STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335790	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER: Elderwood at Wheatfield		STREET ADDRESS, CITY, STATE, ZIP CODE: 2600 Niagara Falls Boulevard, Niagara Falls, NY 14304	

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 43802 Based on observation, interview, and record conducted during the Standard survey completed on 8/14/24, the facility did not ensure that each resident was treated with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for one (Resident #59) of two residents reviewed for dignity. Specifically, Resident #59 was observed to have a hospice (specialized care for people nearing the end of life) nursing assessment completed in the dining room while they were being assisted with their lunch. The finding is: The policy and procedure titled Resident's Rights Policy (General) revised 6/6/22 documented 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 a nondiscriminatory, dignified existence, self-determination, respect, full recognition of their individuality, consideration and privacy in treatment and care for all personal needs, and communication with and access to persons and services inside and outside the facility. Resident #59 had diagnoses that included cerebral infarction (stroke), nutritional marasmus (severe form of malnutrition), and encounter for palliative care. The Minimum Data Set (an assessment tool) dated 5/8/24 documented Resident #59 was usually understood, usually understands, and had severe cognitive impairment. The assessment tool documented that Resident #59 was on hospice care. Review of the comprehensive care plan revised 11/7/23 documented that Resident #59 had a deficit in activities of daily living function and mobility, interventions included that Resident #59 was a maximal assist of one staff member for eating. Resident #59 required hospice care related to a terminal diagnosis. Interventions included to offer choices and honor wishes, honor treatment restrictions per resident wishes and refer to the resident advance directives. Review of the Hospice Progress notes dated 8/8/24 at 2:21 PM, Hospice Nurse #1 documented that the resident was seen for their weekly comprehensive visit. Hospice Nurse #1 documented that Resident #59 was out of bed in a recliner chair, waiting to eat their lunch and the resident was a full feed. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335790	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2024

