STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335757	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harris Hill Nursing Facility, L L C	2699 Wehrle Drive Williamsville, NY 14221

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39086 Based on observation, interview, and record review conducted during a Standard survey completed on 6/28/24, the facility did not ensure a resident was assessed by the interdisciplinary team to determine a resident's ability to safely administer their own medications if clinically appropriate for one (Resident #12) of one resident reviewed. Specifically, Resident #12 was observed with medications in their room and self-administered those medications without being evaluated as to whether they could safely do so. The findings are: The policy and procedure titled Self-Administration of Medications revised on 11/23/21 documented that each resident is given a detailed explanation of the medications that they may self-administer, the reason for the medication, what to expect, and the possible side effects within their cognitive ability to understand. Staff re-evaluates the resident's knowledge by having the resident report their understanding of the information presented to them. The self-administration of medication is monitored by the Team Leader. Continued approval of the self -administration of medication by the resident is dependent on the resident's compliance with physician orders and facility procedures. Resident #12 diagnoses which included peripheral neuropathy (disorder affecting the nervous system), intraspinal abscess (swelling, inflammation, and collection of infected material in or around the spinal cord), and glaucoma (progressive eye disease that can cause vision loss). The Minimum Data Set (MDS- a resident assessment) dated 4/16/24 documented Resident #12 was understood, understands and was cognitively intact. The Comprehensive Care Plan with last review date of 4/23/24, documented for nursing to administer ophthalmic (having to do with the eye) medication per physician's order. Documented in the section titled decision making stated to store medications at bedside for self-administration. During an interview on 6/24/24 at 11:11 AM, Resident #12 stated they self-administered their own eye drops for glaucoma. During observation of Resident #12's room and interview on 6/26/24 at 10:52 AM, revealed one bottle of Latanoprost 0.005% (used to treat glaucoma), one bottle of Dorzolamide HCL 2% (used to treat glaucoma), and one bottle of Refresh Tears 0.5% (used to treat dry eyes) stored in a clear zip lock bag taped onto the over the bed table. Resident #12 stated they administered their own eyedrops daily. (continued on next page)

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

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the physician Order Review Report dated 6/27/24, documented Latanoprost Ophthalmic Solution 0.005% instill 1 drop in both eyes at bedtime for Glaucoma, Dorzolamide HCL Ophthalmic Solution 2% instill 1 drop in both eyes three times a day and Refresh Tears Ophthalmic Solution 0.5% instill 1 drop both eyes as needed for dry eyes every day. There was no active physician's order for Resident #12 to self-administer medications and that medications were to be left at the bedside. The Medication Administration Record dated 6/2024 documented Resident #12 had received Latanoprost Ophthalmic Solution 0.005%, Dorzolamide HCL Ophthalmic Solution 2%, and Refresh Tears Ophthalmic Solution 0.5%. Medications were initialed as being administered by nursing staff. There was no documented evidence that Resident #12 could self-administer their eye drops. Review of the electronic medical record (EMR) dated 6/1/24 through 6/26/24 revealed there was no documented evidence Resident #12 was assessed by the interdisciplinary team to self-administer medications. There was no documented evidence there was a Self-Medication Administration Data Collection Tool completed per the facility process. During medication observation and interview on 6/27/24 at 9:45 AM, Licensed Practical Nurse #4 offered Resident #12 their eye drops. Resident #12 stated they administered their own eyedrops and had not taken them yet. Licensed Practical Nurse #4 stated there should have been a physician's order in the electronic medication administration record for self-administration. During an interview on 6/27/24 at 11:20 AM, Licensed Practical Nurse Unit Manager #3 stated there was no assessment tool completed for Resident #12 to self-administer the eyedrops and there should have been. Licensed Practical Nurse Unit Manager #3 stated self-administration should be documented on the comprehensive care plan and there should be a physician's order in place. During an interview on 6/27/24 at 4:16 PM, Pharmacy Consultant stated there was a policy and procedure for self-administration of medications. An evaluation was expected and would determine if the resident had the ability to self-administer medications. During an interview on 6/28/24 at 12:49 PM, the Director of Nursing stated Resident #12 should not have been administering the eyedrops without a Self-Medication Administration Data Collection Tool and without a physician's order. When a resident expressed the desire to self-administer medication including eye drops, the nurse, or unit manager should complete a [NAME] (user defined evaluation) which was then signed by a registered nurse. The assessment would be shared with the provider and a physician's order would be written. The Director of Nursing stated self-administration assessments were reviewed during the quarterly care plan meetings with the interdisciplinary team and as needed if there was a change in condition with the resident. 