STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335661	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellsville Manor Care Center	4192a Bolivar Road Wellsville, NY 14895

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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 0576 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure residents have reasonable access to and privacy in their use of communication methods. 43785 Based on interviews conducted during the Standard survey completed on 6/14/24, the facility did not assure the residents had the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service. Specifically, the facility did not ensure there was postal service available on Saturdays. This involved Resident #s 22, 30, 36, 44, 49, 82, 84, and 258. The finding is: On 6/11/24 at 10:13 AM, the Resident Council attendees (Resident #s 30, 36, 44, 49, 82, 84, and 258) stated they did not receive mail on Saturdays because they believed the facility didn't have staff available to deliver mail on Saturdays. During an interview on 6/12/24 at 10:51 AM, the Activities Department Director stated the United States Postal Service delivered mail to the facility Monday through Friday. They stated the Administrator set up the mail delivery for Monday through Friday only and stated they didn't know the residents should be able to receive mail on Saturdays. During a telephone interview on 6/12/24 at 11:49 AM, the Postmaster from the United States Post Office stated the facility was listed as a business and closed on Saturdays therefore there is no mail delivery on Saturdays, and believed it was because the facility didn't have staff to provide the mail to the residents on Saturdays. The Postmaster stated if the facility wanted the mail to be delivered on Saturdays, the United States Post Office would accommodate the request. During an interview on 6/12/24 at 12:04 PM, Resident #82 stated they would like the facility to have a process to deliver mail on Saturdays and would expect their mail be delivered to them. During an interview on 6/12/24 at 12:05 PM, Resident #49 stated it bothered them that the facility didn't have a process to deliver mail on Saturdays and that they didn't get their mail. During an interview on 6/12/24 at 12:10 PM, Resident #30 stated the facility should have a process for mail delivery on Saturdays as some residents may be waiting for something important and it bothered them. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0576 Level of Harm - Potential for minimal harm Residents Affected - Many	During an interview on 6/13/24 at 1:46 PM, Resident #22 stated they did not get mail on Saturdays, and it bothered them because they needed to ask a friend to go to the United States Post Office to get their mail on Saturdays and bring it into the facility. During an interview on 6/12/24 at 12:23 PM, the Business Office Manager stated the facility received mail Monday through Friday and believed the facility had not received mail on Saturdays in years because they didn't have staff to deliver the mail to the residents on Saturdays. During an interview on 6/12/24 at 12:17 PM, the Administrator stated they didn't know the residents were not receiving mail on Saturdays and it was a resident's right to receive their mail including Saturdays timely. The Administrator stated they were responsible to ensure the mail delivery process was set up between the postal service and the facility. The Administrator stated the facility was not just a business but also the residents' home. The Administrator stated they did not have a written policy and procedure for mail delivery. 10 NYCRR 415.3(e)(2)(i)

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F 0585 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 43785 Based on interviews and record review conducted during a Complaint investigation (Complaint #NY00312806) during the Standard survey completed on 6/14/24, the facility did not the facility did not make prompt efforts to resolve grievances for one (Resident #257) of three residents reviewed for grievances. Specifically, there was lack of follow through and resolution of a resident's report of missing property. The finding is: Review of a facility policy and procedure titled Resident Grievance, revised 1/2024 revealed that the Social Work Department will inform residents and/or designated representatives of their right to express grievances with the expectation of a response and without fear of reprisal. Each and all grievances will be investigated by the Department Head or their designee against which the complaint is made with cooperation and interventions from other disciplines when necessary. The Social Worker will document the complainant's satisfaction with findings and/or any actions taken by the facility. Review of Your Rights as a Nursing Home Resident in New York State dated 2022 documented, Expect the facility to promptly investigate and try to resolve your concerns. Resident #257 had diagnoses which include aphasia (a language disorder that affects a person's ability to communicate), hypertension (high blood pressure), and major depressive disorder. The Minimum Data