STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335752	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elderwood at Cheektowaga	225 Bennett Road Cheektowaga, NY 14227

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36415 Based on observation, interview and record review conducted during a Standard survey completed [DATE], the facility did not ensure the system developed for advanced directives was implemented in a manner that was consistent with residents' wishes for one (Resident #8) of one resident reviewed for advanced directives. Specifically, Resident #8's Medical Orders for Life-Sustaining Treatment (MOLST) form and was not reviewed and renewed since [DATE]. The finding is: The policy and procedure titled Advanced Directives Surrogates and MOLST (Medical Orders for Life-Sustaining Treatment)-NY (New York) dated [DATE] documented Medical Orders for Life Sustaining Treatment (MOLST) works in alignment with known directives to assure that resident preferences are known and available across all continuum settings at the point of care, to guide 'right now' and 'from this time forward' treatment decisions. Do Not Resuscitate orders on Medical Orders for Life Sustaining Treatment (MOLST) will be reviewed and renewed no less than every 60 days, or upon change in order. Resident #8 had diagnoses that included cognitive communication deficit, hemiplegia (paralysis on one side of body) and hemiparesis (weakness of one side of body) following cerebral infraction (stroke) and type 2 diabetes mellitus. The Minimum Data Set (a resident assessment tool) dated [DATE] documented Resident #8 was understood, understands, and had moderate cognitive impairment. Advance directives in section S of the Minimum data set did not check other treatment restrictions. The comprehensive care plan initiated [DATE] documented Resident #8's advance directives included: Medical Orders for Life Sustaining Treatment (MOLST) for do not resuscitate (DNR)-see orders for additional decisions. Interventions dated [DATE] included: advanced directive wishes will be followed per provider order, review advanced directive documentation status quarterly and as needed. Additional interventions dated [DATE] included: ensure compliance with requirements of state law regarding advanced directives and maintain documentation in the record for the directive to be considered current and binding. Resident #8's goal was for their wishes to be honored throughout facility stay. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #8's Medical Orders for Life Sustaining Treatment (MOLST) signed by Resident #8 on [DATE] and medical provider on [DATE] documented orders: do not attempt resuscitation (DNR) (allow natural death), limited medical interventions, do not intubate (DNI), no feeding tube, a trial of intravenous (administered into vein) fluids, and do not use antibiotics. Review and renewal of the Medical Orders for Life Sustaining Treatment (MOLST) orders on the form were not reviewed and signed since [DATE] by a medical provider. Review of Progress Notes dated [DATE] at 6:31 PM, medical provider note documented Resident #8 was seen for an admission visit. Capacity determination completed by medical doctor and documented Resident #8 did not wish for any changes to their previous medical orders for life sustaining treatment (MOLST), Resident #8 was not to be resuscitated and intubated. There was no additional evidence that advance directives or capacity determination had been reviewed by a medical provider since [DATE]. Review of social services Progress Notes date range [DATE] to [DATE] revealed no evidence that Resident #8's advanced directives, medical orders for life sustaining treatment, were reviewed with Resident #8 during this time. During an interview on [DATE] at 9:45 AM, Resident #8 stated they would want to receive cardio-pulmonary resuscitation (CPR) and didn't recall the last time their advanced directives had been reviewed with them. During an interview and observation on [DATE] at 11:11 AM, Physician Assistant #1 stated the Medical Orders for Life Sustaining treatment (MOLST) form were the orders for life sustaining treatment and should be listed under the order tab in the electronic medical record. Physician Assistant #1 stated the Medical Orders for Life Sustaining Treatment (MOLST) form for Resident #8 should have been reviewed, renewed at intervals, at least every ,d+[DATE] days, and had not been since 2021 per the form. Physician Assistant #1 stated it was important that medical orders for life sustaining treatment were reviewed so residents' goals for care were maintained and wishes are not gone against. Additionally, Physician Assistant #1 stated it was important for nursing staff to know a residents' medical orders for life sustaining treatment so when communicating with medical provider they aren't receiving orders that go against