention for contracture in left hand, as well as for hygiene purposes. Director of Therapy stated the Occupational Therapist forgot to add it as a task and back to Resident #5's plan of care after their most recent evaluation. Director of Therapy stated Resident #5 needed the rolled washcloth to their left hand to prevent worsening contractures and to prevent skin breakdown. 10NYCRR 415.12 (e) (2)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 22485 Based on observation, interview, and record review conducted during a Complaint investigation (#NY00330919) during the Standard Survey completed on 8/9/24, the facility did not ensure each resident received food that accommodated their allergies, intolerances, and preferences for one (Resident #89) of one resident reviewed. Specifically, Resident #89 received a meal tray with foods that did not accommodate their documented preferences. The findings include: The facility policy and procedure titled Food and Nutrition Services, undated, documented each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. Additionally, food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident. Resident #89 had diagnoses that include protein-calorie malnutrition, dysphagia (difficulty swallowing), and chronic diastolic heart failure. The Minimum Data Set (a resident assessment tool) dated 7/16/24 documented Resident #89 had mild cognitive impairment, understood, and understands. The comprehensive care plan dated 12/6/23 documented Resident #89 had a potential nutritional problem and was at risk for malnutrition related to therapeutic diet with an intervention to identify and honor food preferences. The Dietary Progress note dated 5/1/24 at 1:31 PM, Registered Dietician documented they spoke with Resident #89 and obtained preferences. Resident #89 stated they do not want meat at meals. The Meal tracker and care plan was updated. The Dietary Progress note dated 7/15/24 at 2:08 PM, Registered Dietician documented Resident #89 preferred to eat vegetarian (a person who does not eat meat, and sometimes other animal products) This writer reviewed food preferences with Resident #89 and discussed the limitations of dislike of meat. Recommend continue current plan of care with updated preferences. Review of Resident #89's meal tickets dated 8/1/24 through 8/5/24 documented resident was a vegetarian. Vegetarian was documented in all capital letters in red at the top of each meal ticket. During an observation and interview on 8/7/24 at 8:48 AM, Resident #89's breakfast meal was on the tray table with the lid covering it. Resident #89 lifted the lid and 2 sausage links cut up into small pieces were observed on the meal tray, untouched. Resident #89 stated they won't eat it because they were a vegetarian. Resident #89 stated they receive meat products all the time on their meal trays, and it bothered them. Vegetarian was written at the top of Resident #89's meal ticket in capital red letters. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/8/24 at 10:04 AM, Registered Dietician stated Resident #89 was very adamantly a vegetarian and it was written on their meal ticket. Registered Dietician stated they were not aware Resident #89 was served sausage on their meal tray and they would expect the food service staff to follow the tickets and notes written on the tickets. During an interview on 8/8/24 at 1:42 PM, Licensed Practical Nurse #2 stated Resident #89 states they cannot eat certain things so the staff will do their best to accommodate their preferences. During an interview on 8/8/24 at 1:52 PM, Dietary Director stated they expected the dietary staff to look at the meal tickets before going up to the units. There was a supervisor who checks all the trays before they leave the kitchen, and they expected the supervisor to catch anything before the tray was sent. Dietary Director stated dislikes were written at the top of each meal ticket in capital red letters. Dietary Director stated the meal tray with sausage should not have been served to Resident #89 and the dietary staff should have caught it. During an interview on 8/8/24 at 2:09 PM, the Director of Nursing stated they would expect dietary staff to read the meal tickets and make sure they were correct before sending them up to the units. The Director of Nursing stated they would expect the nursing staff to look at the meal tickets to make sure they were correct before serving them to the residents. During an interview on 8/9/24 at 8:00 AM, Certified Nurse Aide #11 stated they were aware that Resident #89 was a vegetarian. Certified Nurse Aide #11 stated before the tray is brought to the resident staff should check to make sure there wasn't anything wrong with it. 10 NYCRR 