

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335647	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/28/2024
NAME OF PROVIDER OR SUPPLIER Williamsville Suburban, L L C		STREET ADDRESS, CITY, STATE, ZIP CODE 163 South Union Road Williamsville, NY 14221	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0575</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency.</p> <p>36415</p> <p>Based on observations and interviews conducted during a Standard Survey completed on 10/28/24, the facility did not post in a manor accessible and understandable to residents and resident representatives, the pertinent contact information for the State Long-Term Care Ombudsman Program and the State Agency Complaint Hotline number, including a statement that the resident may file a complaint. Specifically, for one (North) of two buildings there was no contact information for the State Agency Complaint Hotline, or the Ombudsman Program posted in the building.</p> <p>The finding is:</p> <p>The policy and procedure titled Resident Rights dated 3/1/17, documented Federal and State laws guarantee certain basic rights to all residents of this facility. These rights include the residents right to: communicate with outside agencies (e.g. local, state, or federal officials, state and federal surveyors, state long-term care ombudsman, protection, or advocacy organizations, etc.) regarding any matter.</p> <p>During a Resident Council meeting with the North building residents on 10/22/24 at 10:32 AM, the Resident Council President (Resident #30) and seven council members (Resident #36, #64, #94, #118, #119, #124, #467) stated they did not know where the Long-Term Care Ombudsman and the State Agency Complaint Hotline numbers were posted. They stated they were not aware these numbers needed to be posted for residents and family members.</p> <p>Observations made throughout the North building on 10/22/24 at 12:15 PM and 10/25/24 at 1:25 PM, revealed there were no postings of the State Agency Complaint Hotline or Ombudsman numbers located on the first-floor reception area or bulletin board down the hallway between the A-wing and B-wing units. There were no postings observed of the State Agency Complaint Hotline or Ombudsman numbers by the nursing stations on the first floor A-wing, second floor C wing and D wing, and were not observed to be posted in the elevators or hallways throughout the building.</p> <p>During an interview on 10/25/24 at 12:53 PM, the Assistant Director of Activities stated they were not aware of the Ombudsman contact number being posted in the North building. They stated they believed the State Complaint Hotline number was located by an old-time clock on the first floor which would not be an area accessible to the residents. The Assistant Director of Activities stated these numbers should be available to all residents.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0575</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 10/28/24 at 9:50 AM, Director of Nursing #1 stated that both the Ombudsman and the State Agency Complaint Hotline contact information should be posted by the reception area in both buildings. They stated there was no posting of either contact number in the North building. The Director of Nursing #1 stated both contact numbers should be accessible to the residents and family members, they stated residents should have the right to contact both agencies.</p> <p>During an interview on 10/28/24 at 10:15 AM, the Director of Social Work stated that they had contact information for the Ombudsman and was not aware if the Ombudsman or State Agency Complaint Hotline number was posted throughout the facility. The Director of Social Work stated they were not sure who was responsible for posting both contact numbers, they stated they had not posted any numbers throughout the facility. The Director of Social Work stated both numbers should be accessible to the residents and family members it was important for residents to be able to confidentially express their concerns.</p> <p>During an interview on 10/28/24 at 10:28 AM, The Interim Administrator, stated that the Ombudsman and State Agency Complaint Hotline contact numbers should be posted in areas throughout both buildings that were accessible to residents and family members. They stated they were unsure if both contact numbers were posted in the North building. The Interim Administrator stated they would expect that contact information for the Ombudsman and State Agency Complaint Hotline number to have been posted in both buildings, it was important for the residents and families to have access to an advocate outside of the facility to express issues and concerns.</p> <p>10 NYCRR 415.3 (d)(2)(i)(b)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>36415</p> <p>Based on interview and record review conducted during a Complaint investigation (#NY00332426) during a standard survey completed on 10/28/24, the facility did not ensure that all alleged violations involving abuse, including injuries of unknown source, were reported immediately, but not later than two hours after the allegation was made to the facility's Administrator and the State Survey Agency for one (Resident #62) of five residents reviewed. Specifically Resident #62 was found to have an injury of unknown source to their forehead, and it was not reported within the required timeframe.</p> <p>The finding is:</p> <p>The policy and procedure titled Abuse, Neglect and Exploitation of Residents, reviewed 2/29/24, documented that if abuse is suspected, personnel will report their observation to their supervisor immediately and without delay, and the Administrator, Director of Nursing or designee will notify the appropriate state agencies per state regulations.</p> <p>1. Resident #62 had diagnoses including unspecified dementia, status post fractured hip, and disorientation (a mental state of confusion about time, place, or one's identity). The Minimum Data Set (a resident assessment tool) dated 1/26/24, documented Resident #62 was severely cognitively impaired, rarely or never understood and rarely or never understands. They were dependent on staff for toileting and transfers, and incontinent of bowel and bladder.</p> <p>The comprehensive care plan dated 5/19/23 documented Resident #62 was a risk for injury, with a Hoyer lift (mechanical lift) and required two staff members for transfers.</p> <p>Review of the ACTS (ASPEN Complaint/ Incidents Tracking System) Complaint/Incident Investigation Report submitted on 1/29/24 at 11:14 AM, revealed Resident #62 was found to have a 1.0 centimeter x 1.5 centimeter closed hematoma (a collection of blood under the skin, caused from a broken blood vessel) to their forehead on 1/26/24 around 9:00 PM, and the origin was unknown.