the residents wishes. During an interview on [DATE] at 11:26 AM, Social Worker #2 stated Medical Orders for Life Sustaining Treatment (MOLST) were reviewed by social worker at least yearly or as needed if a resident wishes change. Social Worker #2 stated it was important to honor a resident's Medical Orders for Life Sustaining Treatment (MOLST) as it respected their autonomy and their wishes. Social Worker #2 stated it was nursing responsibility to ensure a resident's medical orders for life sustaining treatment were being carried out. Additionally, Social Worker #2 stated that advance directives should be reviewed quarterly during the interdisciplinary care plan meeting. During an interview on [DATE] at 11:40 AM, Registered Nurse #1 Unit Manager stated they believed a medical provider was supposed to sign resident's medical orders for life sustaining treatment (MOLST) form every 60 days. Registered Nurse #1 Unit Manager stated the physician and social workers were responsible to ensure the medical orders for life sustaining treatment (MOLST) forms were being reviewed with the resident and signed. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 11:47 AM, Social Worker #2 stated they completed an advance directive audit on Resident #8 last week and orders for no feeding tube, trial intravenous fluids and no antibiotic use needed to be added to orders in the electronic medical record. Social Worker #2 stated it was important that the orders were reflected in the electronic medical record so nursing staff could follow them. During an interview on [DATE] at 1:00 PM, the Director of Nursing stated resident's medical orders for life sustaining treatment (MOLST) should be reassessed every 90 days. The Director of Nursing stated they would expect medical provider to review and sign the medical orders for life sustaining treatment (MOLST) form when there were changes in the resident's status and after hospitalization s. 10 NYCRR 400.21 (e)(1)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 36415 Based on interview, and record review conducted during a Complaint investigation (#NY00330303) during the Standard survey completed on 6/18/24, the facility did not ensure the residents representative was notified of the need to alter treatment or to commence a new form of treatment and when there was a change in room assignment for one (Resident #152) of two residents reviewed. Specifically, the resident and resident's responsible party were not notified of a room change on 11/30/23. Additionally, when Resident #152 tested positive for COVID-19 on 12/17/23, there was no evidence their responsible party was notified. The finding is: Review of the policy and procedure titled Notification of Resident Changes dated 5/31/18 documented the facility will immediately inform the resident, consult with the resident's physician, and if known, notify the resident's legal representative or an interested family member when there is a need to alter treatment, commence a new form of treatment or a change in room or roommate assignment. Resident #152 had diagnoses which included hypertension, atrial fibrillation (irregular heart rate), and congestive heart failure (the heart doesn't pump blood as well as it should). The Minimum Data Set (a resident assessment tool) dated 11/9/23 documented the resident had moderately impaired cognition, usually understands and was usually understood. The comprehensive care plan dated 2/24/24 documented Resident #152 had a history of COVID-19 and did not reflect the room change that occurred on 11/30/23. a. Review of the twenty-four-hour Nursing Report dated 11/30/23 documented Resident #152's room changed. There was no documented evidence the resident or the responsible party had been notified. Review of nursing and social work Progress Notes and assessments dated 11/20/23-12/30/23 revealed no documentation Resident #152 and their representative were informed of the room change. Review of the printed screenshot of the census data provided by the facility on 6/14/24, documented Resident #152's room had changed on 11/30/23. During a telephone interview on 6/17/24 at 9:32 AM, Resident #152's family member stated their parent's room was changed on 11/30/23. Resident #152 and family member were not notified of the room change. During an interview on 6/17/24 at 10:55 AM, Social Worker #1 stated room change notification forms were completed and documented by the social worker on the plan of care. The process was the resident and responsible party were supposed to be notified before the change. Social Worker #1 stated there should have been documentation of the room change that occurred on 11/30/23 and there was no documented evidence that the family member or Resident #152 were notified. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/18/24 at 11:18AM, the Director of Social Work stated Unit Managers were responsible for notification when room changes occurred due to illness. Social workers notified residents and their responsible party for planned room changes. b.Review of the COVID-19 Status Evaluation form with an effective date of 12/17/23 documented Resident #152 was symptomatic and tested positive for COVID-19. Review of the twenty-four-hour Nursing Report dated 12/17/23 documented Resident #152 tested positive for COVID-19. There was no documented evidence the responsible party had been notified. Review of the nursing Progress Notes from 12/15/23 through 12/30/23 revealed no documented evidence the responsible party was notified that Resident #152 tested positive for COVID-19 on 12/17/23. Review of the Medication Administration Record dated 12/2023 documented Resident #152 received Molnupiravir (medication used to treat mild to moderate COVID-19) Capsule 200 milligrams, four capsules by mouth every morning and at bedtime for COVID-19 treatment for five days from 12/18/23 through 12/22/23. During a telephone interview on 6/17/24 at 9:40 AM, Resident #152's family member stated they arrived onto Unit one on 12/20/23. A nurse told them they couldn't enter Resident #152's room. The family member was not informed and preferred to be notified sooner of the change in condition. The change occurred over the weekend, there was a lack of communication, and they were upset over the whole situation. During an interview on 6/17/24 at 11:04 AM, Registered Nurse #4, Unit Manager stated families and residents were supposed to be notified to keep them updated on current treatments or changes in the plan of care as changes occurred. During an interview on 6/18/24 at 10:00 AM, the Director of Nursing in the presence of the Registered Nurse/Infection Preventionist stated the unit manager should have notified the responsible party before the room change occurred and immediately when there's a change in condition. Informing the responsible party kept them updated of current treatment and prevented possible further spread of the infection. During an interview on 6/18/24 at 12:41 PM, the Chief Nursing Officer in the presence of the Regional Nurse Consultant and the Administrator stated the unit manager should have notified the family member before the change occurred and documented in the electronic medical record. Change in condition's warranted immediately family notification with documentation in the nursing progress notes and the twenty-four-hour report. A room change notification form should be filed in the chart. There was no documentation for notification of the room change or when Resident #152 had COVID-19. 10NYCRR 415.3(d)(2)(ii)(a) 10NYCRR 415.3(f)(2)(ii)(c)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 36415 Based on observation, interview, and record review conducted during a Complaint investigation (#NY00340373) during a Standard survey completed 6/18/24, the facility did not ensure residents have the right to personal privacy for one (Resident #41) of one resident reviewed. Specifically, staff did not provide privacy during personal care. The finding is: The policy and procedure dated 6/6/22 documented that each staff member will be personally responsible for ensuring that the rights of each resident are respected and not violated. Staff shall ensure that all residents are afforded their right to privacy in treatment and care for personal needs. The policy and procedure dated 8/1/2019 documented each resident has the right to be treated with dignity and respect. All activities and interactions with residents by any staff must focus on assisting the resident in maintaining and enhancing their self-esteem and self-worth. Resident #41 had diagnoses which included congestive heart failure, ischemic cardiomyopathy (disease of the heart muscle), and osteoarthritis (degenerative joint disease). The Minimum Data Set (a resident assessment tool) dated 4/12/24 documented Resident #41 had moderate cognitive impairments, was understood, and understands. The resident was dependent on staff for toileting hygiene. The comprehensive care plan initiated 1/3/24 documented Resident #41 was incontinent of bowel and bladder. Interventions included to provide for privacy. During an observation and interview on 6/14/24 between 9:01 AM and 9:28 AM, Resident #41 was in bed, Certified Nursing Assistant #9 initiated incontinent care by removing top sheet, unfastening incontinent brief, and tucking soiled brief between Resident #41's thighs. At 9:07 AM Certified Nursing Assistant #9 exited Resident #41's room, leaving resident exposed and uncovered from below chest (left breast exposed from under t-shirt) to their feet and visible to the hallway. Resident #41 complained of being left exposed with no modesty. At 9:12 AM Certified Nursing Assistant #9 returned, along with Certified Nursing Assistant #8 and completed incontinent care. Upon completion of