415.3 (e)(1)(vi)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 39086 Based on observation, interview and record review conducted during a Standard survey completed on 6/28/24, the facility did not ensure that a resident is free from abuse, neglect or exploitation for one (Resident #71) of five residents reviewed for abuse and neglect. Specifically, a Certified Nurse Aide did not follow Resident #71's care plan when they transferred the resident using a mechanical lift by themselves and the resident sustained an injury to their left lower leg. The finding is: The policy and procedure titled Abuse Prohibition revised on 2/2023, documented that residents have the right to be free from verbal, sexual, physical, mental abuse, mistreatment, neglect, involuntary seclusion, misappropriation of property, and exploitation. The policy and procedure titled Facility Incident, Abuse Investigation and Reporting dated 6/7/23 documented neglect was defined as the failure of the facility or its employees to provide goods and services to a resident that are necessary to avoid physical harm or pain. Resident #71 was admitted to the facility with diagnoses of stroke and hemiplegia (one sided paralysis caused by a brain or spinal cord injury). Review of the Minimum Data Set (a resident assessment tool) dated 4/9/24 documented that the resident was cognitively intact, understood by others, understands others, and was dependent on others for transfers. Review of Resident #71's comprehensive care plan dated 4/16/24 documented that the resident had issues related to transfer due to limited mobility, activity intolerance, limited range of motion, and cerebrovascular accident (stroke). The comprehensive care plan documented that Resident #71 required an assist of two staff members using a sit to stand lift (allows resident to go from a seated position to a standing position during transfers). Review of a Physical Therapy evaluation dated 4/3/24 documented that Resident #71 required a minimum assistance of two staff members with a manual sit to stand lift for transfers between their wheelchair and their bed. Review of a visual/beside Kardex report (a tool used by staff to guide care) dated 4/15/24 for Resident #71 documented that the resident required an assist of two staff members for transfers between the resident's wheelchair and the resident's bed. Review of a nursing progress note dated 5/13/24 at 9:37 PM, documented that a Certified Nurse Aide noticed an area on the back of Resident #71's left calf. The resident stated that Certified Nurse Aide #1 bumped their leg on the bed and that was the cause. The area was assessed and found to be painful to the touch. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an incident report dated 5/14/24 at 10:38 AM, documented that the resident received an injury to their lower left leg while they were transferred into bed. The resident description included that the back of their leg hit the bed rail and at first it didn't hurt but the next night it was killing me. Review of a radiology report dated 5/14/24 at 5:47 PM, revealed a vein scan was done due to swelling and pain, findings included a left lower extremity (leg) hematoma (collection of blood under the skin). Review of a Coach and Counseling session dated 5/14/24, signed by Certified Nurse Aide #1, documented that Certified Nurse Aide #1 did not follow the care plan for Resident #71 and used the lift to transfer the resident with one assist. Certified Nurse Aide #1 documented that they were one of the Certified Nurse Aides on the unit and going forward they would get someone to help them with transfers to avoid anything going wrong. During an interview on 6/24/24 at 11:53 AM, Resident #71 stated that they were transferred from their wheelchair to bed and the Certified Nurse Aide hit the back of their leg on the bed. They stated that Certified Nurse Aide #1 was by themselves when they were transferred with the manual sit to stand lift. Resident #71 stated that they had to have Dopplers (a diagnostic test used to check the circulation of the large veins of the leg) to make sure they didn't have a blood clot. An observation during this interview revealed the resident had a slight discoloration on the back of their left calf. During an interview on 6/26/24 at 8:43 AM, Certified Nurse Aide #1 stated that they put the resident to bed by themselves and knew the resident needed a two assist. They stated that there was no one else to help them to put Resident #71 to bed. They stated putting the resident to bed by themselves that it was not following the care plan. During an interview on 6/26/24 at 10:01 AM, Licensed Practical Nurse #1 stated that Certified Nurse Aide #1 broke the care plan by transferring the resident by themselves. Licensed Practical Nurse #1 stated that if the care plan says there needed to be two people to assist a transfer, then there should be two people to assist in the transfer. They stated that they do not recall anyone asking them to help transfer Resident #71 on that night. Licensed Practical Nurse #1 stated that if the care plan wasn't followed then that would be neglect. During an interview on 6/26/24 at 11:28 AM, Licensed Practical Nurse Unit Manager #2 stated that staff not following the care plan and the resident was hurt, would be considered neglect. During an interview on 6/26/24 at 12:38 PM, Director of Nursing stated that they expected their staff to follow the care plan of a resident. They stated that they expected their staff to use ask for help when using a manual sit to stand