</p> <p>Review of the facility investigation, dated 2/2/24, revealed Resident #62 was found to have the 1.0 centimeter x 1.5 centimeter hematoma to their forehead when being cared for by two Certified Nurse Aides. The resident had no recent falls, and no reported resident to resident altercations or other incidents. Neurological checks were monitored and remained within normal limits. No mental harm was found. Staff stated they noticed the area during care, and none observed prior. Staff statements were dated 1/26/24. Actions taken following the investigation included staff re-education regarding safety during care, transfers, and the monitoring of residents for any change in condition.</p> <p>Review of Resident #62's progress notes from 1/26/24-1/29/24 revealed the following:</p> <p>1/26/24 at 10:49 PM Licensed Practical Nurse #4 documented the Certified Nurse Aide (#10) notified them of a bump on Resident #62's forehead. The supervisor was notified, neurological checks were initiated and within normal limits, and the resident had no pain or discomfort.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1/27/24 at 5:30 AM Nursing Supervisor, Registered Nurse #3, documented there were no delayed injuries at this time.</p> <p>1/29/24 at 1:25 PM Assistant Director of Nursing #2 documented there were no delayed injuries from incident on 1/26/24. Forehead hematoma with ecchymosis (bruising) noted. Will continue to monitor the resident.</p> <p>During an interview on 10/24/24, Certified Nurse Aide #1 stated they did not recall the incident with Resident #62 from January but Resident #62 could have hit their head during a Hoyer transfer but Resident #62 did not have the ability to self-transfer on their own.</p> <p>During a telephone interview on 10/24/24, Licensed Practical Nurse #4 stated they did not recall the incident with Resident #62 from January. The progress note dated 1/26/24 at 10:49 PM was reviewed with LPN #4 and stated based on their documentation they notified the supervisor of the injury after checking on the resident. However, stated they were unsure when the supervisor assessed the resident.</p> <p>During a telephone interview on 10/25/24 at 10:23 AM, Assistant Director of Nursing #2 stated they did not specifically remember the incident with Resident #62 in January. They stated that injuries of unknown origin needed to be reported within two hours. The supervisor should have called them or the Director of Nursing immediately. They might have needed to assess the resident and they could have reported it on time.</p> <p>During an interview on 10/25/24 at 10:59 AM, Director of Nursing #1 (current Director) stated they were not employed by the facility at the time of the incident with Resident #62, but it was important for all injuries of unknown origin to be reported to the Director of Nursing immediately. An injury of unknown origin could be abuse, and it needed to be investigated as soon as possible.</p> <p>During a telephone interview on 10/25/24 at 12:03 PM, Director of Nursing #2 (Director at time of occurrence) stated they should have been notified by Nursing Supervisor (RN #3) as soon as they assessed the resident. Director of Nursing #2 stated they were notified on Monday 1/29/24 of the injury, and that's when it was reported to the department of health. An injury of unknown origin should have been reported to the state within two hours because injuries of unknown origin could be suspicious of abuse.</p> <p>During an interview on 10/25/24 at 12:39 PM, the Interim Administrator stated the injury should have been reported to the Director of Nursing immediately so they could start the investigation. They might have found that it was not an unknown at all. All injuries of unknown origin need to be reported to the state within two hours. The staff were all aware of the importance of reporting immediately.</p> <p>10 NYCRR 415.4 (b)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36415</p> <p>Based on observation, interview, and record review conducted during a Standard survey completed on 10/28/24, the facility did not ensure that residents who were unable to carry out activities of daily living received the necessary services to maintain good grooming and personal hygiene for two (Residents #71 and #127) of five residents reviewed. Specifically, issues involved unkempt long, dirty, jagged fingernails (#71, #127). In addition, Resident #71 had presence of unwanted facial hair. Additionally, the 3rd floor Bath & Shower Sheet dated 10/23/24 for #71 was inaccurately documented, that care had been provided.</p> <p>The findings are:</p> <p>The policy and procedure titled Activities of Daily Living created 2/13/23 documented a resident who was unable to carry out activities of daily living would receive the necessary services to maintain good grooming and personal hygiene.</p> <p>The policy and procedure titled Care of Fingernails issued 6/26/18 documented nail care was to include daily cleaning and regular trimming on resident assigned bath/shower days and unless otherwise permitted, nails of diabetic residents or residents with circulatory problems were to be trimmed only by licensed nurses. If a resident did not receive a bath/shower or refused on the scheduled bath/shower day, nail care was to still be provided on the scheduled bath/shower day. Finally, the nurse supervisor was to be notified if the resident refused care.</p> <p>1. Resident #71 had diagnoses including hemiplegia (paralysis on one side of body), dysphagia (difficulty swallowing), and diabetes mellitus. The Minimum Data Set, dated dated dated [DATE] documented Resident #71 was moderately cognitively impaired, was understood and understands. The Minimum Data Set documented Resident #71 was substantial/maximal assistance for personal hygiene.</p> <p>The certified nurse aide care profile (a guide used by staff to provide care) dated 8/18/24 documented scheduled bath days were twice weekly on the 7:00 AM to 3:00 PM shift on Wednesdays and Saturdays.</p> <p>The comprehensive care plan revised on 8/23/23 documented Resident #71 was diabetic and the plan documented to trim fingernails weekly.</p> <p>The 3rd floor shower/bath scheduled verified as current by Licensed Practical Nurse #6 Unit Manager documented Resident #71's scheduled baths/showers were scheduled for Wednesday and Saturday during the 7:00 AM to 3:00 PM shift.</p> <p>A physician's order dated 8/23/23 revealed an active physician's order to trim fingernails weekly.</p> <p>During an observation and interview on 10/22/24 at 10:21 AM, Resident #71's fingernails were jagged, and dirty with dried brown debris. The resident also was unkempt and had one-inch white whiskers on their face, chin, and neck. Resident #71 stated their nails were ugly and would like them cleaned and that they were embarrassed to have such long whiskers. Resident #71 stated they haven't had a bath or shower in 2 weeks.