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation in the assistance dining room on 8/8/24 at 1:12 PM, Licensed Practical Nurse #5 began to assist Resident #59 to eat their lunch. Resident #59 was in their reclining chair as Licensed Practical Nurse #5 started to assist them to eat and gave them a few bites of food. At 1:14 PM, Hospice Nurse #1 entered the dining room and approached Resident #59. Licensed Practical Nurse #5 stopped their assistance while Hospice Nurse #1 used a stethoscope and listened to Resident #59's heart, lungs, abdomen, then assessed the resident's lower legs and arms. Eight other residents were in the dining room at that time with three residents two to four feet away from Resident #59. Hospice Nurse #1 exited the dining room and Licensed Practical Nurse #5 resumed assisting Resident #59 with their lunch meal. At 1:21 PM, Hospice Nurse #1 re-entered the dining room and conversed with Licensed Practical Nurse #5 regarding Resident #59's blood sugar trends. During a telephone interview on 8/12/24 at 4:57 PM, Hospice Nurse #1 stated on 8/8/24 they assessed Resident #59's heart rate, lung sounds, abdomen, legs for edema and how well the resident was eating in the dining room. Hospice Nurse #1 stated they did a quick assessment in-between Resident #59 being assisted with eating. Hospice Nurse #1 stated that there were about five other residents in the dining room and thought it was an appropriate setting since Resident #59 could not communicate so they were not talking about things. Hospice Nurse #1 stated that they normally performed their assessments in the common area or in the resident's room. Hospice Nurse #1 stated they feel they maintained Resident #59's privacy because no one know who they were. During a telephone interview on 8/14/24 at 9:11 AM, Licensed Practical Nurse #5 stated they were actively assisting Resident #59 with eating on 8/8/24 in the assistance dining room when Hospice Nurse #1 performed an assessment on the resident. Licensed Practical Nurse #5 stated Hospice Nurse #1 listened to Resident #55 heart and lungs and asked them how the resident was doing. Licensed Practical Nurse #5 stated that there were other residents in the dining room, and it was a dignity issue for the assessment to be taking place in the dining room. During an interview on 8/14/24 at 11:25 AM, the Acting Unit Manager/Assistant Director of Nursing stated that the hospice nurse visit was a nursing assessment and should be completed in a resident room with the door closed or the curtain pulled. They stated that an assessment should not be conducted in a dining room to protect a resident's privacy and dignity. During an interview on 8/14/24 at 11:58 AM, the Director of Nursing stated that the assistance dining room was not an acceptable place for Hospice Nurse #1 to perform their nursing assessment unless the resident insisted for the visit to be completed there. The Director of Nursing stated that a hospice nurse assessment should be completed weekly onsite, and that visit should take place in the resident's room to maintain their privacy and dignity. 10NYCRR 415.3 (e) (1) (i)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43802 Based on observation, record review and interview conducted during a Complaint investigation (#NY00339558) during the Standard survey completed on 8/14/24, the facility did not ensure residents had the right to choose schedules, and health care consistent with their interests, assessments, and plan of care for three (Resident #1, #55, and #56) of six residents reviewed for choices. Specifically, Residents #1, #55, and #56 were not given showers twice a week as care planned and preferred. Additionally, Resident #56 was not gotten out of bed as care planned and preferred. The findings are: The policy and procedure titled Resident's Rights Policy dated 5/23/22 documented 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 self-determination in treatment and care for personal needs. Refer to a copy of Resident's Rights and relevant policy regarding rights of residents. Review of the document Your Rights as a Nursing Home Resident in New York Stated dated 2022, documented as a resident in this facility you have rights guaranteed to you by state and federal laws. This facility is required to protect and promote your rights. Your rights strongly emphasize individual dignity and self-determination, promoting your independence and enhancing your quality of life. You have the right to receive services with reasonable accommodations for individual needs and preferences. 