415.14(d)(4)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22485 Based on observation, interaview and record review conducted during a Standard survey completed on 8/9/24, it was determined that the facility did not ensure that they maintained an effective pest control program so that the facility is free of pests and rodents. Specifically, two (Units 2 & 3) of two Resident Units and the Main Kitchen had issues with insects including house flies, spiders, and fruit flies. The findings are: The policy and procedure titled Pest Control dated January 2024 documented the facility would maintain an effective pest control program. The policy and procedure documented the facility maintains an ongoing pest control program to ensure the facility is free of insects. A request for exterminator service inspection reports from June 2024 to August 2024 was given to the facility. The facility did not provide exterminator service inspection reports from July 2024 and August 2024. Review of the June 2024 exterminator service inspection reports dated 6/13/24 documented that the drain flies have gotten worse and recommended a treatment. During observations on 8/5/24 from 7:00 PM to 7:45 PM: Second Floor East Shower Room - three small live flies on the plastic shower chair in the shower stall. Second Floor Dining Room - a plug-in style flying insect light trap was observed unplugged and sitting on the windowsill. Further observation revealed it had at least 14 small dead flies on the sticky paper. Second Floor Nurses' Station - a plug-in style flying insect light trap was plugged into a wall outlet. Further observation revealed it had at least 20 small dead flies on the sticky paper. During observations on 8/6/24 between 9:00 AM to 3:30 PM: Unit 3 nurses' station - many house flies noted at nurses' station. Unit 3 hallway outside of Resident room [ROOM NUMBER] - six small live flies in the vicinity. At the time of the observation, Maintenance Assistant #1 removed the saturated ceiling tiles from the ceiling and at least twelve more small live flies were observed in the opening. Kitchen - a plug-in style flying insect light trap was plugged into a wall outlet. Further observation revealed it had at least 50 small dead flies on the sticky paper; several small live flies were observed in the Dish Room and the Food Storage Room adjacent to the food preparation area. Resident room [ROOM NUMBER] - four houseflies on resident's food/meal tray; houseflies flew near resident's face/mouth. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During observations on 8/7/24 between 9:00 AM and 4:00 PM: Resident room [ROOM NUMBER] - five live spiders noted on the ceiling over the resident's bed; two live spiders noted in spider web on the window. Unit 3 Hallway - three live flies landed on facility computer; additional flies flew through the hallway. Resident room [ROOM NUMBER] - three houseflies noted on resident's bed linen; three houseflies flew around resident's head. Resident room [ROOM NUMBER] - flies landed on resident's lunch tray. Resident room [ROOM NUMBER] - three flies landed on resident's television. Resident room [ROOM NUMBER] - flies were noted on the wall and the resident's over the bed table. Resident room [ROOM NUMBER] - rectangular insect glue tape was attached to the corner of the door-side resident's television and a strip insect glue trap hanging from the door-side resident's lamp. There were two dead houseflies on the insect glue tape and at least four small dead flies on the strip. Resident room [ROOM NUMBER] - six to seven live houseflies on the tray table at the door-side bed. Additionally, a live housefly was observed on the door-side resident's forehead and on the blanket that covered their legs. Resident room [ROOM NUMBER] - 10 to 15 small live flies in the bathroom and six to ten additional live houseflies in the bedroom. Resident room [ROOM NUMBER] - eleven small live flies on the wall above the window-side bed. There were at least ten small live flies and two live houseflies on the wall above the door-side bed. Additionally, on the privacy curtain between the door-side bed and the door were more than 20 small live flies and five more houseflies on the ceiling tiles in this room. Resident room [ROOM NUMBER] - four live small files on the wall between the bed and the bathroom wall. Unit 3 hallway outside of Resident room [ROOM NUMBER] - at least seven small live flies were in the vicinity. During observations on 8/8/24 between 9:00 AM to 2:00 PM: Therapy Room - a housefly landed on resident. Resident room [ROOM NUMBER] - seven live spiders noted above resident's bed on the ceiling and two live spiders on spider web in window. (continued on next page)