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 10/23/24 at 12:03 PM revealed Resident #71's fingernails were jagged, dirty and had dried brown debris. Resident #71's whiskers remained on their face, chin and neck and they stated they did not receive their scheduled shower this morning.</p> <p>Review of the nursing progress notes dated 10/1/24 through 10/23/24 revealed there was no documented evidence that nail care was provided, that Resident #84 was bathed, or refused showers and nail care.</p> <p>Review of the 3rd floor Bath & Shower Sheets dated 10/2/24, 10/9/24, and 10/16/24 revealed there was no documented evidence the resident's nails were trimmed and cleaned or had been shaved.</p> <p>Further review of the 3rd floor Bath & Shower Sheets dated 10/23/24 revealed Certified Nurse Aide #4 documented Resident #71's fingernails were cleaned and trimmed, and Resident #71 was shaved.</p> <p>Review of the Treatment Administration Record from 10/1/24 through 10/23/24 documented an active physician order to trim fingernails weekly. The Treatment Administration Record documented that Resident #71's fingernails were trimmed on 10/9/24 and blank on 10/2/24, 10/16/24, and 10/23/24.</p> <p>Further observation and interview on 10/24/24 at 10:13 AM Resident #71 stated the staff were too busy. No one had offered them their shower on 10/23/24. Resident #71 had jagged fingernails dirty with dried brown debris and facial and neck whiskers. The resident stated they hoped to be shaved and have their nails cleaned.</p> <p>During an interview on 10/25/24 at 8:45 AM, Certified Nurse Aide #4 stated they did not give Resident #71 a shower on 10/23/24. There was no sling. Certified Nurse Aides were responsible for providing nail care and shaving unless the resident had a diagnosis of diabetes, then the nurse would be responsible for nail care. I should have informed the nurse the shower was not done or grabbed a sling from laundry.</p> <p>During an interview on 10/25/24 at 10:30 AM, Licensed Practical Nurse #8 stated they were unaware if Resident #71 had their shower on 10/23/24. Certified Nurse Aide #4 never notified them to complete a skin check. Therefore, likely the shower was not given. Resident #71 was diabetic and Licensed Practical Nurse #8 stated they did not clean or trim Resident #71's nails.</p> <p>During an interview on 10/25/24 at 10:33 AM, Licensed Practical Nurse #6, Unit Manager stated they expected proper care daily which included cleaning fingernails, and shaving.</p> <p>2. Resident #127 had diagnoses of diabetes mellitus type 2 and dementia with mood disturbance. The Minimum Data Set, dated dated dated [DATE] documented Resident #127 was severely cognitively impaired and was dependent on staff to perform personal hygiene.</p> <p>The comprehensive care plan and the certified nurse aide care profile (a guide used by staff to provide care) the dated 9/26/24 did not include instructions for staff regarding nail care.</p> <p>During an observation on 10/22/24 at 9:56 AM, Resident #127 had long yellow fingernails and were dirty with dark brown debris.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During follow-up observations on 10/23/24 at 9:16 AM, 10/25/24 at 10:23 AM, and 10/28/24 at 10:13 AM, Resident #127's nails were long and yellow with no dark brown debris under them.</p> <p>During an interview on 10/28/24 at 11:04 AM, Certified Nurse Aide #8, stated they only cleaned under Resident #127's nails and did not clip them, as Resident #127 was diabetic and nurses would need to clip their nails.</p> <p>During an interview on 10/28/24 at 10:15 AM, Licensed Practical Nurse #2 Unit Manager D-wing stated they were the only licensed nurse on the unit for this shift and were also responsible for passing medications scheduled during this day shift. At this time, Licensed Practical Nurse #2 reviewed the month's Bath & Shower Sheets for Resident #127, stated they were to receive a bath or shower on Wednesday during the AM shift and on Saturday during the PM shift. They stated the most recent Wednesday AM check was documented on 10/9/24 and only documented that skin was checked. None of the other categories (nails) were checked off, and there was no Saturday evening check documented during October 2024. They stated they had not been made aware of any bath/shower refusals by Resident #127.</p> <p>During an interview on 10/28/24 at 11:15 AM, Assistance Director of Nurses (ADON) #1, stated Resident #127's fingernails were too long and needed to be clipped. They stated that any resident with a diagnosis of diabetes was to have their nails trimmed by a Licensed Nurse, not a Certified Nurse Aide. They stated it was expected that facility staff notify their supervisor when residents refused baths or showers. They were not aware of any refusals by Resident #127.</p> <p>10NYCRR 415.12(a)(3)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>36415</p> <p>Based on observation, interview, and record review conducted the Standard survey completed on 10/28/24, the facility did not ensure that residents who had an indwelling (foley) catheter (tube inserted into the bladder to drain urine) received the appropriate care and services to manage catheters for one (Resident #84) of one resident reviewed. Specifically, Resident #84 was symptomatic for a urinary tract infection, and the foley catheter drainage bag was not draining to gravity below their bladder.</p> <p>The finding is:</p> <p>The policy and procedure titled Catheter Care: Urinary revised on 4/30/24 documented the purpose of this procedure is to prevent catheter-associated urinary tract infections. The position of the urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder.</p> <p>Resident #84 had diagnoses which included anxiety, stage IV pressure ulcer (most severe type of pressure ulcer and involves full-thickness tissue loss that exposes bone, tendon, or muscle), and urinary tract infection. The Minimum Data Set (MDS- an assessment tool) dated 10/4/24 documented Resident #84 had moderate cognitive impairment, was understood, understands. Resident #84 had an indwelling foley catheter.</p> <p>The undated resident care profile (tool used by staff to provide care) documented Resident #84 was dependent for toileting needs and to offer toileting every 2-3 hours. There was no documentation the resident had an indwelling foley catheter.</p> <p>The comprehensive care plan dated 4/12/24 documented Resident #84 had a foley catheter with a history of urinary tract infections, and to monitor for signs and symptoms of infection.</p> <p>Review of the nursing progress notes dated 10/22/24, revealed Resident #84 complained of burning on 10/21/24. The nurse practitioner was notified. The foley catheter was changed, an order was obtained for a urinalysis (a laboratory test that provides important clinical information on kidney function). The urine sample was collected and sent on 10/22/24.