1. Resident #1 had diagnoses including traumatic brain injury, left side hemiparesis (weakness or partial paralysis on one side of the body), and diabetes. The Minimum Data Set (a resident assessment tool) dated 7/17/24 documented Resident #1 was cognitively intact and displayed no rejection of care behaviors. The Minimum Data Set, dated dated dated [DATE] documented, it was very important for Resident #1 to choose between a tub bath, shower, bed bath or sponge bath. The comprehensive care plan dated 12/20/23 documented Resident #1's customary routine included bathing preference and shower frequency 2 times a week on Wednesday and Saturday evening shifts. Review of the kardex (a guide used by staff to provide care) dated 8/13/24 documented Resident #1 was to have a shower 2 times a week on Thursday and Sunday day shifts. Review of the Unit 2 Shower Schedule revised on 7/9/24, documented that Resident #1 was to receive a shower on Wednesdays 6:00 AM - 2:00 PM (day shift) and Saturdays 2:00 PM - 10:00 PM (evening shift). Review of the electronic medical record task documentation from 7/13/24 to 8/13/24, documented showers were to be given 2 times a week on Thursday and Sunday day shift. The resident received a sponge bath/bed bath on 7/18/24 and 7/28/24 with no documented evidence Resident #1 received any showers. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/9/24 at 7:55 AM, Resident #1 stated they do not receive showers 2 times a week per their preference because of short staffing. During an interview on 8/12/24 at 10:07 AM, Resident #1's Health Care Agent stated Resident #1 did not receive their showers 2 times a week per their preference and sometimes they did not receive a shower for over a week. During another interview on 8/13/24 at 10:09 AM, Resident #1's Health Care Agent stated the last time Resident #1 was provided a shower was on 7/31/24. During an interview on 8/13/24 at 4:38 PM, the Acting Unit Manager/ Assistant Director of Nursing stated they were unable to locate the Certified Nursing Assistant's assignment sheets for 8/3/24, 8/7/24 and 8/10/24 and had no documented evidence Resident #1 received their showers according to the Unit Shower Schedule. During an interview on 8/13/24 at 4:48 PM, Licensed Practical Nurse #4 stated they didn't recall if Resident #1 had received a shower as scheduled on 8/7/24 and didn't recall if staff had reported to them that it was not given. They stated they expected the certified nursing assistant to report to them if showers were not completed according to the plan of care and they would report it to the Acting Unit Manager/Assistant Director of Nursing. During an interview on 8/14/24 at 10:57 AM, Certified Nursing Assistant #10 stated they were responsible to provide a shower to Resident #1 that day and they did not believe they would be able to provide the shower because they had an assignment of 19 residents and there was too much to do. They stated they had informed their Acting Unit Manager/Assistant Director of Nursing. During an interview on 8/14/24 at 11:13 AM, Certified Nursing Assistant #7 stated they had Resident #1 on their assignment on 8/10/24 from 2:00 PM - 6:00 PM and reported to Certified Nursing Assistant #20 that Resident #1 was not provided their shower and their shower needed to be done. During an interview on 8/14/24 at 11:17 AM, Certified Nursing Assistant #20 stated Resident #1 was on their assignment 6:00 PM - 10:00 PM on 8/10/24 and they had not provided a shower to Resident #1 because they didn't know they were scheduled for a shower. Certified Nursing Assistant #20 stated they usually were provided an assignment sheet with the shower information on it but didn't believe they received an assignment sheet. They stated they recalled Resident #1 going to bed immediately after the dinner meal and they did not offer a shower to Resident #1. During another interview on 8/14/24 11:25 AM, the Health Care Agent for Resident #1 stated they didn't believe Resident #1 would be getting their shower today as scheduled because there was not enough staff. The Health Care Agent stated they often washed Resident #1's hair, so they looked clean. During an interview on 8/14/24 at 11:27 AM, the Acting Unit Manager/Assistant Director of Nursing stated they were aware Certified Nursing Assistant #10 may not be able to provide Resident #1 their shower today due to staffing and they would inform the next shift. They stated Resident #1's shower preference was 2 times a week on Wednesday day shift and Saturday evening shifts and the certified nursing assistants were to follow the Unit 2 Shower Schedule. They stated the care plan information in the electronic record was incorrect and it should not read Sunday day shift as it had been changed a few weeks ago per the resident's preference. The Acting Unit Manager/Assistant Director of Nursing stated they had no documented evidence Resident #1 received their showers per their preference. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/14/24 at 12:47 PM, the Director of Nursing stated they believe Resident #1 had received their shower today because their hair was wet and clean when they had observed the resident around 11:30 AM. The Director of Nursing stated they were unable to verify if Resident #1 had received a shower or if Resident #1's Health Care Agent had washed their hair for them in their room. The Director of Nursing stated upon review of Resident #1's care pan and Unit 2's Shower Schedule Resident #1 should be receiving their showers twice a week. The Director of Nursing stated they would have expected the Acting Unit Manger/ Assistant Director of Nursing to inform them if showers were not being provided. The Director of Nursing stated Resident #1's preferences were not being met. During an interview on 8/14/24 at 1:31 PM, the Administrator stated they were not aware staff were not able to provide showers to Resident #1 per their preference 2 times a week. The Administrator stated they were unable to provide documented evidence Resident #1 had received their showers 2 times a week according to their preference and they were unable to say whether Resident #1's preferences were followed. 2. Resident #56 had diagnoses that included hemiplegia (one sided weakness) following a cerebral infarction (stroke), need for assistance with personal care and coronary artery disease. The Minimum Data Set, dated dated dated [DATE] documented Resident #56 was cognitively intact, required a substantial/maximal assistance (help does more than half of the effort) for bathing, and they did not have any behaviors or refusals of care. The Annual Minimum Data Set, dated dated dated [DATE] documented it was very important for Resident #56 to choose between a tub bath, shower, bed bath or sponge bath. Review of the comprehensive care plan revised on 1/26/24, documented Resident #56 had a deficit in their activities of daily living function/mobility, interventions included the resident required substantial or maximal assist of one person for shower or bathing and was independent with decision making. Resident #56 had a potential for alteration in their daily customary routine. Interventions included the resident's bathing preference was 2 times a week on Wednesday and Saturday evenings and staff were to ask Resident #56 their preferred rising time. Review of the Unit 2 Shower Schedule revised on 7/9/24, documented that Resident #56's showers were on Wednesdays and Saturdays on the 2:00 PM-10:00 PM shift. Review of the Documentation Survey Report v2 (electronic medical record task documentation) dated July 2024 and August 2024 documented Resident #56 was to have showers on Wednesday and Saturday evening shifts. From 7/1/24-7/31/24 it was documented that Resident #56 was given a shower once on 7/24/24. From 8/1/24-8/13/24 no showers were documented as given. Observations and interviews revealed the following: -on 8/8/24 at 11:40 AM, Resident #56 was in bed wearing just a t-shirt. Resident #56 stated that they were waiting for a staff member to get them out of bed. At 12:34 PM, Resident #56 was observed to be out of bed in their motorized wheelchair and dressed. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-on 8/9/24 at 8:48 AM, Resident #56 stated that they were lucky if they got a shower once a week and Saturdays were even worse because of lack of staff. Resident #56 stated that they like to be out of bed by 10:00 AM and they mostly never were. Resident #56 stated that they did not get out of bed until right before lunch on 8/8/24 and they did mind. They stated that usually there was only one certified nursing assistant for that wing of the unit. The resident stated they liked to get up into their chair and go outside on the patio to read before lunch. -on 8/12/24 at 12:37 PM, Resident #56 was sitting in their motorized wheelchair and stated that they did not receive their shower on Saturday (8/3/24). They stated they did not get a bed bath nor did any staff speak to them about a different shower day. -on 8/14/24 at 11:05 AM, Resident #56 was observed in bed in just a t-shirt with their call bell activated. Resident #56 stated they were waiting to get up and had not talked to or seen their aide yet today. During an interview on 8/8/24 at 5:05 PM, Certified Nursing Assistant #4 stated when they picked up for Unit 2 the unit was usually staffed with just two aides on the day shift. Certified Nursing Assistant #4 stated Resident #56 requested to be out of bed