

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335669	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Degraff Memorial Hospital-Skilled Nursing Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 445 Tremont Street North Tonawanda, NY 14120	

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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>34587</p> <p>Based on observation, record review, and interviews conducted during the Extended survey completed on 10/3/24, the facility did not exercise reasonable care for the protection of the resident's property from loss or theft for one (Resident #51) of three residents reviewed for personal property. Specifically, Resident #51 had no pants available to wear in their closet and their inventory sheets documented the resident had 17 pairs of pants.</p> <p>The finding is:</p> <p>Resident #51 had diagnoses including dementia, age related physical debility, and high blood pressure. The Minimum Data Set (a resident assessment tool) dated 8/11/24 documented the resident had moderately impaired cognition.</p> <p>The comprehensive care plan dated 8/21/24 documented the resident required extensive assistance with dressing, was non ambulatory, and was not able to make their needs known.</p> <p>During a telephone interview on 9/27/24 at 9:54 AM, the resident's family member stated when they came to visit, the resident would be wearing clothes that were too small for them, like they weren't the clothes they had brought in for the resident. The family member stated the resident's clothes were always missing, they get labeled with the resident's name but that didn't mean anything. When asked if the resident owned a red (name of video character) t shirt that they were observed wearing that morning, the family member stated, no that was not something they brought in for the resident.</p> <p>During an observation and interview on 9/30/24 at 1:29 PM, Certified Nurse Aide #1 exited Resident #51's room and stated they needed pants for the resident and the resident didn't have any in their room. Certified Nurse Aide #1 then went into the resident's room. The resident was observed sitting in their chair with an incontinence brief on and no pants. Observation of the resident's closet revealed there were t shirts and long-sleeved shirts on hangers, but there were no pants available. Certified Nurse Aide #1 stated the resident used to have a bunch and that new staff might put them in a wrong bag or maybe laundry didn't bring them up yet. The Unit Secretary brought a pair of maroon-colored pants for the resident, the Certified Nurse Aide #1 stated they were not the resident's pants, they were extra.</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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and interview on 10/1/24 at 8:56 AM, Registered Nurse Unit Manager #1 went to the laundry area to look for pants for Resident #51. They looked around the laundry area where there were clean clothes on hangers and another pile of clothes that were unlabeled and stated they could have been the resident's pants, but they were not labeled. The Laundry Attendant #1 arrived and stated they brought up a pair of pants for Resident #51 last night and hasn't seen any pants for that resident. Registered Nurse Unit Manager #1 stated that the resident was wearing those pair of pants right now.</p> <p>Observation on 10/1/24 at 9:56 AM, the Laundry Attendant #1 passed out laundry on the unit. At 10:03 AM, observation of Resident #51's closet revealed there were no pants.</p> <p>Review of Resident #51's Resident Inventory Personal Linen/Appliances dated 3/22/23 and 1/11/24 documented the resident had 17 pairs of pants. They were described as joggers, lounge, or sweatpants in assorted colors.</p> <p>During an interview on 10/1/24 at 10:18 AM, Registered Nurse Unit Manager #1 reviewed the inventory lists and stated the resident should have like 30 pairs of pants. The Registered Nurse Unit Manager #1 stated they were not sure where the pants were, they would wait for laundry to get through what they had, but she hopes there weren't 30 pairs of the resident's pants in laundry. The Certified Nurse Aides were supposed to put resident's personal clothing in purple bags that were then taken down to laundry. Maybe more re-education was needed for staff on which bags staff were to use for personal clothing.</p> <p>During an interview on 10/1/24 at 12:41 PM, Social Worker #1 stated they bought four pairs of new pants for Resident #51, and they would let the family member know about them.</p> <p>During an interview on 10/1/24 at 1:06 PM, Social Worker #1 stated they were aware the resident was getting low on pants in the last couple of days. At times there might be more of a lag with laundry. Social Worker #1 stated they didn't know if they would find all the resident's pants but was hopeful for finding at least 6 pairs. When families bring clothing in, they are inventoried and sent down to laundry to be labeled. Social Worker #1 stated they were not exactly sure why so many of this resident's pants were missing, but they use an offsite laundry service for facility linens so maybe the personal items were getting put into the wrong-colored bags. Social Worker #1 stated when items went missing the business office needed receipts for reimbursement, so they asked families to buy replacements and submit the receipts. Social Worker #1 stated the resident's family had been reimbursed for clothing items in May 2023 but don't have any further reimbursements or grievance/customer service forms since then.