lift for a resident. The Director of Nursing stated that it would be neglect if the staff member didn't ask for help with a transfer if the care plan required two staff members for a transfer. During an interview on 6/26/24 at 12:49 PM, the Administrator stated that they expected the Certified Nurse Aide to follow the care plan. 10NYCRR 415.4(b)(1)(i)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 39086 Based on record review and interviews conducted during the Standard survey completed on 6/28/24, the facility did not ensure that the facility's infection prevention and control program included antibiotic use protocols and a system to monitor antibiotic use for one (Resident #12) of one resident reviewed. Specifically, Resident #12 received prophylactic Rifampin and Bactrim (antibiotics) since 10/18/22 and there was no ongoing monitoring by the Antibiotic Stewardship Program including laboratory tests, communication, or appointments with the Infectious Disease Physician. The finding is: Review of the policy and procedure titled Antibiotic Stewardship Program dated 5/2017, documented that the antibiotic stewardship program promotes the appropriate use of antimicrobials, improves patient outcomes, reduces microbial resistance, and decrease the spread of infections caused by multidrug-resistant organisms. The goal of antibiotic stewardship is to optimize the treatment of infections and clinical outcomes while minimizing unintended consequences of antibiotic use. The facility has a quality assessment and assurance committee that will review the antibiotic and resistance data. The Administrator, Medical Director, Director of Nursing Services, and Consultant Pharmacist are responsible for antibiotic stewardship in the facility. The Consultant Pharmacist reviews every antibiotic that is prescribed in the facility under the Drug Regimen Review and will report to the quality assessment and assurance committee on antibiotic use, agents, dose, and duration of use. Resident #12 was admitted with diagnoses including peripheral neuropathy (disorder affecting the nervous system), intraspinal abscess (swelling, inflammation, and collection of infected material in or around the spinal cord), and glaucoma (progressive eye disease that can cause vision loss). Review of the Minimum Data Set (a resident assessment tool) dated 4/16/24 documented Resident #12 was cognitively intact and received antibiotics. The comprehensive care plan dated 4/23/24 documented Resident #12 had a risk for infection related to long term prophylactic antibiotic use for a history of a paraspinal abscess (infection around the spinal cord). Interventions included to monitor for signs and symptoms of infection and administer antibiotics per physician orders. Infectious disease consults and recommendations were not included in the planned interventions. Review of the infectious disease consult dated 5/18/23 documented that Resident #12 had been tolerating chronic suppressive antibiotics since 4/2022 for an abscess in the epidural space of thoracic (middle section of spine) spine. The Infectious Disease Physician recommended continued treatment with Bactrim and Rifampin for indefinite therapy. Blood work that was requested to be done at three-month intervals was not done and was reinforced to be done as soon as possible. It would not be unreasonable to stop the Rifampin after 18-24 month use if no toxicity was noted on blood work. The plan was discussed with Licensed Practical Nurse #3, Unit Manager. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a handwritten Physician Verbal Telephone Orders dated 5/18/23 at 3:00 PM, documented by Licensed Practical Nurse #3, Unit Manager, revealed a physician's order for an erythrocyte sedimentation rate (blood test to measure inflammation in the body), c-reactive protein (blood test to identify inflammation), complete blood count (blood test to diagnose and monitor diseases), basic metabolic panel (blood test to monitor chemical balance and metabolism) in the morning, and every 3 months. Review of the infectious disease consult dated 7/20/23 documented continued surveillance of laboratory tests specifically, complete blood count, comprehensive metabolic panel, sedimentation rate, and c-reactive protein were to be obtained every 3 months. The infectious disease consult documented that the plan was discussed with Licensed Practical Nurse #3, Unit Manager. The next follow up appointment would be in 6 months. There were no additional infectious disease consults after 7/20/23. Review of the Order Review Report printed by the facility on 6/27/24, documented a physician's order with start date of 10/18/22 for Rifampin Capsule 300 milligrams give one capsule by mouth every twelve hours and Sulfamethoxazole-Trimethoprim (Bactrim) tablet 800-160 milligrams give one tablet by mouth every twelve hours for an intraspinal abscess. There was no documented physician's order for the six month follow up appointment with the infectious disease provider, erythrocyte sedimentation rate, c-reactive protein, complete blood count, basic metabolic panel every 3 months. Review of the provider's Medical Visit Notes from 7/21/23 through 6/18/24 documented Resident #12 continued Rifampin and Bactrim prophylaxis per infectious disease recommendations. There was no documentation for lab monitoring related to antibiotic use. Review of Resident #12's medical record including laboratory reports and nursing progress notes from 11/1/23 through 6/19/24 revealed no documentation that the recommended labs including a c-reactive protein, and erythrocyte sedimentation rate were drawn every three months and communicated