</p> <p>During observation and interview on 10/23/24 at 9:22 AM and 10:06 AM, Resident #84 was in their wheelchair next to the bed. An empty blue privacy bag was hanging off the bottom of the wheelchair. The foley catheter drainage bag was lying flat and was empty on Resident #84's lap. There was visible yellow urine with white mucous shreds contained throughout the catheter tubing. At 10:06 AM Resident #84 stated that's where they left it when they got me up. Resident #84 stated they had a burning sensation.</p> <p>Further observation and interview on 10/23/24 at 10:10 AM, Certified Nursing Assistant #5 stated they got Resident #84 into the wheelchair at 8:00 AM and was sidetracked, left the room, leaving the bag on Resident #84's lap. The foley drainage bag should have been placed in the privacy bag and should be below the bladder to prevent infections.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/23/24 at 12:48 PM, Licensed Practical Nurse #7 stated foley drainage bags were positioned below the bladder and drained to gravity. Resident #84 had complained of burning and a urine had been collected on 10/22/24.</p> <p>Review of the Physicians' Order Form as of 10/23/24 revealed a physician's order for a Urinalysis to be collected on 10/22/24.</p> <p>Review of the Bacteriology preliminary report dated 10/23/24 revealed a urinalysis collected on 10/22/24 had a colony count greater than 100,000 colony forming units/milliliters Escherichia Coli and was signed by Licensed Practical Nurse #6, Unit Manager on 10/24/24.</p> <p>During an interview on 10/24/24 at 10:39 AM, Nurse Practitioner #1 stated they'd expect foley drainage bags be positioned below the bladder to avoid the risk of urinary tract infections.</p> <p>During an interview on 10/28/24 at 9:17 AM, Licensed Practical Nurse #6 Unit Manager stated Resident #84 was on antibiotics for a urinary tract infection. Certified Nursing Assistant #5 should have placed the drainage bag in the privacy bag under the wheelchair and not on Resident #84's lap to prevent discomfort or the backflow of urine into the bladder.</p> <p>During an interview on 10/28/24 at 10:45 AM, the Director of Nursing stated foley drainage bags should never be placed on someone's lap. The urine flow would back into the bladder and for someone with a urinary tract infection, could make the infection worse.</p> <p>During an interview on 10/28/24 at 12:05 PM, Corporate Quality Assurance/Infection Preventionist stated foley drainage bags left on the lap was an infection control issue, and lead to urinary tract infections.</p> <p>10NYCRR 415.12 (d) (2)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36415</p> <p>Based on interview, observation and record review conducted during a Complaint investigation (Complaint #NY00353284, #NY00329150) during the standard survey completed on 10/28/24, the facility did not ensure that there was sufficient nursing staff on a 24-hour basis to provide care for all residents. Specifically, one of one facility reviewed for sufficient staffing the facility did not meet their assessed minimum staffing levels for Certified Nurse Aides on 8/24/2024, 9/8/2024, 9/16/2024, 9/22/24, 10/5/2024, 10/6/2024, and 10/20/2024 to meet the needs of the residents.</p> <p>The finding is:</p> <p>Refer to F 677 Activities of daily living care for dependent residents.</p> <p>The policy and procedure titled Nursing Department Staffing dated 2/17/2021 documented the facility provides adequate staffing to meet needed care and services for our resident population. It documented that Certified Nurse Aides are available on each shift to provide the needed care and services of each resident as outlined in the resident's comprehensive care plan.</p> <p>The policy and procedure titled Resident Rights dated 3/1/2017 documented that residents have the right to have communication with and access to people and services, both inside and outside the facility.</p> <p>The resident council meeting minutes dated 7/31/2024 documented that residents were concerned about low staffing and how it impacted their care and treatments. The resident council meeting minutes dated 9/19/2024 documented that multiple residents stated that nursing staff was short-handed and affected how residents were treated. The resident council meeting minutes dated 10/17/2024 documented the residents were concerned that being short staffed affected personal hygiene and showers were not a priority.</p> <p>The resident census analysis report for August 2024 documented that on 8/25/2024 there were 169 residents in the facility. The resident census report for September 2024 documented that on 9/8/2024 and 9/16/24 there were 167 residents in the facility; and on 9/22/2024 there were 171 residents in the facility. The resident census analysis report for October 2024 documented that there were 172 residents in the facility on 10/5/2024, 10/6/2024, and 10/20/2024.</p> <p>The facility assessment dated [DATE] documented minimum staffing levels for Certified Nurse Aides were 12 aides on the day shift (7:00 AM to 3:00 PM), 10 aides on the evening shift (3:00 PM to 11:00 PM), and five aides on the night shift (11:00 PM to 7:00 AM) for a facility census of 171 residents.</p> <p>The facility nursing daily staffing sheets documented the following:</p> <p>8/25/2024 - 10 Certified Nurse Aides on the day shift (down 2).</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>9/08/2024 - 9 Certified Nurse Aides on the day shift (down 3) and 8 Certified Nurse Aides on the evening shift (down 2).</p> <p>9/16/2024 - 11 Certified Nurse Aides on the day shift (down 1).</p> <p>9/22/2024 - 5 Certified Nurse Aides on the day shift (down 7).</p> <p>10/5/2024 - 10 Certified Nurse Aides on the day shift (down 2).</p> <p>10/6/2024 - 10 Certified Nurse Aides on the day shift (down 2).</p> <p>10/20/2024 - 8 Certified Nurse Aides on the day shift (down 4) and 9 Certified Nurse Aides on the evening shift (down 1).</p> <p>During an interview on 10/21/2024 at 10:03 AM, Resident #70 stated that over the weekend there were two Certified Nurse Aides working on the day shift. They stated that they wanted to get out of bed at 10:00 AM but did not get out of bed until 2:30 PM. Resident #70 stated that sometimes they don't get out of bed at all because there was not enough staff</p> <p>During an interview and observation on 10/22/2024 at 10:21 AM, Resident #71 stated that the staff were too busy to clean their fingernails or shave them. They stated they were embarrassed about the chin hairs, their nails were ugly and would like them cleaned. Resident #71 was observed with long, white whiskers on their chin and long nails with brown debris underneath.