midmorning, but they could not get the resident up until just before lunchtime. They stated they could not get Resident #56 out of bed at their preferred time because they were the only aide for that side and could not get to them sooner. During a telephone interview on 8/12/24 at 4:38 PM, Certified Nursing Assistant #7 stated they worked Unit 2 b side from 2:00 PM-6:00 PM on 8/3/24. They stated they were responsible for Resident #56, and they did not have time to give them their shower. They stated they reported to Certified Nursing Assistant #20 that Resident #56 still needed a shower when they took over the assignment. During a telephone interview on 8/12/24 at 7:57 PM, Certified Nursing Assistant #20 stated they worked on Unit 2 with another aide on 8/3/24 from 6:00 PM-10:00 PM. They stated they were responsible for Resident #56, and they did not give the resident a shower. Certified Nursing Assistant #20 stated they were not aware that Resident #56 needed a shower and should have looked at the unit shower list to see if they were supposed to give any showers. They weren't told by Certified Nurse Aide #7 that Resident #56 needed a shower. During a telephone interview on 8/13/24 at 1:28 PM, Certified Nursing Assistant #9, stated they worked on Unit 2 and when there were only two aides, they could not complete their showers due to staffing. They stated they would either let their nurses know or report to the oncoming shift which showers they did not do. Certified Nursing Assistant #9 stated they could not say for sure why they did not sign off for Resident #56's shower on 7/13/24. During an interview on 8/14/24 at 11:08 AM, Certified Nursing Assistant #10 was walking down the hallway about to enter Resident #56's room. Certified Nursing Assistant #10 stated that Resident #56 preference was to be out of bed after breakfast and they were late getting them out of bed. Certified Nursing Assistant #10 stated they were the only aide working the b side and they were providing morning care to the other residents first. They stated that was the time they could get to the resident due to staffing. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Resident #55 had diagnoses that included cerebral infarction, need for assistance with personal care, and Alzheimer's disease. The Minimum Data Set, dated dated dated [DATE] documented Resident #55 sometimes understood, sometimes understands, and had severe cognitive impairment. The Minimum Data Set documented that Resident #55 required a total assistance for bathing and had no behaviors or refusals of care. The Annual Minimum Data Set, dated dated dated [DATE] documented that Resident #55 felt it was somewhat important to them to choose between a tub bath, shower, bed bath or sponge bath. Review of the comprehensive pare plan revised on 7/9/24, documented Resident #55 had a deficit in activities of daily living function/mobility, interventions included the resident required total assistance of one person for shower or bathing and was severely impaired with decision making. Resident #55 had a potential for alteration in their daily customary routine. Interventions included the resident preferred showers on Wednesday and Sunday day shift. Review of Resident #55's Kardex dated 8/13/24 documented that Resident #55 was to have a shower two times a week on Wednesday and Sunday day shift. Review of the Unit 2 Shower Schedule with revised date 7/9/24 documented that Resident #55's showers were scheduled on Wednesday and Sunday on the day shift. Review of the Documentation Survey Report v2 dated July 2024 and August 2024, documented Resident #55 was to have a shower on Wednesday and Sunday day shift. From 7/1/24-7/31/24 it was documented that Resident #55 was given a shower on 7/10/24, 7/14/24 and 7/28/24. From 8/1/24-8/13/24 there were no showers documented as given. During an interview and observation on 8/12/24 at 5:31 PM, Resident #55 was out of bed in their wheelchair visiting with their family member. Resident #55's family member stated that it had been three weeks since the resident had a shower. During an interview on 8/8/24 at 5:05 PM, Certified Nursing Assistant #4 stated when they picked up for Unit 2 the unit was usually staffed with just two aides on the day shift. During a further interview on 8/13/24 at 4:11 PM, Certified Nursing Assistant #4 stated on 7/21/24 and 7/24/24 they had not been able to give Resident #55 their preferred showers because they didn't have enough time due to staffing. During an interview on 8/13/24 at 1:19 PM, Certified Nursing Assistant #10 stated when they were the only aide that worked Unit 2 b wing, they did not have enough time to provide showers. They stated