

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335777	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/06/2024
NAME OF PROVIDER OR SUPPLIER  Father Baker Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  6400 Powers Road Orchard Park, NY 14127	

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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>34587</p> <p>Based on interview and record review conducted during a Complaint investigation (#NY00359145) during a Standard survey completed on 11/6/2024, the facility did not ensure that each resident receives adequate supervision and assistive devices to prevent accidents for one (Resident #106) of five residents reviewed for accidents. Specifically, a gait belt (an assistive device used to help someone move) was not utilized by staff during a transfer as care planned and Resident #106 sustained skin tears to their left forearm.</p> <p>The finding is:</p> <p>The policy and procedure titled Gait Belt Use dated 3/28/2024 documented all patients/residents requiring touching, partial/moderate, substantial/maximal, or dependent times two people assistance will have a gait belt provided to them for use during transfers.</p> <p>The policy and procedure titled Modes of Transfer dated 7/27/2023 documented that all residents will have a safe mode of transfer from all surfaces.</p> <p>Resident #106 had diagnoses of Parkinson's disease, muscle weakness, and difficulty in walking. The Minimum Data Set (a resident assessment tool) dated 10/3/2024 documented Resident #106 was cognitively intact and required touching or steady assistance for transfers to the toilet.</p> <p>The comprehensive care plan dated 4/6/2024 documented Resident #106 had a loss in functional mobility, required a gait belt and a grab bar for transfers to the toilet.</p> <p>A nursing progress note completed by Registered Nurse Unit Nurse Manager #3 dated 10/30/2024 at 4:02 PM documented that Resident #106 sustained a skin tear to their left forearm when Certified Nurse Aide #2 transferred the resident to the toilet.</p> <p>An occurrence report statement form dated 10/31/24 from Certified Nurse Aide #2 documented they had transferred Resident #106 with the grab bar and not a gait belt. Certified Nurse Aide #2 documented they did not read the care plan before they transferred Resident #106.</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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/31/24 at 9:24 AM, Resident #106 stated they were transferred hurriedly to the toilet by Certified Nurse Aide #2. Resident #106 stated they fell against their wheelchair and received two skin tears on their left arm. They stated that they were not wearing a gait belt when they were transferred to the toilet.</p> <p>During an interview on 11/5/2024 at 8:48 AM, Registered Nurse Unit Nurse Manager #3 stated Resident #106 had reported that Certified Nurse Aide #2 did not use a gait belt when transferring them to the toilet. Registered Nurse Unit Nurse Manager #3 stated Resident #106 was care planned to have a gait belt on during transfers as they could fall. The incident was reported to the Director of Nursing.</p> <p>During an interview on 11/5/2024 at 9:06 AM, the Director of Social Work stated they spoke with Resident #106 who stated Certified Nurse Aide #2 did not use a gait belt when they were transferred. The Director of Social Work stated that the Certified Nurse Aide #2 violated the resident's care plan.</p> <p>During an interview on 11/5/2024 at 9:16 AM, the Director of Nursing stated they expected staff to follow the resident's care plan and use a gait belt for transfer for a resident who required it.</p> <p>During an interview on 11/5/2024 at 12:21 PM, Certified Nurse Aide #2 stated they didn't use a gait belt when they transferred Resident #106 to the toilet and should have for resident safety.</p> <p>NYCRR 10 415.12(h)(2)</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>34587</p> <p>Based on observation, interview, and record review conducted during the Standard survey completed on 11/6/24, the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for one (Resident #138) of three residents reviewed for enhanced barrier precautions (interventions designed to reduce transmission of multi-drug resistant organisms including gown and glove use during high contact resident care activities). Specifically, a nurse did not wear proper personal protective equipment during care of the resident's feeding tube (a tube inserted into the stomach to provide nutrition).</p> <p>The finding is:</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 indwelling medical devices even if the resident was not known to be infected or colonized with a multidrug-resistant organism. Examples of indwelling medical devices included feeding tubes. The memo documented enhanced barrier precautions were employed for high contact resident care activities including the care or use of a feeding tube.</p> <p>The policy and procedure titled Transmission Based Precautions with an effective 1/10/24, documented that gowns were to be worn if clothes were likely to be soiled with secretions or excretions. Enhanced barrier precautions and tube feedings were not addressed in this policy and procedure.</p> <p>The policy and procedure titled Community Based Care: Nasogastric Tube insertion and Enteral Feedings Guidelines effective 7/27/18, included procedures for gastrostomy tubes with bolus feeds (a method of tube feeding where a large amount of liquid formula is given over a short period of time) and bolus medication administration. The policy and procedure did not include instructions to wear a gown and did not address enhanced barrier precautions.</p> <p>Resident #138 had diagnoses which included dysphagia, oropharyngeal phase (swallowing problems occurring in the mouth and/or the throat), gastro esophageal reflux disease (a condition in which stomach acid repeatedly flows back up into the tube connecting the mouth and the stomach), and congestive heart failure (a condition in which the heart doesn't pump blood as well as it should). The Minimum Data Set (a resident assessment tool) dated 10/4/24 documented Resident #84 had no cognitive impairment, had a feeding tube and received more than 51% of total calories through tube feeding.</p> <p>The comprehensive care plan initiated on 9/27/24 and revised on 10/2/24 documented that Resident #138 required tube feeding related to their inability to swallow and needed maximum assist with tube feeding and water flushes. Interventions included to monitor, document, report any signs and symptoms of aspiration, infections at the tube site, and tube dysfunction or malfunction.</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 observation on 11/5/2024 at 11:52 AM, outside of Resident #138's room was an enhanced barrier precautions set up in plastic, portable storage drawers containing disposable surgical gowns, gloves, and face masks. On the side of the doorway was a sign that Resident #138 was on enhanced barrier precautions and staff were to wear a gown and gloves during hands on care. At 11:55 AM, Licensed Practical Nurse #1 entered the room with a towel and Resident #138's tube feed formula. Licensed Practical Nurse #1 washed their hands and applied gloves. Resident #138 sat in a reclining chair and helped Licensed Practical Nurse #1 place the towel underneath their feeding tube opening. Licensed Practical Nurse #1 opened the feeding tube and approximately 20 milliliters of yellowish colored liquid splashed onto the towel and onto Licensed Practical Nurse #1's glove. Licensed Practical Nurse #1 wiped off their glove onto the towel. Licensed Practical Nurse #1 was not wearing a gown during this procedure.</p> <p>During an interview on 11/5/2024 at 12:25 PM, Licensed Practical Nurse #1 stated that they should have worn a surgical gown during the resident's bolus feed because the resident was on enhanced barrier precautions. They stated that they should have worn a gown for a resident with a gastric tube to prevent cross contamination between residents.</p> <p>During an interview on 11/5/2024 at 12:51 PM with Registered Nurse Unit Nurse Manager #2, they stated they expected their staff to wear gowns, gloves, and a mask for direct care for a resident on enhanced barrier precautions. They stated that if the nurse or the aide thought care might be messy they should wear goggles as well to protect themselves from getting contaminated with germs. They stated that enhanced barrier precautions were to prevent germs from being spread from one resident to another.</p> <p>During an interview on 11/5/2024 at 12:58 PM, the Assistant Director of Nursing Infection Preventionist stated that they expected staff to wear personal protection equipment such as a gown, mask, or goggles with a resident who was on enhanced barrier precautions.</p> <p>During an interview on 11/5/2024 at 1:12 PM, the Director of Nursing stated that they expected staff to wear personal protective equipment when providing care to residents on enhanced barrier precautions to prevent cross contamination with other residents.</p> <p>10NYCRR 415.19(a)(2)</p>		