</p> <p>During an interview on 10/3/24 at 11:06 AM, Registered Nurse Unit Manager #1 stated they tried to ensure resident's personal property was kept safe from loss by using the different color bags to keep personal clothing separate from facility linens. If staff weren't using this process, things could get lost. When asked if this process worked, the Registered Nurse Unit Manager #1 stated yes and no.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34587</p> <p>Based on observations, interviews, and record reviews conducted during a complaint investigation (NY00346092) conducted during an extended standard survey from 9/26/2024 to 10/3/2024, the facility did not to ensure that each resident receives adequate supervision to prevent accidents for three (Residents #12, 14, and 29) of three reviewed. Specifically, the facility did not monitor the wander guard signaling device's (tag/bracelet) battery life/functionality of those that were assigned (#12, 14, 29) and Resident #14 exited the building unsupervised without staff's knowledge. In addition, the facility staff lacked education and training regarding the wander alert system and policy.</p> <p>The findings are:</p> <p>The policy and procedure titled WanderGuard dated 12/2022 documented all batteries of activated bracelet signaling devices are continuously monitored by the wander guard computer system and, if a battery is low, an alarm on the computer will be activated and identify the low battery; and nursing will be responsible to change the bracelet signaling device.</p> <p>The policy and procedure titled Elopement, Missing Person revised 10/27/2022 documented a resident elopement was defined as when a cognitively impaired resident leaves the facility without staff observation or knowledge of the resident's departure. The Quality Assurance functions after an elopement should include random test personal alarm systems.</p> <p>Resident #14 had diagnoses of dementia, depression, and borderline personality disorder (a mental disorder characterized by instability in mood, behavior, and functioning). The Minimum Data Set (a resident assessment tool) dated 4/28/2024 documented Resident #14 was cognitively intact. Resident #14 could wheel their wheelchair up to 150 feet and make turns.</p> <p>The comprehensive care plan dated 12/22/2022 (current) documented Resident #14 was alert and oriented but has fluctuating memory issues due to dementia and was high risk for falls due to confusion. The comprehensive care plan dated 1/5/2023 documented Resident #14 was an elopement risk due to impaired safety awareness, wandered aimlessly, and stated they need to go home. The comprehensive care plan dated 4/23/2023 documented the resident had poor impulse control, ineffective coping skills, and aggression towards others due to dementia.</p> <p>The physician orders dated 3/8/2024 documented Resident #14 was to have a wander guard on the back of their wheelchair, to check the wander guard once a shift, and to notify security if the wander guard was missing or broken.</p> <p>The Kardex care plan (guide used by staff to provide care) dated 6/1/2024 documented Resident #14 was a risk for elopement, check whereabouts after meals, at change of shift, and may not leave the facility unaccompanied.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The undated (the manufacturer of the wander guard system) Skilled Nurse Facility Wandering System instructions documented each resident is assigned a wander guard tag that actively monitors a resident when they are near a door controller. It documented the battery life can be checked by bringing the wander guard tag to a door controller, holding it there for a few seconds then going back to the wander guard monitor to look for the tag in the tag health field that would indicate if the battery was good or if the battery needed to be replaced.</p> <p>Resident #14's progress notes dated 2/1/2024 to 6/30/2024 documented</p> <p>the resident had exit seeking behaviors on the following dates: 2/9/2024, 2/15/2024, 2/29/2024, 3/7/2024, 3/10/2024, 3/24/2024, 4/8/2024, 4/11/2024, 4/18/2024, 4/25/2024, 5/13/2024, and 5/14/2024. On 6/23/2024 at 6:55 AM Resident #14 was found outside of building on the sidewalk and stated they were waiting for a ride.</p> <p>An undated investigation completed by the Director of Nursing documented Resident #14 was on the sidewalk in their wheelchair and found by Registered Nurse Nursing Supervisor #4 on 6/23/2024 at 6:55 AM. Resident #14's wander guard device was intact but did not lock the doors to prevent them from leaving the building. The investigation documented the batteries were changed for Resident #14's wander guard bracelet that didn't work.