that if the shower was not signed off in the electronic medical record, then it was not completed. Certified Nursing Assistant #10 stated they had not given any showers on 8/13/24 and they let the unit manager know. Certified Nursing Assistant #10 stated they prioritized incontinent care over providing the residents with their preferred showers. During an interview on 8/13/24 at 1:45 PM, Certified Nursing Assistant #18 stated that they did not give Resident #55 a shower on 8/4/24. They stated that they could not get to the residents preferred showers when they worked with only one other aide on the unit. Certified Nursing Assistant #18 stated that they notified the nurse, but the nurses do not help. They stated the nurses tell us to do our best to keep the residents dry and fed. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/14/24 at 11:40 AM, the Acting Unit Manager/Assistant Director of Nursing stated that Resident #56 preference was to get out of bed after breakfast around 10:00 AM. The Acting Unit Manager/Assistant Director of Nursing stated that Resident #56 preference was to have two showers a week on Wednesday and Saturday evening shift and Resident #55 preference was to have two showers a week on Wednesday and Sunday day shift. They stated they were aware that neither resident was receiving their preferred showers twice a week. The Assistant Director of Nursing stated that the facility was supposed to be giving Resident #56 and Resident #55 twice a week showers, they were trying, and they needed more help. During an interview on 8/14/24 at 12:03 PM, the Director of Nursing stated per the care plan Resident #56 preference was staff were to ask them when they liked to get out of bed in mornings. They stated that Resident #56 and Resident #55 preference was to have twice a week showers. The Director of Nursing stated they were not aware that Resident #56 was not getting out of bed at their preferred time nor was getting their preferred twice a week showers. The Director of Nursing also stated they were not aware that Resident #55 was not getting their preferred showers twice a week. The Director of Nursing stated Resident #55 and Resident #56 were not having their preferences honored. 10 NYCRR 415.5 (b)(1,3)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43802 Based on observation and interview during the Standard survey completed on 8/14/24, the facility did not ensure housekeeping services necessary to maintain a sanitary, comfortable interior. Specifically, one (Unit 1) of 3 resident units had a strong urine odor present throughout the survey period. The findings are: The policy and procedure titled Cleaning Occupied Resident Room last modified 10/12/18 documented the room occupied by a resident will be maintained in a clean, hygienic, and attractive state, without disrupting resident health care, routines, or the privacy of the resident. During an observation on 8/8/24 at 10:00 AM, 8/9/24 at 8:57 AM, 8/13/24 at 1:38 PM there was strong urine odor upon entering Unit 1 and down the Side B of the unit. During an observation on 8/8/24 at 11:46 AM, 8/12/24 at 8:39 AM, and 8/13/24 at 1:40 PM, Resident room [ROOM NUMBER] had a strong urine odor. During an observation and interview on 8/9/24 at 10:42 AM and 8/12/24 at 8:44 AM, there was a strong urine odor in the room and bathroom of Resident room [ROOM NUMBER]. At this time the resident that residing in the room stated that the smell of urine in the room didn't bother them anymore, something's you just have to get used to. During an interview on 8/12/24 at 11:37 AM, a family member of Resident #63 stated the unit smelled like urine. During an interview on 8/13/24 at 1:47 PM, Licensed Practical Nurse #2 stated the unit was not homelike when the urine odors were present. They stated Unit 1 wasn't always like this, depends on what was happening that day and which rooms you were near. They stated they have residents that urinate on the floor and other residents that were incontinent on the unit that contribute to the odor. Licensed Practical Nurse #2 stated they would notify housekeeping if odors were present, nursing staff stripe soiled bedding and housekeeping wipes down mattresses. During an interview on 8/14/24 at 8:26 AM, Registered Nurse Unit Manager #1, stated they could smell the odor of urine on the unit. They stated they usually had two housekeepers but have recently had only one which made it more difficult to keep up on cleaning. They stated the unit was not homelike when odors were present. During an interview on 8/14/24 at 8:58 AM, Certified Nursing Assistant #6 stated when they smell urine, they let the housekeeper know. (continued on next page)