Set (a resident assessment tool) dated 1/24/23 documented the resident was moderately cognitively impaired. Review of Resident #257's comprehensive care plan dated 5/6/21 revealed the resident needed assistance with activities of daily living (oral care, washing, dressing, repositioning, transferring, ambulation, mobility, toileting, and eating). An intervention dated 5/9/22 documented the resident wore glasses. Review of facility document titled Missing Items Report dated 1/11/23, provided by the Social Work Department Director, documented the resident's eyeglasses with metal frame were missing. The glasses were not found but per resident documents they had readers. The resident was going to be added to the eye doctor list for replacement. There was a handwritten entry along the margin of the document that said, Notified by nursing on 7/11/23 found their glasses. The form was not signed. The Social Work Department Director stated all the documentation on the form was completed by them. Review of an e-mail dated 1/24/23 at 8:27 AM, from the Social Work Department Director to the Director of Medical Records Department documented, (Resident #257) - can they be added to the eye doctor list, apparently they had glasses missing that we have not located. An e-mail dated 1/24/23 at 8:32 AM, from the Director of Medical Records Department to the Social Work Department Director documented, Okay. (continued on next page)

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F 0585 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of Resident #257's medical record including nurse progress notes, consult reports and physician notes from 1/1/23 through 7/6/23 revealed no documented evidence the resident was seen for an eye consult or had their glasses replaced. During a telephone interview on 6/12/24 at 8:33 AM, Resident #257's family member stated the facility did not find the resident's glasses and didn't believe the resident was seen by an eye doctor for new glasses. They stated the glasses that were provided to the resident upon discharge in July 2023 were not theirs and they did not accept them from the staff. During an interview on 6/12/24 at 9:11 AM, the Social Work Department Director stated they were unable to find the resident's glasses therefore they sent an email to have the resident seen by the eye doctor for new glasses. The Social Worker Department Director stated they assumed the resident was seen. During an interview on 6/12/24 at 9:49 AM, the Director of Medical Records Department stated the follow up action for the missing glasses was not completed as documented on the missing items report; the resident was not seen by an eye doctor. During an interview on 6/12/24 at 10:12 AM Social Work Department Director stated the follow-up to the missing glasses was not completed, they didn't know the resident wasn't seen by the eye doctor and were not provided glasses and should have been. During an interview on 6/12/24 at 1:57 PM, Unit Manager Licensed Practical Nurse #2 stated the follow up to the grievance for the missing glasses should have been followed through and would have expected the resident to have been seen by the eye doctor so their glasses could have been replaced. During an interview on 6/12/24 at 2:50 PM, the Administrator stated the resident should have been seen by the eye doctor and their glasses replaced. They stated they were responsible to ensure the Social Work Department Director and the Medical Records Department Director provided follow-up and there is a lack of the facility following through to ensure the resident's personal property was replaced. 10 NYCRR 415.3(d)(1)(i)

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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. 43785 Based on observations, interviews, and record review conducted during a Standard survey completed on 6/14/24, the facility did not ensure each resident with limited range of motion received appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion for one (Resident #58) of three residents reviewed for positioning and mobility. Specifically, the staff did not ensure that Resident #58's right hand splint was worn at all times as ordered and care planned. The finding is: The policy and procedures titled Assistive Devices and Equipment, revised on 1/2024, documented that devices and equipment that assist with resident mobility, safety and independence are provided for residents. These include but are not limited to wheelchairs (manual and powered), walkers, canes, adaptive devices etc. Recommendations for the use of devices and equipment are based on the comprehensive assessment and documented in the resident's plan of care. Resident #58 had diagnoses of cellulitis (a bacterial skin infection), urinary tract infection, and adult failure to thrive (a state of decline that is multifactorial). The Minimum Data Set (a resident assessment tool) dated 4/4/24, documented Resident #58 had severe cognitive impairment and could not understand others or was not understood by others, and had a right upper extremity functional limitation in range of motion. The Comprehensive Care Plan dated 6/1/24, documented that