care, Certified Nursing Assistants #8 and #9 exited Resident #41's room, leaving hallway door opened and Resident uncovered, wearing only their t-shirt and brief. Resident #41 called out Hey would you cover me up, the doors open! During an interview on 6/14/24 at 9:54 AM, Licensed Practical Nurse #5 stated all nursing staff were responsible to ensure that personal privacy was provided during care to maintain residents' dignity. During an interview on 6/14/24 at 10:28 AM, Certified Nursing Assistant #8 stated Certified Nursing Assistant #9 should have closed Resident #41's door upon leaving their room so they weren't exposed and visible to others. Certified Nursing Assistant #8 stated a resident's personal privacy should be maintained for dignity. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/14/24 at 11:01 AM, Certified Nursing Assistant #9 stated they did not cover Resident #41 up prior to leaving their room during incontinent care and should have for dignity. During an interview on 6/17/24 at 4:43 PM, the Director of Nursing stated they expected staff to provide dignity and privacy both during and after care. 10 NYCRR 415.3(e)(1)(i)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 36415 Based on interview and record review conducted during the Standard survey completed on 6/18/24, the facility did not ensure that the pharmacist reported irregularities to the attending physician, the facility's Medical Director and Director of Nursing (DON) for one (Resident #25) of five residents reviewed for drug regimen reviews. Specifically, the Consultant Pharmacist did not identify, or report medications prescribed and administered (antibiotic) for an excessive duration and did not identify and report inadequate indications for the continued use of that antibiotic. The finding is: The policy and procedure titled Medication Regiment Review by Pharmacy Consultant dated 12/2021 documented the pharmacy consultant will assess the medication regimen and review the medical chart of all residents monthly. The pharmacy consultant will review the medication regimen for appropriateness and rationality to determine if the medication therapy is optimally effective and has the least possible risk of adverse effects and identify irregularities. Irregularities include but are not limited to excessive duration; without adequately monitoring; without adequate indications for its use; and in the presence of adverse consequences which indicate the dose should be reduced or discontinued. The policy and procedure titled Antibiotic Stewardship Program dated 10/2018 documented the Consultant Pharmacist will monitor and track oral antibiotic utilization and pattern of use: Antibiotics with no expiration dates and make recommendations for discontinuation. Review of the policy and procedure titled Care Planning (IDT) revised 1/2019 documented the interdisciplinary team will develop and implement a comprehensive person-centered care plan for each resident consistent with the resident rights that include measurable objectives and timeframe's to meet a resident's needs. Resident #25 had diagnoses which included osteomyelitis (infection of bone), pressure ulcers of left and right hip, and schizophrenia. The Minimum Data Set (a resident assessment tool) dated 5/24/24 documented Resident #25 had severe cognitive impairment, was sometimes understood, and sometimes understands. The Minimum Data Set documented that Resident #25 received antibiotics. The comprehensive care plan dated 5/29/20 and revised 5/28/24, documented Resident #25 had pressure ulcers to left and right trochanter (widest part of the hip). Interventions included to apply treatment as ordered and assess for signs and symptoms of infection. Long-term antibiotic use was not reflected in the care plan. The Order Summary Report printed by the facility on 6/18/24 documented an active physician's order to give Doxycycline Monohydrate Capsule 100 milligrams by mouth every morning and at bedtime. The start date was 11/22/20 and there was no end date documented. The Medication Administration Record dated June 2024 documented Resident #25 received Doxycycline Monohydrate 100 milligrams by mouth every morning and at bedtime as ordered. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Medication Regimen Reviews from 11/2022 through 5/2024 revealed there was no evidence of recommendations to the provider regarding the continued use of Doxycycline Monohydrate for Resident #25. During a telephone interview on 6/18/24 at 8:33 AM, the Pharmacy Consultant stated they were aware of the prophylactic antibiotic for Resident #25 since 11/22/20. A list was sent to the facility which included the monthly antibiotics used. The Pharmacist Consultant stated they had no documented evidence to the provider in regarding the use of Doxycycline Monohydrate dated back to 2020. Prophylactic antibiotics should be reviewed monthly for appropriateness. Communication was not good, It's my responsibility. There were no specific recommendations for the indication or the duration of the antibiotic. During an interview on 6/18/24 at 10:10 AM, the Director of Nursing stated they didn't know Resident #25 received an antibiotic, and that four years was a long time, Prophylactic antibiotics should be included on the comprehensive care plan, reviewed quarterly. The Director of Nursing stated they expected antibiotics be reviewed monthly by the provider and the Pharmacy Consultant for effectiveness and irregularities. During an interview on 6/18/24 at 12:50 PM, the Chief Nursing Officer in the presence of the Administrator stated the Pharmacy Consultant should have identified the irregularities and notified the provider to reevaluate the antibiotic during their monthly reviews. That was the expected role. 10 NYCRR 415.18(c)(2)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 36415 Based on observation, interview, and record review conducted during the Standard survey completed on 6/18/24, the facility did not ensure that drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles and include the expiration date when applicable for one (Unit 4) of two medication storage rooms observed. Specifically, the Unit 4 medication storage room refrigerator had three opened, undated and one opened, outdated multi-dose vials of Tubersol solution (medication injected just under the skin to test for tuberculosis). Additionally, the Unit 4 medication storage room cabinet had issues with expired over the counter medications. The finding is: The policy and procedure titled Medication Rooms on Nursing Units dated 1/18/2024 documented medication rooms on the nursing units of the facility will be the areas where medications for residents are stored. The policy documented authorized persons are allowed in the room for the purposes outlined: Licensed Nurses (Licensed Practical Nurse, Registered Nurse) for administration of medication to residents or for storage and or return of medication, Purchasing Assistant /designee under supervision of the Unit Manager/Assistant Unit Manager/Charge Nurse for storing or inventory stock medication and general supply items, and Pharmacy Consultant or Pharmacy staff to conduct inspections or re-label medication containers. Review of the manufacturer's Package Insert for Tubersol solution vial revealed that a vial of solution which has been entered and in use for 30 days should be discarded. A Unit 4 medication storage room observation with Licensed Practical Nurse #5 on 6/14/24 at 11:25 AM, revealed there were four open multi-dose vials of Tubersol in the medication storage room refrigerator. Three of the four opened vials had no documented open date on the vials or outer box. The other vial of Tubersol was opened, with a date 8/18 written on the vial and box, the manufacturer expiration date was 10/2026. Additionally, there were expired stock medications stored in the medication storage room cabinet that included one bottle of liquid Acetaminophen (pain reliever) with an expiration date of December 2021, one bottle of liquid Sorbitol Solution (laxative) with an expiration date of May 2024, and one bottle of Multi-Vite Liquid (multi-vitamin) with an expiration date February 2024. During an interview on 6/14/24 at 11:25 AM at the time of observation, Licensed Practical Nurse #5 stated the Shipping/Receiving Manager was responsible for stocking the medications in the storage room cabinet and would remove expired medications. Licensed Practical Nurse #5 verified three Tubersol vials were open with no open date and stated the other Tubersol vial was dated 8/18. They stated when they administered one dose last month, they opened a new bottle but did not label it with the open date. Licensed Practical Nurse #5 stated they should have dated the new bottle when they opened it. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/17/24 at 3:15 PM, the Shipping/Receiving Manager stated they were responsible for stocking the nursing medication storage rooms with the over the counter medications. They stated they only stocked the medications in the cabinet and would not stock refrigerator medications because they did not have access. The Shipping/Receiving Manager stated the Pharmacy Technician would be responsible for checking and removing expired medications from the medication storage rooms and medication carts. During a telephone interview on 6/18/24 at 8:52 AM, the Pharmacy Consultant stated multi-dose vials should be dated once opened and discarded within 28 days, specifically Tubersol solution, it would be less potent. The Pharmacy Consultant stated staff should not use vials without an open date documented and would expect staff to discard medications if expired or not labeled with an open date. During an interview on 6/18/24 at 10:16 