to the infectious disease provider or that the resident was seen by the Infectious Disease Physician. Review of the monthly Pharmacy Drug Regimen Review dated 7/2023 through 6/2024 documented no irregularities or recommendations made for continued antibiotic therapy. Review of the Infection and Antibiotic Tracking Tool dated April 2024 to June 2024 provided by the facility, documented Resident #12 was on prophylactic antibiotics per infectious disease with an onset date of 10/18/22 for a skin and soft tissue infection. The white blood cell count column was blank and there were no documentation labs were monitored or communicated with the infectious disease provider. During a telephone interview on 6/26/24 at 3:24 PM, the Medical Assistant for the Infectious Disease Physician stated Resident #12 was seen last on 7/20/23. The last documented complete blood count, comprehensive metabolic profile, c-reactive protein, erythrocyte sedimentation rate results received from the facility were from 8/25/23. There were no further lab results communicated to their office as recommended. Resident #12 had an upcoming appointment in July 2024 and should have been seen in January 2024 for a six month follow up and was unaware why the appointment never occurred. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 6/26/24 at 3:46 PM, the Infectious Disease Physician stated Resident #12 received Bactrim and Rifampin for history of methicillin-resistant staphylococcus aureus, bacteremia, discitis (inflammation between the discs of the spine), and osteomyelitis (bone infection). Frequent blood chemistries and infection markers monitored for presence of infection and antibiotic resistance. Follow up appointments were to be scheduled by the facility every 6 months to re-evaluate the need of the continued long-term use of the medications. Lab tests were not completed every three months as they recommended. During an interview on 6/27/24 at 12:55 PM, Licensed Practical Nurse #3, Unit Manager stated they reviewed the infectious disease consults and attended tele med visits with Resident #12 and should have informed the Infection Preventionist of the recommendations for tracking purposes. They were responsible to ensure labs and appointments were completed, documented, and communicated to infectious disease. The recommended labs were not completed since August 2023. Resident #12 should have had a complete blood count, comprehensive metabolic panel, c-reactive protein, and erythrocyte sedimentation rate drawn in November 2023, February 2024, and April 2024. There was no documented evidence the blood work was completed and faxed to infectious disease. Licensed Practical Nurse #3, Unit Manager stated they were not involved in the facility antibiotic stewardship program and that was something the Director of Nursing/Infection Preventionist should monitor. During an interview on 6/27/24 at 3:41 PM, the Director of Nursing/Infection Preventionist stated Resident #12's antibiotics were documented on the facility infection and antibiotic tracking tool. Criteria, trends, and stop dates were discussed during monthly meetings. Resident #12 was stable from a medical standpoint, was followed by infectious disease and therefore, not discussed at their monthly meetings. The Director of Nursing/Infection Preventionist stated they were not aware that labs or scheduled appointments with infectious disease were recommended for Resident #12. Unit Managers reviewed recommendations with providers and documented changes in the medical record. A physician's order would be written, and they would have expected some kind of communication from Licensed Practical Nurse #3 Unit Manager. Standing lab orders for Resident #12 should have been documented in the lab book on the unit and the unit clerk should have made sure appointments were scheduled. The blood work should have been drawn, documented, and faxed to infectious disease for effective monitoring. During a telephone interview on 6/27/24 at 4:16 PM, the Pharmacy Consultant stated Resident #12 was on long term antibiotic therapy for discitis. They reviewed provider notes, diagnostics, consults, and physician orders during the monthly regimen review. The Pharmacy Consultant was unaware of the infectious disease consult dated 7/20/23 and the recommended labs for Resident #12. The Pharmacy Consultant stated effective antibiotic monitoring included review of labs and continued communication with infectious disease. During an interview on 6/28/24 at 12:58 PM, the Administrator stated they expected the unit manager to document a note in the medical record about the infectious disease recommendations for labs and appointments. The Administrator stated unit managers were responsible to follow up with consult recommendations, update providers and follow the orders once approved. The Administrator stated if the resident had been stable, they would not necessarily have been reviewed during the monthly antibiotic stewardship meetings. They would have just been monitored for a change in status which included monitoring for sepsis, pain, decline in status and lab work if ordered. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 6/28/24 at 1:30 PM, the Medical Director stated they participated in the antibiotic stewardship program in the facility which were reviewed during quality assurance meetings. They did not review Resident #12. The Medical Director stated prophylactic antibiotics were tracked under the antibiotic stewardship program and expected recommendations of infectious disease be followed when approved by the provider. This ensured for effective monitoring. 10 NYCRR 415.12(l)(1)