</p> <p>During an interview on 10/22/2024 at 11:16 AM, the Staffing Coordinator stated they have trouble staffing the facility on the weekends. They stated they try to get staff to come and work shifts but that doesn't always happen.</p> <p>During an interview on 10/24/2024 at 10:57 AM, Certified Nurse Aide #3 stated they cannot get showers or nails done when there were only two aides working on a shift. They stated they try to get showers completed by the next day but that was not always possible.</p> <p>During an interview on 10/25/2024 at 9:31 AM, Licensed Practical Nurse #1 stated they cannot get their charting done on residents when there were not enough Certified Nurse Aides working. They stated they have to help the Certified Nurse Aides transfer patients and other things which take away from their nursing duties.</p> <p>During an interview on 10/25/2024 at 11:03 AM, Registered Nurse Nursing Supervisor #1 stated that it was very difficult for them to be on a medication cart and be a supervisor at the same time. If they have to do an assessment on a resident, they have to leave the floor and the Certified Nurse Aides have to watch the floor until they come back. Then the other floor nurse must cover the floor they were working on as well.</p> <p>During an interview on 10/25/2024 at 11:04 AM, Certified Nurse Aide #4 stated they work double shifts because the facility was short staffed. They stated the weekends were terrible. They stated they can't get people out of bed if they only have two aides working on a unit.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 10/25/24 at 11:18 AM, Registered Nurse Nursing Supervisor #2 stated they cannot do what they need to do in providing care for the residents. They stated if they were on a medication cart, watching a floor, and being a supervisor at the same time, a 16-hour shift turns into 18 hours just to complete everything they need to complete.</p> <p>During an interview on 10/25/24 at 1:12 PM, the Assistant Director of Activities stated there were times when residents miss activities because there wasn't enough staff to change the resident's brief or to toilet the residents. They stated residents come in late or miss activities a couple of times a week because there wasn't enough staff to take care of them.</p> <p>During an interview on 10/25/2024 at 1:23 PM, the Director of Nursing #1 stated they do not have enough staff to take care of the residents' needs on a daily basis. They stated that they have been trying to get staffing for the facility, but it has been very difficult.</p> <p>During an interview on 10/28/2024 at 9:20 AM, the Interim Administrator stated the issue of not having enough Certified Nurse Aides was that personal hygiene and care was getting missed for the residents. This included showers, nail care, and shaving. They stated they have been working getting more staff.</p> <p>During an interview on 10/28/2024 at 10:48 AM, Licensed Practical Nurse Unit Manager #2 stated they cannot get resident care done with only two Certified Nurse Aides working on a shift. They stated that resident showers may be shortened with no nail care or shaving done on the residents.</p> <p>10NYCRR 415.13(a)(1)(i-iii)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>36415</p> <p>Based on observation, interview, and record review conducted during a Standard Survey completed on 10/28/24, the facility did not provide separately locked, permanently affixed compartments for the storage of controlled drugs for one (A Wing North Building) of three medication rooms observed for medication storage. Specifically, three bottles of liquid Lorazepam (a Schedule IV controlled substance-sedative/antianxiety medication) were stored in a removable locked box inside a small refrigerator that was not permanently affixed, which was located in a room with an unlockable door. This involved Resident #32.</p> <p>The finding is:</p> <p>The policy and procedure titled Controlled Substances with effective date 12/1/17 documented that refrigerated controlled substances must be stored in a refrigerator that has a locked, affixed narcotic box inside of the refrigerator with a separate lock on the outside of the refrigerator. The refrigerator must be affixed to the floor or wall. The refrigerator and interior narcotic container must remain locked at all times.</p> <p>During a medication storage room observation on 10/23/24 at 3:42 PM, Licensed Practical Nurse #9 unlocked the refrigerator in the medication room and removed a small, locked metal box that was not in an affixed compartment. The small metal box contained three bottles of Lorazepam concentrate 2 milligrams per milliliter for Resident #32. Bottle #1 for Resident #32 had 27 milliliters remaining; bottle #2 for Resident #32 was unopened and had 30 milliliters remaining; bottle #3 for Resident #32 was unopened and had 30 milliliters remaining. Further observation revealed the medication refrigerator was not affixed to the wall or counter and was in a room with an unlockable door.</p> <p>During an interview on 10/23/24 at 3:42 PM, Licensed Practical Nurse #9 stated they had not been using the locked compartment inside the medication refrigerator because there was no key. They stated they were not sure if the locked box needed to be affixed.</p> <p>During an interview on 10/23/24 at 4:44 PM, the [NAME] President of Clinical Services stated that they were unaware that the medication refrigerator on the A wing was not affixed or secured and should have been. They stated they did not know how long it had been unsecured or why and they would have maintenance address the issue immediately.</p> <p>During an interview on 10/24/24 at 9:52 AM, Licensed Practical Nurse Unit Manager #5 stated they had not been aware the medication refrigerator was not secured and was unsure why the affixed locked compartment in the refrigerator was not being used to store controlled substances. They stated when the residents transferred over from B wing in June the medication refrigerator was already in place on the unit. Licensed Practical Nurse Unit Manager #5 stated they believed the nurse was not aware they had a key to the affixed locked compartment for the medication refrigerator.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/24/24 at 10:14 AM, Licensed Practical Nurse #9 stated they were not aware they had a key on their key ring for the affixed locked compartment in the medication refrigerator.</p> <p>During an interview on 10/28/24 at 9:46 AM, the Director of Nursing #1 stated they were unaware that the medication refrigerator on the A wing was not secured and did not know why the affixed locked compartment in the refrigerator was not being used for controlled substances. The Director of Nursing #1 stated they would have expected both the medication refrigerator and narcotic box to be affixed and secured to ensure no one could remove and walk out with medications.