AM, the Pharmacy Technician stated they were responsible as well as the nurses to check medication storage rooms and refrigerators for expired or unlabeled medications. The Pharmacy Technician stated they checked the medication storage rooms once a week and was not aware of expired medications. The Pharmacy Technician stated nurses were responsible to date multi-dose vials once opened. They stated medications should be discarded and not used if there was not an open date documented or if it was expired. They stated bacteria could form on vials or there was a potential that the resident would have an adverse reaction when the medication was administered. During an interview on 6/18/24 at 10:45 AM, Registered Nurse #1 Unit Manager stated that they expected all nurses on every shift to check medication rooms, remove expired medications and to label all multi-dose vials with an open date. They stated an open multi-dose vial was good for 28-30 days and would expect nurses to discard it, if it was not dated. During an interview on 6/18/24 at 11:09 AM, the Director of Nursing stated the expectation was that every nurse would check for expired and unlabeled prior to administration. The Director of Nursing stated multi-dose vials should be labeled and dated by the nurse when opened. They stated the expectation would be for the nurses to discard any expired or unlabeled medications, because that medication could be ineffective. During an interview on 6/18/24 at 11:46 AM, the Administrator stated their expectation would be all medication rooms and carts would be free of expired medications and open vials of medications would be labeled and dated. 10 NYCRR 415.18 (e)(4)

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. 36415 Based on record review and interview conducted during a Complaint investigation (#NY00336714) during the Standard survey completed on 6/18/24, the facility did not obtain or provide radiology services to meet the needs of its residents for one (Resident #150) of one resident reviewed. Specifically, Resident #150 was ordered to have a lumbar (section of the spine) x-ray completed on 2/28/24 but did not have the x-ray completed until 3/4/24. Additionally, the order for x-rays obtained on 2/28/24 was not entered into Resident #150's electronic medical record. The finding is: The policy and procedure titled Electronic Physician Orders (Create, Confirm, Processing Orders) dated 7/23/2018 documented the licensed nurse who has obtained the order from the Medical Doctor, Physician Assistant or Nurse Practitioner transcribing the medical order into the electronic medical record will ensure the correct date, time, ordering prescriber, medication name, order category, communication method, route of administration, frequency, schedule, indications for use or diagnosis and source details are listed. Resident #150 had diagnoses including dementia, hemiparesis (weakness of one side of the body) and repeated falls. The Minimum Data Set (a resident assessment tool) dated 3/11/24 documented Resident #150 was usually understood, usually understands and was severely cognitively impaired. The comprehensive care plan dated 11/29/23 documented Resident #150 was at risk for falls related to a history of falls. Interventions included call light within reach, bed mat next to bed, and a low bed. Review of the Un-witnessed Fall documentation dated 2/28/24 at 9:30 AM, completed by Registered Nurse #1, documented Resident #150 was observed laying on the floor with their knees bent, complaining of lower back pain and left elbow pain. It was documented Resident #150 was medicated with Tylenol, Nurse Practitioner #1 was notified, and x-rays ordered of elbow and lumbar, sacral (area of the spine above the tail bone) spine. Review of the text message documentation provided by Nurse Practitioner #1 dated 2/28/24 at 9:40 AM, revealed Registered Nurse #1 notified Nurse Practitioner #1 that Resident #150 was on the floor complaining of right elbow and back pain. Nurse Practitioner #1 responded to RN #1 with an order for a right elbow x-ray and asked Registered Nurse #1 where the back pain was. Registered Nurse #1 responded the pain was in the low back. Nurse Practitioner #1 responded to get lumbar and sacral x-ray. Review of the nursing progress note dated 2/28/24 at 10:12 AM, Registered Nurse #1 documented at 9:30 AM Resident #150 was found on the floor behind the nurse's station complaining of left elbow pain and low back pain. X-rays were ordered of the elbow and sacral lumbar area. Nurse Practitioner #1 was notified. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335752	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elderwood at Cheektowaga	225 Bennett Road Cheektowaga, NY 14227