</p> <p>An observation and interview on 10/2/2024 at 8:11 AM, Resident #14's wander guard was tested at the front doors. The front doors locked, and the alarm sounded at the wander guard monitor. A red icon appeared on the screen with Resident 14's name and the location of the alarm. During this observation of the wander guard monitor, Registered Nurse Unit Manager #2 stated they did not know how to find out the battery life of the wander guard tag through the tag health field.</p> <p>During an interview on 9/30/2024 at 11:52 AM, Registered Nurse Supervisor #4 stated they saw Resident #14 sitting outside of the building on the sidewalk on 6/23/2024 at 6:55 AM. They stated they checked Resident 14's wander guard, and the door did not lock or alarm.</p> <p>During an interview on 10/1/2024 at 9:03 AM, the Plant Operations Manager stated the maintenance department does not do anything with the wander guard system, and the nursing department was responsible for checking the functionality of the wander guards.</p> <p>During an interview and observation on 10/1/2024 at 9:06 AM, Security Officer #1 stated they only check the alarms on the egress doors and if the front doors lock; they do not check the individual wander guard bracelets that were assigned to the residents. Security Officer #1 demonstrated the egress doors alarmed with a wander guard, and the front doors locked when the wander guard bracelet was nearby, and if the front doors were wide open the alarm would sound. They stated if the alarm does not go off or the front doors do not lock, there was something wrong with the wander guard bracelet.</p> <p>During a telephone interview on 10/1/2024 at 9:28 AM, the sales representative of the wander guard system stated the wander guard system will not work if there was a power outage. They stated metal from a wheelchair could interfere with the alarm system if it was placed on the chair where the metal could block the frequency. They stated there was an issue with a firewall which could have caused the wander guard not working. They stated the wander guard system could still work even if the network was offline.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 10/1/2024 at 10:14 AM with the technical support customer service representative of the manufacturer of the wander guard system, stated the wander guard tags might not work if the Wi-Fi was not working, if the power was out, if the battery of the wander guard tag was dead, and there was a small possibility the wander guard tag would not work if there was a lot of metal surrounding the tag. They stated there is no device to check the battery life of the individual tag. However, the tag batteries life could be found on the tag health on the wander guard monitor.</p> <p>During an interview on 10/1/2024 at 10:50 AM, Licensed Practical Nurse #1 stated they were working on the morning of 6/23/2024 and did not hear an alarm going off from the front door. They stated they do not check the individual resident's wander guard's functionality; they only check for the placement of the wander guard tag on the resident's person or their wheelchair.</p> <p>During an interview on 10/1/2024 at 11:02 PM, Certified Nurse Aide #1 stated they worked on 6/23/2024. They stated they were on their way to do rounds at approximately 6:45 AM that day and saw Resident #14 in the front foyer. They stated they did not hear an alarm sounding. They stated the resident had tried to elope before.</p> <p>During an interview on 10/2/2024 at 11:11 AM, Licensed Practical Nurse #3 stated they were not sure of the lifespan of the battery of the wander guard tag/bracelet or when the batteries needed to be changed. They stated they were not sure if security tests each individual wander guard tag of each resident.</p> <p>During an interview on 10/2/2024 at 11:24 AM, Registered Nurse Unit Manager #1 stated when someone's wander guard was removed, they had to discontinue it from the system. To reactivate it, they'd go to the front door and hold it up, then it would come up on the monitor and staff would put in the resident's name it was assigned to. The Registered Nurse Unit Manager #1 stated if there was a feature in the system to check the battery life, they were not aware of it.</p> <p>During an interview on 10/2/2024 at 11:28 AM, Registered Nurse Unit Manager #2 stated they check for physical placement of the wander guard tag/bracelet but not batteries.</p> <p>During an interview on 10/2/2024 at 1:56 PM, the Director of Nursing stated they never checked the batteries on the individual resident's wander guard tag but should have been.</p> <p>During an interview on 10/2/24 at 3:00 PM, Licensed Practical Nurse #4 stated they never checked the battery life of the wander guard tags. They stated they only checked the placement of the wander guard tag and check it off on the treatment administration record.</p> <p>During an interview on 10/3/2024 at 8:15 AM, the Administrator stated they attempted to find out how the battery life was shown on the wander guard monitor. They stated they found the tag health field to determine the battery life. They stated they were not aware how the tag health function worked prior to 10/2/24.