</p> <p>During an interview on 10/28/24 at 10:25 AM, the Interim Administrator stated they would expect all medication refrigerators to be secured, not removable and would expect that controlled substances were stored in a locked box that was affixed to the refrigerator. They stated this would be important as someone could walk away with the controlled substances if not securely stored.</p> <p>10 NYCRR 415.18 (e)(1)(2)</p>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain dental services for each resident.</p> <p>36415</p> <p>Based on observation, interview, and record review conducted during the Standard survey completed on 10/28/24, the facility did not provide or obtain dental services to meet the resident's needs for one (Resident #84) of one resident reviewed. Specifically, there was no follow up to recommendations for a crown for a chipped tooth. In addition, the care plan was not revised to include Resident #84's chipped tooth.</p> <p>The finding is:</p> <p>The policy and procedure titled Dental Services with a revised date 1/28/20 documented routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care. The Director of Nursing, or his/her designee, is responsible for notifying Social Services of a resident's need for dental services and coordinate appointments with Medical Records/Unit Clerks. Social Services personnel will be responsible for assisting the resident/family in making dental appointments and transportation arrangements as necessary whenever an outside appointment is requested. The Medical Records Department/Unit Clerks will schedule and track resident dental appointments as per the required and recommended visits in the medical appointment tickler tracking system document.</p> <p>The policy and procedure titled Quality of Life - Dignity dated 9/1/17 documented each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. Treated with dignity means the resident will be assisted in maintaining and enhancing his/her self-esteem and self-worth.</p> <p>Resident #84 had diagnoses which included anxiety, stage IV (4) pressure ulcer (full thickness tissue loss with exposed bone, tendon, or muscle), and urinary tract infection. The Minimum Data Set (a resident assessment tool) dated 10/4/24 documented Resident #84 had moderate cognitive impairment, was understood, understands, and had no mouth or facial pain, or difficulty chewing.</p> <p>The undated resident care profile (used by staff to guide care) documented Resident #84 was dependent on staff for oral hygiene.</p> <p>The comprehensive care plan dated 4/12/24 documented that Resident #84 had poor dentition. The plan included dental consults annually and as needed, and to monitor for pain or problems with chewing. The comprehensive care plan documented to examine the oral cavity and assess for lesions, broken or missing teeth on admission, annually and as needed. Resident #84's chipped front tooth was not reflected on the plan of care.</p> <p>During observation and interview on 10/21/24 at 10:20 AM, Resident #84 stated they had a cracked tooth and hadn't seen the dentist. The tooth wasn't painful, they were self-conscious about it, and wished it was fixed. Resident #84's right front tooth was visibly chipped.</p> <p>(continued on next page)</p>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Dental Orders and Progress Notes Form dated 7/29/24 documented Resident #84 was seen by the facility dentist for an initial visit and had obvious broken natural teeth. Tooth #8 was chipped. The tooth would need a crown and Resident #84 would have to follow up with an outside dentist as this service was not provided by the facility dentist. The dental progress note was signed by the medical provider on 8/6/24.</p> <p>Review of the nursing progress notes from 7/29/24 through 8/10/24 revealed no documented evidence the dental recommendations were addressed, or an appointment had been arranged.</p> <p>During an interview on 10/25/24 at 11:31 AM, Licensed Practical Nurse #6, Unit Manager stated dental consults were placed in medical records mailbox by the dentist. Medical records staff distributed the consults to the units. Unit managers addressed recommendations with the medical provider and Unit Clerks were responsible to schedule the outside appointments. Licensed Practical Nurse #6, Unit Manager stated Resident #84's dental consult was signed by the medical provider on 8/6/24 and Licensed Practical Nurse #10, Unit Manager should have followed up on the recommendations. There were no nursing progress notes that reflected Resident #84 had been seen by the dentist on 7/29/24. The process was not working because this was obviously missed. Resident #84's care plan should have reflected the chipped tooth for monitoring potential weight loss, pain or difficulty chewing.</p> <p>During an interview on 10/25/24 at 11:32 AM, Unit Clerk #2 stated the dental consult was given to Licensed Practical Nurse #10, Unit Manager and could not recall that an outside appointment was made and must have been overlooked. Typically, it was the responsibility of unit managers or unit clerks.</p> <p>During a telephone interview on 10/25/24 at 12:51 PM, Director of Nursing #2 stated dental consults went directly to medical records. Medical records distributed the consults to the unit managers who reviewed them for recommendations. Unit clerk #2 was responsible for arranging follow up appointments once the medical provider agreed.</p> <p>During an interview on 10/25/24 at 1:17 PM, the Director of Medical Records stated dental consults were given to medical records staff after a resident had been seen. Medical records staff then distributed them to the units for the unit manager to address any recommendations with the provider. Unit managers would inform the unit clerk if an outside appointment needed to be scheduled. Unit Clerk #2 should have made the appointment.</p> <p>During an interview on 10/25/24 at 1:25 PM, the Interim Administrator stated Licensed Practical Nurse #10, Unit Manager was unavailable for interview until further notice.</p> <p>During an interview on 10/28/24 at 1:28 PM, the Interim Administrator stated Licensed Practical Nurse #10, Unit Manager should have reviewed Resident #84's dental consult for recommendations and Unit Clerk #2 should have scheduled the appointment. There needed to be an extra step in the process to ensure the appointments were really scheduled or why it was missed.</p> <p>10 NYCRR 415.17(c)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>36415</p> <p>Based on observation, interview, and record review conducted during the Standard survey completed on 10/28/24, the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for one (Resident #84) of three residents reviewed for infection control practices during care. Specifically, Certified Nurse Aide's #2, 4, 5, and 6 did not wear appropriate personal protective equipment (PPE) during care activities for a resident on enhanced barrier precautions who had an indwelling catheter (tube inserted into the bladder to drain urine) and a stage IV pressure ulcer.