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a radiology report dated 2/28/24 at 11:29 AM, documented Resident #150 received an x-ray to the right elbow, sacrum, and coccyx due to pain from a fall. Results showed no evidence of acute fracture or dislocation. There was no evidence a lumbar spine x-ray was obtained. Review of the nursing progress note dated 2/29/24 at 1:55 PM, Registered Nurse #1 documented the sacral and elbow x-rays were negative. There was no documentation that a lumbar spine x-ray was obtained. Review of the addendum progress note dated 3/1/24 at 10:18 AM, Nurse Practitioner #1 documented they ordered lumbar spine and sacral x-rays on 2/28 given a mechanical fall. Review of the Order Recap Report (medical provider orders) dated 2/1/24 through 3/31/24 documented lumbar sacral x-ray stat for pain with an order date of 3/4/24. There were no orders for the x-rays obtained on 2/28/24. Review of the progress note dated 3/4/24 at 4:20 PM, Nurse Practitioner #1 documented I wanted to order a STAT (without delay) lumbar x-ray, as it appears (Resident #150) only received a sacral/coccyx x-ray. During an interview on 6/17/24 at 9:28 AM, Unit Clerk #1 stated when there was a new order for x-rays or labs, they were responsible for calling the company to set up the x-ray and labs. Unit Clerk #1 stated when there was a new order, Registered Nurse #1 would write the order in a book that was kept at the nurse's station, and they would leave the book open on the Unit Clerk's keyboard to signal there were new orders. Unit Clerk #1 stated Resident #150's orders for x-rays were not written in the book on 2/28/24. During an interview of 6/17/24 at 10:30 AM, Registered Nurse #1 stated when there was a new order for an x-ray, they would tell Unit Clerk #1. Registered Nurse #1 stated they did not use the notebook that Unit Clerk #1 had for x-rays in February. Registered Nurse #1 stated they remembered Resident #150 had x-rays ordered for the elbow and sacral/lumbar regions and they had told Unit Clerk #1 that all three x-rays were needed. Registered Nurse #1 stated they received the results for the sacrum and elbow x-rays on 2/29/24 around 2:00 PM but did not remember noticing if there was an x-ray for the lumbar spine. Registered Nurse #1 stated the lumbar x-ray should have been done on 2/28/24 and completing it on 3/4/24 was considered a delay in treatment. During a telephone interview on 6/17/24 at 11:20 AM, Nurse Practitioner #1 stated when they were notified of the fall, they specifically ordered a lumbosacral x-ray which would include the lumbar region of the spine and the sacrum below it. Nurse Practitioner #1 stated they were notified that Resident #150 was complaining of lower back pain which included both the lumbar and sacral regions. Nurse Practitioner #1 stated it was important to receive both x-rays because when Resident #150 complained of lower back pain it was difficult to exactly pinpoint where the pain was in the lower back. Nurse Practitioner #1 stated Registered Nurse #1 should have entered the orders into the electronic medical record. (continued on next page)

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	335752	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elderwood at Cheektowaga	225 Bennett Road Cheektowaga, NY 14227

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/18/24 at 11:26 AM, the Director of Nursing stated it was expected that when a Nurse Practitioner, Medical Doctor or Physician Assistant ordered x-rays, that the nurses ordered the correct x-rays. The Director of Nursing stated there was a breakdown in communication on 2/28/24 between the staff ordering the x-rays for Resident #150 and that the nurses were able to put orders into the electronic medical record. During an interview on 6/18/24 at 12:04 PM, the Medical Doctor stated they would have expected Resident #150 to receive all x-rays as ordered by Nurse Practitioner #1. 10NYCRR 415.21(a)(1)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 36415 Based on record review and interviews conducted during the Standard survey completed on 6/18/24, the facility did not ensure that the facility's infection and control program included antibiotic use protocols and a system to monitor antibiotic use for one (Resident #25) of one resident reviewed. Specifically, Resident #25 was receiving an antibiotic since 11/22/20. The use of the antibiotic was not monitored and tracked by the Infection Preventionist (IP)/Antibiotic Stewardship Program. The finding is: Review of the policy and procedure titled Antibiotic Stewardship Program dated 1/2018, documented that the antibiotic stewardship program will provide a framework to ensure that antimicrobials are used appropriately and prudently within the facility. The framework would be overseen by the Infection Prevention and Control Committee. The Consultant Pharmacist will be aware of established guidelines and verify appropriate doses of antimicrobial therapy upon review of the medical chart. Tracking of antibiotic usage will