</p> <p>During a telephone interview on 10/3/24 at 8:41 AM, Licensed Practical Nurse #5 stated Resident #14 tried to leave at times, they were on the wanderer list and have a wander alert band. Nurses checked for placement of the wander guard. They were not responsible for checking the functionality and how long the band had been in use. The nursing supervisors checked the functionality.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a telephone interview on 10/3/2024 at 9:04 AM, Registered Nurse Supervisor #3 stated they have never checked individual wander guard tags. They stated they do recall a device to check the wander guard tag's batteries, but they stated, it didn't work that well.</p> <p>During an interview on 10/3/24 at 10:13 AM, the Director of Nursing stated they were using the tags that required batteries. In June when they looked at the tags they had, some were totally sealed and those went in the garbage. The Director of Nursing stated they couldn't confirm which residents had which type of tags on in June, they all just got new ones (that required batteries) at that point. The Director of Nursing stated when staff go to activate or reactivate the tags, if it wasn't working, it won't show up on the monitor, and they would throw the tag out. The Director of Nursing stated they weren't checking the batteries and didn't know about their policy to check the batteries. The Director of Nursing stated maybe checking the batteries was something they should have been in tune with in June. The Director of Nursing stated they worked at the facility for 2.5 years and there wasn't a record of doing any checks when they first got there or since they've worked there.</p> <p>During an interview on 10/3/2024 at 12:00 PM, the Administrator stated that no one knew the wander guard system was down or that there was a malfunction with the wander guard tags. The Administrator stated they would have to read the policy again and update the policy to reflect any changes.</p> <p>2. Resident #12 had diagnoses of Alzheimer's disease and depression. Review of Resident #12's Minimum Data Set, dated dated dated [DATE] documented Resident #12 was cognitively impaired, needed supervision or touching assistance (help provides verbal cues or steadying assistance as resident completes the task) to wheel 150 feet, and rejected care from staff.</p> <p>The comprehensive care plan dated 1/20/2020 (current) documented Resident #12 was an elopement risk and wanderer related to impaired safety awareness and the resident's wandering is not purposeful. It documented staff were to check the resident's wander guard placement every shift, an elopement tool to be completed, and all staff are to be notified of wandering risk.</p> <p>The physician orders dated 7/18/23 documented Resident #12's wander guard tag every shift and to notify the supervisor or security if the wander guard tag is missing or broken.</p> <p>The treatment administration records dated February 2024 to September 2024 documented nursing staff were to check wander guard placement on the back of Resident #12's wheelchair once a shift.</p> <p>The Elopement Risk Scale dated 2/21/24 documented Resident #12 the resident ambulated with their wheelchair, cognitively impaired with poor decision-making skills, and displays body language or behavior that indicates an elopement may be forthcoming.</p> <p>A plan of care progress note dated 2/21/2024 documented Resident #12 was an elopement risk and made comments about leaving the facility.</p> <p>A social work progress note dated 3/20/24 documented the resident was upset and wanted to leave the facility to go home. A plan of care note dated 6/24/2024 documented Resident #12 asked to return to the community and their home.</p> <p>The undated investigation completed by the Director of Nursing documented Resident #12's wander guard tag was not setting off the alarm or locking the front doors as it should have been.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 10/2/2024 at 11:28 AM, Registered Nurse Unit Manager #2 stated checking the individual wander guard tags for residents, including Resident #12's was not implemented until today 10/2/2024.</p> <p>During an interview on 10/3/24 at 12:00 PM, the Director of Nursing stated they would expect security to notify them the internet system or the wander guard system was down or not working.</p> <p>3. Resident #29 had diagnoses of anxiety and depression. The Minimum Data Set, dated dated [DATE] documented Resident was #29 cognitively impaired, would reject hands on care, and required assistance to wheel their wheelchair 150 feet.</p> <p>The comprehensive care plan dated 4/2/2024 documented Resident #29 had a wander guard tag placed on their wheelchair. It was documented the resident repeatedly asks when they can go home.</p> <p>The physician's orders dated 4/2/2024 documented the wander guard tag placement on the back of Resident 29's wheelchair was to be checked every shift by nursing staff.