</p> <p>The findings are:</p> <p>The undated policy and procedure titled Enhanced Barrier Precautions documented enhanced barrier precautions are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms to residents. Enhanced Barrier Precautions employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. Gloves and gowns are applied prior to performing the high contact care activity. Examples of high-contact care activities requiring the use of a gown and gloves for enhanced barrier precautions include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs, or assisting with toileting, urinary catheter care and wound care. Enhanced Barrier Precautions remain in place for the duration of the resident's stay or the discontinuation of the medical device that places them at increased risk. Staff are trained prior to caring for residents on Enhanced Barrier Precautions. Signs are posted in the door or wall outside the resident room.</p> <p>Resident #84 had diagnoses which included stage IV pressure ulcer (the most severe type of pressure ulcer and involves full-thickness tissue loss with exposed bone, tendon, or muscle), obstructive uropathy (blockage of urinary flow) and urinary tract infection. The Minimum Data Set (MDS- an assessment tool) dated 10/4/24 documented Resident #84 had moderate cognitive impairment. #84 had an indwelling foley catheter and a stage IV pressure ulcer.</p> <p>The undated resident care profile (guide used by staff to provide care) documented Resident #84 was dependent on 2 staff members for toileting needs and transferred with a mechanical lift. Resident #84 had a pressure ulcer of the sacral region. There was no documentation the resident had an indwelling foley catheter. Enhanced Barrier Precautions were included as special instructions under Infection Control.</p> <p>The comprehensive care plan revised on 9/16/24 documented that Resident #84 had a foley catheter, monitor for infection, maintain precautions as needed, and impaired skin integrity related to a pressure ulcer of the sacral region.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 10/21/24 at 10:20 AM outside Resident 84's room an orange sign was posted and indicated Enhanced Barrier Precautions with the directive to wear gloves and a gown for high contact care activities. The high contact activities included dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs, or assisting with toileting, device care or use which included urinary catheter, and wound care: any skin opening that required a dressing. Additional observation revealed a clear plastic bin outside of Resident #84's room with 3 drawers that contained gowns, facial masks, and surgical gowns.</p> <p>During a mechanical lift transfer observation on 10/23/24 at 12:50 PM Certified Nurse Aide's #5 & #6 each donned (put on) a pair of gloves. Certified Nurse Aide's #5 & #6 lifted Resident #84 out of their wheelchair using a mechanical lift. During the transfer Certified Nurse Aide #5 removed Resident #84's foley catheter drainage bag from the privacy bag and held the catheter tubing during the transfer and lowered Resident #84 onto the bed. Certified Nurse Aide's #5 & #6 rolled Resident #84 over and removed Resident #84's incontinence brief. Resident #84 had a large dressing affixed to their sacrum. Certified Nurse Aide #5 removed the catheter tubing through the pant leg and placed the foley drainage bag onto the bed frame. Certified Nurse Aide's #5 then changed their gloves, completed hand hygiene and gathered supplies for fecal incontinence care. There were no gowns worn during this care observation by either staff member.</p> <p>During an observation on 10/23/24 at 1:02 PM Certified Nurse Aide #5 donned a clean pair of gloves and performed fecal incontinence care as Certified Nurse Aide #6 assisted with bed mobility. Certified Nurse Aide #2 entered Resident #84's room at 1:08 PM, donned a pair of gloves and assisted Certified Nurse Aide #5 with fecal incontinence care. Certified Nurse Aide #6 continued to assist with bed mobility. Certified Nurse Aide #4 then entered Resident #84's room at 1:11 PM donned a pair of gloves and finished fecal incontinence care with Certified Nurse Aide's #2, 5 & 6 then completed hand hygiene and left Resident #84's room. No gowns were worn by any of the staff during this care observation.</p> <p>During an observation on 10/23/24 at 1:15 PM, Certified Nurse Aide #5 donned a pair of gloves and emptied 750 milliliters of yellow urine into a graduate (container), then emptied the container into the toilet in Resident #84's bathroom.</p> <p>During an interview on 10/23/24 at 1:19 PM, Certified Nurse Aide #2 stated enhanced barrier precautions included wearing gowns, gloves, and masks when providing direct care for residents with foley catheters and wounds to reduce the risks of infection. We all should have had on gowns, masks, and gloves.</p> <p>During an interview on 10/23/24 at 1:20 PM, Certified Nurse Aide #6 viewed the orange enhanced barrier precaution sign outside Resident #84's room and stated that they should have worn a gown and mask in addition to wearing gloves.</p> <p>During an interview on 10/23/24 at 1:22 PM, Certified Nurse Aide #4 stated they should have had additional personal protective equipment on due to Resident #84's urinary catheter and wound.</p> <p>During an interview on 10/23/24 at 1:33 PM, Certified Nurse Aide #5 enhanced barrier precautions were used during direct care for residents who were at a higher risk of infection such as pressure ulcers and foley catheters. Certified Nurse Aide # 5 stated they should have worn a gown and mask during care for Resident #84 to avoid cross contamination.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 10/23/24 at 2:30 PM, Licensed Practical Nurse #7 stated the additional protection was a reminder to the staff and protected the residents and others from transmission of germs. I should have enforced them to follow the enhanced barrier precautions.</p> <p>During an interview on 10/28/24 at 8:49 AM, Licensed Practical Nurse #6, Unit Manager stated gowns, gloves, and masks were located outside of resident rooms who required enhanced barrier precautions. Certified Nurse Aides were expected to acknowledge the postings outside the resident's room by wearing the appropriate personal protective equipment. Licensed Practical Nurse #7 should have ensured that Certified Nurse Aide # 2, 4, 5, & 6 had worn a gown, glove, and a mask during the high contact care activity.</p> <p>During an interview on 10/28/24 at 10:41 AM, Director of Nursing #1 stated residents with foley catheters and wounds were susceptible to infection. Certified Nurse Aides #2, 4, 5, & 6 should have worn a gown and masks in addition to gloves for infection control purposes.</p> <p>During an interview on 10/28/24 at 12:05 PM, the Corporate Quality Assurance/Infection Preventionist stated they would expect the staff to wear gloves, gown, and a mask for residents on enhanced barrier precautions.</p> <p>During an interview on 10/28/24 at 1:28 PM, the Interim Administrator stated staff were educated on the policy, signage, expectations and were expected to follow it.</p> <p>NYCRR10 415.19(b)(4)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335647	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/28/2024