occur by the Infection Preventionist/designee and will be reported to the Infection Prevention and Control Committee on a routine basis to ensure the compliance, effectiveness, and outcomes of the antimicrobial program. Antibiotic tracking and infection tracking forms will be used to determine benchmarks and assist with determining the success of the antibiotic stewardship program. The consultant Pharmacist will monitor and track antibiotic utilization, pattern of use, make recommendations for discontinuation. Resident #25 had diagnoses which included osteomyelitis (infection of bone), pressure ulcers of left and right hip, and schizophrenia. The Minimum Data Set (a resident assessment tool) dated 5/24/24 documented Resident #25 had severe cognitive impairment, was sometimes understood, and sometimes understands. The Minimum Data Set documented Resident #25 received antibiotics . The comprehensive care plan dated 5/29/20 and revised 5/28/24, documented Resident #25 had pressure ulcers to left and right trochanter (widest part of the hip). Interventions included to apply treatment as ordered and assess for signs and symptoms of infection. The Infectious Disease Consult dated 6/15/20 documented a diagnosis of Methicillin-Resistant Staphylococcus Aureus (bacteria) sepsis (infection in the bloodstream) and recommended Doxycycline Monohydrate 100 milligrams by mouth twice daily for lifelong suppression. There were no additional infectious disease consults. The Physicians' Progress Notes dated 2/26/24 documented that Resident #25 was followed by infectious disease in the past for Methicillin-Resistant Staphylococcus Aureus, osteomyelitis, bacteremia, and wound infections. Resident #25 receives Doxycycline Monohydrate 100 milligrams by mouth twice daily for chronic lifelong suppression with no issues. The Order Summary Report printed by the facility on 6/18/24 documented an active physician's order to give Doxycycline Monohydrate Capsule 100 milligrams by mouth every morning and at bedtime. The start date was 11/22/20 and there was no end date documented. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Medication Administration Record dated June 2024 documented Resident #25 received Doxycycline Monohydrate 100 milligrams by mouth every morning and at bedtime as ordered. Review of the facilities Resident Infection Tracking from 3/1/24 through 6/18/24 revealed there was no evidence the Doxycycline Monohydrate for Resident #25 was reviewed, monitored and tracked. During a telephone interview on 6/18/24 at 8:33 AM, the Pharmacy Consultant stated the pharmacy generated an Antimicrobial Days of Therapy Report (list of antibiotics used) and was sent monthly to the Administrator, Corporate and Regional staff. The Administrator was expected to share that report with the Infection Preventionist, the Director of Nursing, and medical providers. The Pharmacy Consultant stated prophylactic antibiotics should be included in the facilities monthly antibiotic monitoring program. During an interview on 6/18/24 at 9:32 AM, Registered Nurse/Infection Preventionist stated they reviewed/tracked/monitored antibiotics monthly based on what was displayed on the dashboard in the computer. There were currently two residents in the facility that received prophylactic antibiotics for wounds. They stated that they were unaware that Resident #25 was ordered a prophylactic antibiotic. The Doxycycline Monohydrate did not appear on the dashboard for Resident #25, was not on the generated monthly report and therefore was not monitored and it should have been. During an interview on 6/18/24 at 10:10 AM, the Director of Nursing stated they didn't know Resident #25 received an antibiotic, and that four years was a long time. Prophylactic antibiotics were monitored by the antibiotic stewardship program for appropriateness and trends. If the antibiotics didn't appear on the dashboard, they were not monitored. The Director of Nursing stated they expected antibiotics to be reviewed monthly by the provider and the Pharmacy Consultant for effectiveness and irregularities. There was a break in the system. During an interview on 6/18/24 at 11:06 AM, the covering Medical Director stated Doxycycline Monohydrate was used for chronic wound osteomyelitis and should be traced through the antibiotic stewardship program. During an interview on 6/18/24 at 12:50 PM, the Chief Nursing Officer in the presence of the Administrator stated Registered Nurse/Infection Preventionist should have monitored and tracked the use of the prophylactic antibiotic. This could have limited the duration of its use. They further stated there was no process in place to review the Antimicrobial Days of Therapy Report that's generated by the pharmacy. The Chief Nursing Officer stated that limiting the use of antibiotics prevented multidrug resistance within the resident population. 10 NYCRR 415.12(l)(1)