</p> <p>The treatment administration record dated 4/1/2024 to 7/31/2024 documented nursing staff checked Resident 29's wander guard tag for placement every shift.</p> <p>The elopement risk scale dated 4/29/2024 documented Resident #29 was an elopement risk related to the resident statements of leaving, cognitively impaired with poor decision-making skills, and the resident had a history of wandering.</p> <p>A review of the interdisciplinary progress notes dated 4/1/2024 to 7/31/2024 documented the resident had exit seeking behaviors 4/2/24, 4/29/2024, and 5/31/2024.</p> <p>The undated investigation completed by the Director of Nursing documented Resident 29's wander guard tag was intact and working when tested by security.</p> <p>During an interview on 10/2/2024 at 1:56 PM, the Director of Nursing stated they should be following the wander guard policy about checking battery life.</p> <p>NYCRR 10 415.12(h)(1)</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>34587</p> <p>Based on interview and record review conducted during an extended survey completed on 10/3/24, the facility's quality assurance and performance improvement program did not perform improvement activities that tracked adverse resident events, analyze their causes, and implement preventative actions and mechanisms that include feedback and learning throughout the facility. Specifically, the facility did not ensure their WanderGuard policy was updated; that staff were educated about the wander guard system, and did not ensure preventive actions were implemented to ensure resident safety.</p> <p>The finding is:</p> <p>Refer to:</p> <p>F 689 - Free from Accident Hazards/Supervision and Devices to Prevent Accidents</p> <p>The 2024 Facility Assessment Review dated 2/6/2024 documented the facility assessment was used to determine gaps in service or expected outcomes, when identified, are reviewed and correction plans are discussed for implementation. The corrective activities are then review during subsequent meetings to assure changes are sustained and there is no recurrence of the issue.</p> <p>The policy and procedure titled LTC (long term care) Quality Assessment and Performance Improvement revised on 9/23/2021 documented the mission of the LTC Quality Assurance Performance Improvement Plan (QAPI) was to promote the delivery of resident care in keeping with the highest standards of outcomes and services valued by our customers, medical staff, employees, and payors; its institutional relationships and the community served. It documented the Facility QAPI (Quality Assessment and Performance Improvement) Plan includes the policies and procedures used to identify and use data to monitor facility performance: establish goals and thresholds for performance measurement using data from published sources; utilize resident, staff and family input through Resident Council minutes, discharge interviews, concerns, and other ad hoc (for this situation) committee forums; identify and prioritize problems and opportunities for improvement; analyze underlying causes of systemic problems and adverse events; and develop corrective action or performance improvement activities.</p> <p>The facility Quality Assessment and Performance Improvement Plan documented data from multiple sources (performance indicators, input from residents and families, audits) are utilized to monitor care and services. It documented the Quality Assessment and Performance Improvement focuses on a systematic approach to identify problems, their causes, and implications of change, and focuses on processes rather than addressing individual behaviors.</p> <p>(continued on next page)</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>An undated investigation completed by the Director of Nursing documented Resident #14 was on the sidewalk in their wheelchair and found by Registered Nurse Nursing Supervisor #4 on 6/23/2024 at 6:55 AM. Resident #14's wander guard device was intact but did not lock the doors to prevent them from leaving the building. It documented that the sales representative for the vendor for the security system thought the reason why the wander guard tag did not set off the alarm was due to a possible software update. It documented the batteries were changed for Resident #14 who's wander guard tags didn't work. On 6/28/2024 the sales representative for security system arrived at the facility to test the wander guard tags and they were found to be working.</p> <p>During an interview on 9/30/2024 at 11:52 AM, Registered Nurse Supervisor #4 stated they saw Resident #14 sitting outside of the building on the sidewalk on 6/23/2024 at 6:55 AM. They stated they checked Resident 14's wander guard, and the door did not lock or alarm.</p> <p>During an interview on 9/30/2024 at 3:00 PM, the Administrator stated they discussed the elopement that occurred on 6/23/2024 but did not discuss the any communication issues with their IT or security IT computer network related to the issues of software.