NAME OF PROVIDER OR SUPPLIER Williamsville Suburban, L L C		STREET ADDRESS, CITY, STATE, ZIP CODE 163 South Union Road Williamsville, NY 14221	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Implement a program that monitors antibiotic use.</p> <p>36415</p> <p>Based on interview and record review conducted during a Standard survey completed on 10/28/24, the facility did not implement an effective antibiotic stewardship program that included antibiotic use protocols and a system to monitor antibiotic use for one of one infection control program reviewed. Specifically, the facility did not provide documentation showing that antibiotics were being monitored and tracked to optimize the treatment of infections while reducing the adverse events associated with antibiotic use. This involved Resident #84.</p> <p>The finding is:</p> <p>The policy and procedure titled Antibiotic Stewardship - Review & Surveillance of Antibiotic Use & Outcomes, dated 8/2018, documented that Antibiotic usage and outcome data will be collected and documented using a facility-approved antibiotic surveillance tracking form, and all clinical infections treated with antibiotics will undergo review by the Infection Preventionist. All Antibiotic starts will be reviewed by the Infection Preventionist within 48 hours to determine if continued therapy is justified, justified with needed intervention, or not justified.</p> <p>Resident #84 had diagnoses including chronic pain syndrome, stage 4 pressure ulcer of the sacral region (wound on the lower back, above the buttocks, that includes full thickness skin loss that extends into muscle, bone, or supporting structures), and osteomyelitis (bone infection) of the sacral region. The minimum data set (a resident assessment tool) dated 7/12/24, documented Resident #84 was moderately cognitively impaired, was always understood, always understands, had a wound infection and was on an antibiotic medication.</p> <p>The comprehensive care plan, revised 9/16/24, documented Resident #84 had an infection. Interventions included to observe for side effects from antibiotic therapy and report to the provider.</p> <p>Review of Resident #84's Physician's Order Form dated 10/23/24, revealed they had multiple antibiotics ordered including Cefdinir oral capsule 300 milligrams every 12 hours for pressure ulcer from 6/7/24-9/12/24, and 9/13/24-9/17/24. Bactrim DS oral tablet 800-160 milligrams, 1 tablet by mouth every 12 hours for cellulitis, from 7/23/24-8/3/24. Ertapenem sodium injection 1 gram intravenously daily for urinary tract infection, from 9/17/24-9/17/24.</p> <p>Review of the Antibiotic Stewardship binder contained no documentation that the facility had an effective antibiotic stewardship program. There was no tracking of antibiotics used in the facility for the months of July 2024 - October 2024.</p> <p>During an interview on 10/28/24 at 8:49 AM, Licensed Practical Nurse #6, stated they used to keep track of the antibiotics on their unit, but since recently returning from a leave, they did not know if there was a process in place. They used to track them on a list and give it to the Director of Nursing at the beginning of each month, but no one had been tracking them recently.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Williamsville Suburban, L L C		STREET ADDRESS, CITY, STATE, ZIP CODE 163 South Union Road Williamsville, NY 14221	
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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 10/28/24 at 9:30 AM, the Corporate Infection Preventionist stated they oversaw the Antibiotic Stewardship program in the facility. The Director of Nursing, that recently left, used to be responsible for it. They were in the process of training the new Director of Nursing and Assistant Director of Nursing to take over the responsibility. They stated they used the McGeer criteria (a standardized set of guidelines for identifying infections in long term care facilities) as their guide for antibiotic stewardship. They stated that recently they had been running a report from their electronic medical record to track antibiotic use. They were unable to provide the monthly documentation to support their process. They stated the previous Director of Nursing left in early September; however, they were unable to locate the tracking documentation from July 2024 - current. The Corporate Infection Preventionist also stated the unit managers should have lists of residents on antibiotics for their units, however they were unable to provide that documentation.</p> <p>During an interview on 10/28/24 at 10:13 AM, the Director of Nursing #1 stated they were not yet involved in the antibiotic stewardship program, but they started the infection preventionist training to take it over. They stated it was important to track and monitor antibiotic use, so residents didn't develop a resistant infection and to monitor for side effects, lab values, or cultures, and make sure they were on the correct antibiotic.</p> <p>During an interview on 10/28/24 at 12:24 PM, the Pharmacy Consultant stated their role in antibiotic monitoring was to check if the order had an accurate duration and diagnosis for the treatment. They were not directly involved in the antibiotic stewardship process.</p> <p>During an interview on 10/28/24 at 12:47 PM, the Interim Administrator stated that having an effective antibiotic stewardship was very important. The purpose of the Antibiotic Stewardship program was to make sure they didn't overuse antibiotics and to make sure the residents were on the appropriate antibiotic. They should track whether it's been effective, and if the resident has responded appropriately. They can also use the information to track trends like which units are having more infections and then can use that to educate staff or monitor more closely. The Acting Administrator stated that the system they currently had was not an effective process and they needed to be more consistent.</p> <p>During an interview on 10/28/24 at 1:11 PM, The [NAME] President of Clinical Services stated they were unable to locate the antibiotic tracking sheets from the last few months.</p> <p>10 NYCRR 415.19(a)(1,3)</p>		