a right functional hand splint was to be worn at all times during the day and at bedtime. It could be removed for hygiene, range of motion or functional tasks. The staff were to monitor for signs of discomfort every shift. Review of Resident Orders dated 2/2/24, documented a right functional hand splint was to be worn at all times during the day and bedtime. It could be removed for hygiene and range of motion or functional tasks. Staff were to monitor for signs of discomfort every shift, day, evenings, and overnights. During an observation and interview on 6/10/24 at 11:55 AM, Resident #58 was observed in their wheelchair in the hallway with a family member. Resident #58 did not have their functional hand splint on. The family member stated that Resident #58 should wear a splint on their right hand. During an observation on 6/12/24 at 10:47 AM, Resident #58 was in the common area resting in their wheelchair and did not have their functional hand and splint on. The Resident demonstrated the inability to extend their right hand all of the way. During an observation and an interview on 6/14/24 8:47 AM, Resident #58 was in the television room without their functional hand split on. The device was attached to their wheelchair. When asked why they did not have their splint on they stated they never had it on. (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 interview on 6/14/24 at 9:37 AM, Registered Nurse #1 stated that Resident #58 should wear a right-hand splint. Registered Nurse #1 observed the resident and stated they were not wearing their hand splint. Registered Nurse #1 checked the residents care plan and stated the resident was care planned to wear the functional splint at all times. Registered Nurse #1 stated this was important because it was a therapy recommendation, and they may have a contracture. During an interview on 6/14/24 9:49 AM, Certified Nursing Assistant #3 stated that Resident #58 was compliant with their plan of care. They looked at the resident's care plan to verify if the resident was care planned for a functional hand splint. They stated that they did see the splint in the resident's chart. They stated the resident once wore a functional splint and but did not think they did anymore. During an interview on 6/14/24 10:09 AM with Certified Nursing Assistant #2, they stated Resident #58 normally wore a wrist splint. Certified Nursing Assistant #2 observed Resident #58 and stated they did not have it on. Certified Nursing Assistant #2 stated they were not familiar with the new kiosk system to look if the Resident had was care planned for a functional hand splint. They stated that they did not think that Resident #58 normally wore the splint. Certified Nursing Assistant #2 stated that it was important to check residents care plans and that the splint should be worn to so that the resident's hand does not further contract. During an interview on 6/14/24 at 10:32 AM with Occupational Therapist #1, they stated that Resident # 58 should be wearing a splint on their right hand and was care planned for this. They stated that Resident #58 could be confused but was compliant with wearing the splint and it was important to make sure they wore their splint to reduce contractures and stop them from getting worse. They stated it was important to not let the contracture get to the point where it closed and would become painful, and the splint was to help preserve the joints. They stated it was the nurse's responsibility to make sure they are following plan of care orders. During an interview on 6/14/24 at 10:57 AM, the Director of Nursing stated they expected that Resident #58 would wear the splint if they should and have staff put it on. They stated that it was the responsibility of the Unit Manager, but it was everyone's responsibility to make sure the resident's care plan was followed. They stated it was important to make sure splints were worn to prevent contractures and to prevent further decline in residents. During an interview on 6/14/24 at 11:04 AM, the Administrator stated staff should be well informed about the care plan of each resident and it was on the kiosk with the resident's profile. They stated all staff have received training on how to find information and utilize the electronic medical record and how to document and chart properly. They stated this was important to ensure that the residents care plan was being met. 10NYCRR 415.12(e)(2)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 43785 Based on interview and record review conducted during a Standard survey completed 6/14/24, the facility did not employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service. Specifically, one of one facility reviewed for sufficient staffing did not have a full-time (working 35 or more hours a week) qualified Director of Food and Nutrition services or other clinically qualified nutrition professional. The finding is: The policy and procedure titled Food and Nutrition Services revised 1/2024 did not include qualifications and skills sets for clinically qualified nutrition professionals. Review of the undated job description job title Nutrition Service Director revealed the candidate