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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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident room [ROOM NUMBER] - houseflies flew around the resident in the window-side bed and the tray table over the window-side bed. The tray table contained the resident's lunch, and a housefly was observed flying around a bowl of baked beans. Resident room [ROOM NUMBER] - one housefly and two fruit flies on over the bed table with one housefly on privacy curtain. During an interview on 8/5/24 at 7:45 PM, the Director of Maintenance stated there had been an uptick in fly activity in the facility in the last few weeks and they informed their contracted licensed exterminator and added six or seven plug in style devices around the facility to help the situation. During an interview on 8/6/24 at 10:26 AM, the Director of Maintenance stated the sticky paper needed to be replaced in the plug-in device in the kitchen. During an interview on 8/7/24 at 10:47 AM, Resident #92 stated the spiders above their bed bothered them and said, wouldn't they bother you? Resident #92 also stated they did tell staff about the spiders. During an interview on 8/7/24 at 11:45 AM, Resident #40 stated they had have had flies in their room for one or two months. They stated, Flies are always in my face, it is a pain in the butt. During an interview on 8/7/24 at 12:02 PM, the Housekeeping Supervisor stated they did not know where the flies originated from. The Housekeeping Supervisor stated they were not aware of any specific issue with flies in resident rooms. During an interview on 8/7/24 at 1:27 PM, Resident #89 stated flies were always around and that was why they wanted to keep a lid on their lunch tray, so the flies did not land on their food. During an interview on 8/7/24 at 1:50 PM, Housekeeping Aide #2 stated there were many flies and told their supervisor about them. During an interview on 8/7/24 at 2:45 PM, the Director of Maintenance stated the facility had a contract with a licensed exterminator for two visits per month. They stated they were made aware that small flies were being observed in the facility around mid-July 2024. At that time, the facility increased the frequency of the exterminator's visits to weekly, and since 7/24/24, the exterminator has completed two treatments for the flies. The Director of Maintenance stated they did not have documentation for the fly treatments, but they had requested it from the exterminator. During an interview on 8/8/24 at 1:45 PM, Resident # 15 stated they saw flies every day and it annoyed them. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335640	A. Building B. Wing	08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grand Rehabilitation & Nursing at Delaware Par	1205 Delaware Avenue Buffalo, NY 14209

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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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 8/8/24 at 1:47 PM, Resident #148 stated they had been at the facility for two weeks and noticed flies in their room earlier this week. Their spouse brought in glue traps to get the flies, which they thought were common houseflies and fruit flies. Resident #148 stated three days ago, they placed a glue trap on their tray table, and it caught eight flies. They further stated the flies were unsanitary and annoying and they could feel them on their body when they tried to sleep. Resident #148 stated they chose to eat their meals in their room and when asked if the flies bothered them while they ate, Resident #148 responded, Wouldn't they bother you? During an interview on 8/9/24 at 8:52 AM, Licensed Practical Nurse #1, they stated the flies have been in the facility at least a month. They stated the facility needed to fix the windows so that flies and other bugs don't come into the building. During an interview on 8/9/24 at 9:55 AM, Licensed Practical Nurse #2, they stated that the flies have been in the building at least the last two weeks. They stated that flies would bother the residents. During an interview on 8/9/24 at 9:07 AM, Registered Nurse Unit Manager #2, stated the flies have been here for at least two weeks ago. Registered Nurse Unit Manager #2 stated the staff try to remove food trays timely to keep food off the floor. They stated they have seen flies on residents and staff remembers trying to keep them off residents. During an interview on 8/9/24 at 9:55 AM, the Administrator, they stated were aware of insects in the building. They stated it is a team effort to keep the insects in check. They stated that staff need to throw out food or other things that may attract insects. 10NYCRR 415.29 (j)(5)