</p> <p>During an interview on 10/1/2024 at 9:06 AM, Security Officer #1 stated they do not check the individual wander guard tags on residents or their wheelchairs. They stated they only check the alarms on the egress doors and if the front doors lock. They stated if they alarm does not go off or if the front doors do not lock, there was something wrong with the wander guard tag.</p> <p>During an interview on 10/1/2024 at 4:00 PM, the sales representative of the wander guard system stated they have not done an in-service on how the wander guard monitor works in at least two to three years. The sales representative stated, it sounds like the nurses need education on how the wander guard monitor works and even if it the system is offline; the tags should still work no matter what.</p> <p>During an interview on 10/2/2024 at 11:11 AM, Licensed Practical Nurse #3 stated they were not sure of the life span of the battery of the wander guard tags or when the batteries needed to be changed. They stated they were not sure if security tests each individual wander guard tag of each resident.</p> <p>During an interview on 10/2/2024 at 11:24 AM, Registered Nurse Unit Manager #1 stated if there was a feature in the system to check the battery life, they were not aware of it.</p> <p>During an interview on 10/2/2024 at 11:28 AM, Registered Nurse Unit Manager #2 stated they were not checking the individual wander guard tags of residents prior to 10/2/2024.</p> <p>During an interview on 10/2/2024 at 1:56 PM, the Director of Nursing stated they have never checked the batteries on the individual resident's wander guard tag. They stated they should have been checking the batteries of resident's wander guard tags.</p> <p>During an interview on 10/3/2024 at 8:15 AM, the Administrator stated they were not aware how the tag health function worked on the wander guard system prior to 10/2/24. They stated there was no wander guard tag battery audit log prior to 10/2/24.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Degraff Memorial Hospital-Skilled Nursing Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 445 Tremont Street North Tonawanda, NY 14120	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 10/3/24 at 10:13 AM, the Director of Nursing stated they were using the tags that required batteries. In June 2024 when they looked at the tags they had, some were totally sealed and those went in the garbage. The Director of Nursing stated they couldn't confirm which residents had which type of tags on in June, they all just got new ones (that required batteries) at that point. The Director of Nursing stated they weren't checking the batteries and didn't know about their policy to check the batteries. The Director of Nursing stated maybe checking the batteries was something they should have been in tune with in June.</p> <p>During an interview on 10/3/2024 at 12:00 PM with the Director of Nursing and the Administrator, the Administrator stated the Quality Assurance and Performance Improvement committee meets monthly. No one knew the wander guard system was down or that there was a malfunction with the wander guard tags. The Administrator stated they would have to read the policy again and update the policy to reflect any changes.</p> <p>NYCRR 415.27(c)(3)(iv)(4)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34587</p> <p>Based on observation, interview, and record review conducted during an Extended Recertification survey completed on 10/3/24, the facility did not 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 #2) of four residents reviewed for infection control processes during care. Specifically, staff did not wear proper personal protective equipment during hands on care and transfer of the resident, who required enhanced barrier precautions.</p> <p>The finding is:</p> <p>The policy and procedure titled Enhanced Barrier Precautions dated 6/18/24 documented personal protective equipment is used to prevent the spread of multi-drug resistant organism transmission. The recommendations include the use of enhanced barrier precautions during high-contact activities for residents with chronic wounds (open wounds that typically require a dressing change such as pressure injuries, venous and vascular ulcers, diabetic ulcers, and open surgical wounds) or indwelling medical devices (any devices that are inserted into the resident and have contact with external environment) regardless of [NAME]-drug resistant organism status. High contact activities include dressing, bathing/showering, providing hygiene, and transferring.</p> <p>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 and/or indwelling medical devices even if the resident is not known to be infected or colonized with a multidrug-resistant organism. Examples of chronic wounds include, but are not limited to, pressure ulcers and examples of indwelling medical devices included urinary catheters. The memo documented enhanced barrier precautions are employed for high contact resident care activities.