must provide documentation of registry/certificate upon application for the position, must have training in cost control, food management, and diet therapy. Review of the undated job description job title Diet Tech revealed the purpose of the job position is to oversee nutritional well-being of residents by conducting nutrition assessments, identifying patients at risk, and creating diet plans. Qualifications listed included a two-year associate degree in Dietetics Education or related field. Review of the Facility Survey Report signed and dated 6/13/24 revealed Dietitian #1 was not the full-time dietetic service supervisor and Dietary Supervisor #2 (Food Service Director) was listed as the full-time dietetic service supervisor. Review of timecards dated 3/12/24 through 6/12/24 revealed Dietitian #1, a registered dietician, worked less than 35 hours per week at the facility. During an interview on 6/11/24 at 10:45 AM, Dietary Supervisor #2 stated they were hired as the Food Service Director for the facility this past September. They stated they were the full-time Food Service Director for the facility. They stated they did not have a certificate as a Certified Dietary Manager or a Certified Food Service Manager. They stated they had not completed any course of study in food safety and management. During an interview on 6/11/24 at 10:50 AM, Dietary Supervisor #1 stated they were the full-time Diet Tech at the facility. They stated they did not have any certification in food service management or nutrition and hospitality and had been hired as a Diet Tech three years ago after having been a Certified Nurse Aide at the facility. During an interview on 6/13/24 at 10:28 AM, Dietician #1 stated they did not work full time at the facility and that they worked there two days a week. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/13/24 at 3:41 PM, the Administrator stated the Dietician was available in the building a minimum of 2 days per week. They stated they thought Dietary Supervisor #2 (Food Service Director) and Dietary Supervisor #1 (Diet Tech) were qualified for their positions. The qualifications of the regulations were reviewed with the Administrator, and they stated the Food Service Director was not qualified for the position per the regulations. They stated it was important for Food Service Directors and/or Diet Techs to have the proper certifications, so the residents will receive safe and nutritious food and there will be not food related illnesses. 10NYCRR 415.14(a)(1)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 43785 Based on observation, interview and record review conducted during a Standard survey completed 6/14/24, the facility did not ensure provision of a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections, for one (Resident #307) of two residents reviewed for infection control practices during pressure ulcer care. Specifically, staff did not maintain proper hand hygiene during wound care and the resident was not on enhanced barrier precautions (infection control interventions including gown and glove use for high contact resident care activities designed to reduce transmission of multidrug-resistant organisms). The finding is: Review of the policy and procedure titled Hand Washing/hygiene dated 1/24 documented that all personal should follow the hand washing/hand hygiene procedures to help prevent the spread of infections to other personnel, resident, and visitors. The use of alcohol-based hand rub or soap and water should be used for the following situations: before handling clean or soiled dressings, gauze pads; before moving from a contaminated body site to a clean body site during care; after contact with blood or bodily fluids; after handling used dressings, contaminated equipment; after contact with objects in the immediate vicinity of the resident; and after removing gloves. The use of gloves does not replace hand washing/hygiene and integration of glove use along with routine hand hygiene was the best practice for preventing healthcare-associated infections. The Centers for Medicare and Medicaid Services Quality Safety and Oversight memoranda QSO-24-08-NH dated 3/20/24, documented enhanced barrier precautions were indicated for residents with wounds even if the resident was not known to be infected or colonized with a multidrug-resistant organism. Examples of wounds included chronic pressure ulcers. Enhanced barrier precautions were to be used when staff performed wound care for any skin opening that required a dressing. Review of the policy and procedure titled Enhanced Barrier Precautions dated 4/24 documented that it was the policy of the facility to adhere to the Centers for Disease Control and Prevention and the Centers for Medicare and Medicaid Services guidelines as related to enhanced barrier precautions to prevent the transmission of multidrug-resistant organisms. Enhanced barrier precautions were a Centers for Disease Control and Prevention recommendation to provide guidance for the use of personal protective equipment in facilities for preventing the spread of multi-drug resistant organisms. The facility would implement enhanced barrier precautions for