</p> <p>Resident #2 had diagnoses that included multiple sclerosis (an autoimmune disorder that affects the brain, spinal cord, and other nerves), pressure ulcer of sacral region and neuromuscular dysfunction of bladder (a condition where the bladder function is impaired due to a brain, spinal cord or nerve problem). The Minimum Data Set (a resident assessment tool) dated 9/8/24 documented Resident #2 was cognitively intact, understands others, and was understood by others. Resident #2 required substantial assistance for personal hygiene and was dependent on staff for toileting hygiene and transfers. Additionally, they had a urinary catheter (a thin tube inserted into the bladder to drain urine) and a stage 4 (full thickness tissue loss with exposed bone, tendon, or muscle) pressure ulcer.</p> <p>The comprehensive care plan dated 7/12/23 documented that Resident #2 required extensive assist for bathing/showering and was dependent for toilet hygiene/clothing management. They required a full mechanical lift with 2 person assist for transfers. The comprehensive care plan initiated 8/23/23 documented the resident had a neurogenic bladder that required a suprapubic catheter and had a stage 4 pressure ulcer on their sacrum. The comprehensive care plan did not document evidence that Resident #2 was on enhanced barrier precautions.</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 - Few</p>	<p>Review of the Kardex (a guide for resident care) dated 10/2/24 documented that Resident#2 had a urinary catheter. There was no documented evidence that Resident #2 was on enhanced barrier precautions.</p> <p>During an observation on 9/26/24 at 9:43 AM, an orange-colored Enhanced Barrier Precaution sign was observed on Resident #2's room door.</p> <p>During an observation on 10/1/24 at 10:22 AM-11:00 AM, Certified Nurse Aide #3 was observed providing hands on morning care for Resident #2 that included bathing, hygiene, and dressing wearing only gloves. The Certified Nurse Aide #3 was not wearing a gown. Registered Nurse #2 Unit Manager assisted Certified Nurse Aide #3 with positioning Resident #2's transfer sling, adjustment of their clothing and transfer out of bed while wearing gloves and no gown. Registered Nurse #2 Unit Manager and Certified Nurse Aide #3's clothing was observed in direct contact with the resident's bedding during care.</p> <p>During an observation and interview on 10/2/24 at 10:53 AM, Certified Nurse Aide #3 was providing hands on care, wearing only gloves, to Resident #2 while they were in their bed without wearing a gown. Certified Nurse Aide #3 stated they didn't know they had to gown up during hands on care of residents with urinary catheters. They stated they identified what residents were on precautions by the signs posted on their hallway door, or by the resident's care plan. Certified Nurse Aide #3 stated they did not gown up during hands on care with Resident #2 on 10/1/24 or 10/2/24 and they should have because something could have splashed on them, or they could have had contact with the resident's wound. Certified Nurse Aide #3 stated they did not see the enhanced barrier precaution sign posted on Resident #2's door.</p> <p>During an interview on 10/2/24 at 11:11 AM, Licensed Practical Nurse #3 stated they can identify what residents are on enhanced barrier precautions by the signs posted on the residents' doors. They stated the precaution sign told them what personal protective equipment was to be worn with catheter and wound care.</p> <p>During an interview on 10/2/24 at 11:28 AM, Registered Nurse #2 Unit Manager stated enhanced barrier precautions were for residents that had a urinary catheter or were receiving active wound care. They stated that personal protective equipment was required when emptying, providing urinary catheter care and when performing wound care such as dressing changes. Registered Nurse #2 Unit Manager stated a gown was not required during care if care didn't involve managing a urinary catheter or wound. They stated they didn't believe they needed to wear gown prior to assisting with Resident #2's care on 10/1/24 because they weren't managing their catheter or pressure wound at that time.</p> <p>During an interview on 10/2/24 at 3:37 PM, the Director of Nursing stated nursing staff should be wearing gowns when they were performing high contact activities on residents who were on enhanced barrier precautions. The Director of Nursing expected nurses, aides, whoever was performing care to follow the precaution signs posted for the resident's protection and safety.</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 - Few</p>	<p>During an interview on 10/3/24 at 10:48 AM, the Registered Nurse #1 Unit Manager/Infection Preventionist stated staff were supposed to wear personal protective equipment that included gowns and gloves while they provided hands on care, bathing and any personal hygiene to residents who were on enhanced barrier precautions. Residents who were on enhanced barrier precautions included anyone with central lines, urinary catheters, or open wounds. It was important for staff to wear the gown and gloves to reduce the risk of spreading multi drug resistant organisms. The Registered Nurse Unit Manager #1/Infection Preventionist stated they would need to work on more education with the staff.</p> <p>10 NYCRR 415.19(a)(2)</p>		