any resident that had a chronic wound and would remain in effect until the resolution of the wound. Appropriate signage for the type of precaution would be posted on the resident's room door. Gown and gloves would only be needed when providing high-contact resident care activities. Resident #307 diagnoses included pressure ulcer of the sacrum (area above the tail bone on right and left buttocks), adult failure to thrive (a state of decline that is multifactorial) and diabetes mellitus type II. The Minimum Data Set (a resident assessment tool) dated 4/24/24 documented the resident was cognitively intact, had one stage II (shallow open wound when the top layer of skin breaks down and extends into the deeper layer of skin) pressure ulcer upon admission and two stage IV (full thickness tissue loss with exposed bone, tendon or muscle) pressure ulcers upon admission. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Comprehensive Care Plan with problem start date 4/19/24 and resolved on 5/30/24 documented that Resident #307 may have enhanced barrier precautions applied. Interventions included for signage on doors and gowns and gloves to be worn with high contact with affected source. The Comprehensive Care Plan with problem start date of 5/4/24 documented that Resident #307 was admitted with a stage IV pressure ulcer on their coccyx (tail bone). Interventions did not include enhanced barrier precautions. Review of the Physician Order Report dated 6/1/24-6/14/24 documented on 5/7/24, Resident #307 had an order to cleanse the pressure ulcer on their coccyx with soap and water, pat dry, apply hydrogel to wound bed, cover with bordered gauze daily and as needed. The order report documented on 6/13/24, Resident #307 was to have enhanced barrier precautions every shift due to their wound. Review of the Wound Physician Services notes dated 5/9/24-6/13/24, Medical Doctor #2 documented weekly that Resident #307 had a healing stage IV pressure injury to their sacrum. Review of Resident Progress Notes dated 5/30/24 at 3:28 PM, Registered Nurse #3 documented that Resident #307's enhanced barrier precautions were discontinued because the resident's wound was no longer draining. During intermittent observations on 6/10/24 at 12:09 PM and 6/11/24 at 10:04 AM, Resident #307 did not have enhanced barrier precaution signage on their room door. During an observation and interview on 6/12/24 at 1:15 PM, Certified Nursing Assistant #3 stated they wore a gown and gloves while providing incontinent care because Resident #307 was on contact precautions. Certified Nursing Assistant #3 stated they were unsure what Resident #307 was on precautions for, but they knew when a resident was on precautions because the name placard was marked with a green dot and there would be a precaution sign above that. Certified Nursing Assistant #3 observed Resident #307's door did not have a precautions sign and the name placard did not have a green dot. Certified Nursing Assistant #3 stated that Resident #307 was on contact precautions at one point during their stay and was unsure why there was not a green dot or precaution sign now. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a wound care observation on 6/12/24 at 1:41 PM, Licensed Practical Nurse #1 performed hand hygiene and entered Resident #307's room, there was no enhanced barrier precaution signage on the door. They cleansed Resident #307's overbed table with an antibacterial wipe, placed a barrier towel on the table and turned on the hot water in the bathroom. Without performing hand hygiene, Licensed Practical Nurse #1 donned two pairs of gloves and moved the resident's overbed table, wheelchair and rolling walker. Then they placed the dressing change supplies on the table with their gloved hands. Licensed Practical Nurse #1 wet a washcloth with the running sink water and put the washcloth on top of the supplies on the overbed table. Licensed Practical Nurse #1 then grabbed their scissors out of their pocket and cleansed them with an antibacterial wipe. Without changing their gloves or performing hand hygiene, Licensed Practical Nurse #1 applied soap to the washcloth then proceeded to wash, rinse and dry Resident #307's open wound on their coccyx. Licensed Practical Nurse #1 then removed their top layer of gloves, packed the wound with the dressing and covered it with border gauze. Licensed Practical Nurse #1 removed their gloves and placed the dressing wrappers into a garbage bag. They then applied new gloves without performing hand hygiene, repositioned the resident in the bed and then doffed their gloves. Licensed Practical Nurse #1 then donned one glove, picked up the garbage bag with their gloved hand, and exited the room. They applied antibacterial hand rub to their ungloved hand and walked down the hallway to the dirty utility room. Licensed Practical Nurse #1 entered the dirty utility room, threw the garbage bag into the garbage, doffed the one glove, and then performed antibacterial hand hygiene to both hands. Licensed Practical Nurse #1 did not wear a gown during wound care. During an observation of a televisit Wound Rounds with Medical Doctor #2, on 6/13/24 at 8:01 AM, Resident #307's room did not have enhanced barrier precautions signage on their door. Registered Nurse #3 rolled Resident #307 onto their side while the Director of Nursing was holding a cellular phone for Medical Doctor #2 to visualize the coccyx wound. Neither staff had donned a gown for the televisit. During an interview on 6/13/24 at 7:37 AM, Licensed Practical Nurse #1, stated that they were working as a graduate nurse and have completed Resident #307 treatment in the past. Licensed Practical Nurse #1 stated during wound care observation on 6/12/24 they had missed hand hygiene opportunities. Licensed Practical Nurse #1 stated hand hygiene should always be performed in-between doffing and donning of gloves. Licensed Practical Nurse #1 stated they did not change their gloves prior to cleansing Resident #307 wound. They stated that they should have doffed the dirty gloves after touching items in Resident #307's room, then performed hand hygiene prior to donning new gloves to prevent the possible spread infection to the wound. Licensed Practical Nurse #1 stated that the process of double gloving was not taught in the facility but was a process they learned in nursing school. Licensed Practical Nurse #1 stated that Resident #307 was not on enhanced barrier precautions and would be if they had a history of multiple drug resistant organisms. During an interview on 6/13/24 at 10:39 AM, Registered Nurse #3 stated that Resident #307 had a chronic pressure ulcer. Registered Nurse #3 stated that hand hygiene needed to be performed every time a staff member donned or doffed a pair of gloves. They stated prior to the start of cleansing a wound Licensed Practical Nurse #1 staff member needed to perform hand hygiene and don a new pair of gloves to prevent the possible contamination of the wound. Registered Nurse #3 stated the Director of Nursing discontinued enhanced barrier precautions for Resident #307 on 5/30/24 when the wound was no longer draining. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335661	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellsville Manor Care Center	4192a Bolivar Road Wellsville, NY 14895

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/13/24 at 2:42 PM, Registered Nurse #2 (Infection Control Nurse) stated that it was not facility practice to double glove and that hand hygiene should be performed prior to/after leaving a resident's room and in between glove changes. Registered Nurse #2 stated that a new pair of gloves should be worn, after staff performed hand hygiene, prior to cleansing an open wound to prevent possible cross contamination. Registered Nurse #2 stated that a resident with an open draining wound should be on enhanced barrier precautions to reduce the spread of multiple drug resistant organisms and staff were to wear a gown and gloves when coming into close contact with the open area or bedding. During an interview on 6/13/24 at 3:07 PM, Registered Nurse #2 stated Resident #307 should have been on enhanced barrier precautions because their wound was open and greater than a stage II. During a telephone interview on 6/14/24 at 11:14 AM, Medical Doctor #1 (Medical Director) stated they have followed Resident #307 since they were residing at their previous nursing facility, and they had a chronic pressure ulcer to their sacrum. Medical Doctor #1 stated that any resident that had skin breakdown or a pressure ulcer needed to be on enhanced barrier precautions due to the new federal regulation that was just released. During an interview on 6/14/24 at 11:23 AM, the Director of Nursing stated staff should be preforming hand hygiene in between glove changes. They stated that Licensed Practical Nurse #1 should have doffed old gloves, performed hand hygiene, and donned new gloves prior to cleansing Resident #307's open wound to their sacrum. They stated that touching items in the room without hand hygiene and a glove change could have possibly contaminated Resident #307 open wound. The Director of Nursing stated that any resident that had open, draining wounds would need to be on enhanced barrier precautions that would consist of staff wearing gown and gloves for care. The Director of Nursing stated Registered Nurse #3 nor themselves wore a gown during wound round observation for Resident #307 on 6/13/24. The Director of Nursing stated they discontinued Resident #307 enhanced barrier precautions at the end of May because the wound was no longer draining. The Director of Nursing stated the precautions should not have been discontinued because stage IV pressure ulcers had a possibility of drainage. The Director of Nursing stated that the purpose of enhanced barrier precaution was to prevent the spread of infection, protect the staff and other residents from the spread of infection and any open wound had a higher risk for infection. During an interview on 6/14/24 at 12:07 PM, the Administrator stated they expected staff performed hand hygiene before and after resident interaction, when they touched soiled surfaces and if their hands were visibly soiled. They stated hand hygiene should be performed in between glove changes to mitigate germs being spread. 10NYCRR 415.19(b)(4)