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and observation on 8/14/24 at 9:10 AM to 9:21 AM, Environmental Services Supervisor stated every unit had one housekeeper currently and they were expected to clean as much as possible, check bathrooms, clean floors as needed, and empty the garbage. They stated it was impossible to wash every floor every day. They stated there was an odor of urine in Resident room [ROOM NUMBER] that radiated into hallway. They stated the odor needed to be addressed to make it homelike. During an interview on 8/14/24 at 1:23 PM, the Administrator stated if urine odors were identified they would have expected housekeeping to be notified right way. NYCRR 415.29

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335790	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elderwood at Wheatfield	2600 Niagara Falls Boulevard Niagara Falls, NY 14304

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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 0609

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.

43802

Based on interview, and record review conducted during a Complaint investigation (#NY00343934) during the Standard survey completed on 8/14/24 the facility did not ensure that all alleged violations including abuse, or mistreatment were reported immediately, but not later than two hours after the allegation was made to the State Survey Agency for one (Resident #69) of six residents reviewed. Specifically, an allegation of resident abuse/mistreatment was not reported to the New York State Department of Health as required.

The finding is:

The policy and procedure titled Abuse Prevention, Identification, Investigation, Protection and Reporting last modified 4/30/2024 documented the facility will provide protection for the health, welfare and rights of each resident residing in the facility. The Administrator or designee will report all alleged violations to, state agencies immediately, but no later than two hours after the allegation of abuse, mistreatment.

1.Resident #69 had diagnoses that included stroke affecting right dominant side with hemiplegia (paralysis on one side of body) and hemiparesis (weakness of one side of body), repeated falls, and aphasia (absence or difficulty with speech). The Minimum Data Set (a resident assessment tool) dated 4/27/24 documented Resident #69 was usually understood, usually understands and was cognitively intact.

Review of an email sent 5/31/24 at 8:22 PM from Registered Nurse #2 Unit Manager to the Director of Nursing and Administrator, documented report of a concern that had occurred Tuesday (5/28/24) morning. It was reported that the nurse who had Resident #69 that morning yanked them out of the bed and threw them into their wheelchair for breakfast. Resident #69 stated they didn't want to get up for breakfast and they were told they had to.

Review of a corresponding email sent 5/31/24 at 8:55 PM from the Director of Nursing to Registered Nurse #2 Unit Manager and the Administrator, acknowledged they received the email by requesting scheduled staff.

Review of Witness Account of Accident/Incident dated 5/31/24 at 9:00 PM, documented Resident #69 stated the nurse came in and woke them up and told them they had to go to breakfast. The resident told them No and the nurse said they had to go. They grabbed the resident by their arm and threw them in the wheelchair. This happened on Tuesday (5/28/24). The statement was completed by Registered Nurse #2 Unit Manager on 5/31/24.

Review of the Nursing Home Facility Incident Report Submission report revealed this allegation was submitted by the Director of Nursing on 6/1/24 at 10:05 AM.

(continued on next page)

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NAME OF PROVIDER OR SUPPLIER Elderwood at Wheatfield		STREET ADDRESS, CITY, STATE, ZIP CODE 2600 Niagara Falls Boulevard Niagara Falls, NY 14304	

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 8/12/24 at 10:04 AM, Resident #69 was self-propelling their wheelchair in the hallway with their right arm supported on an arm trough (a device that attaches to a wheelchair to provide support). Resident #69 stated shortly after they were admitted to facility, an unknown female staff member told them they had to get up, yanked them out of bed and threw them into their chair. Resident #69 stated the unknown staff member pulled their right arm causing them discomfort. Resident #69 stated they have not seen this staff member since. Resident #69 stated they reported the incident to a male nurse, who got on it right away. During an interview on 8/13/24 at 9:41 AM, Registered Nurse #2 Unit Manager stated they reported Resident #69's allegation of abuse/mistreatment immediately on 5/31/24 to the Director of Nursing and the Administrator via email. Registered Nurse #2 Unit Manager stated they take all allegations of abuse/mistreatment seriously and do their due diligence to investigate and report for resident safety and dignity. During an interview on 8/13/24 at 9:53 AM, the Director of Nursing stated 6/1/24 was the day they wrote the abuse allegation report to the Department of Health. They stated this would have been the first day they were really notified of Resident #69's abuse allegation. They stated there may have been an email prior to 6/1/24 regarding Resident #69's allegations. They stated they tried to report allegations of abuse within the two-hour notification period to the Department of Health but believed they were trying to gather more facts regarding Resident #69's allegation. The Director of Nursing reviewed the email sent on 5/31/24 at 8:22 PM, which they responded to on 5/31/24 at 8:55 PM, and stated they should have reported Resident #69's complaint prior to 6/1/24. During an interview on 8/13/24 at 10:08 AM, the Administrator stated they expected the Director of Nursing to report allegations of abuse within two hours to the Department of Health, it was a regulation. 10 NYCRR 415.4(b)(2)

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 43802 Based on observation, interview and record review conducted during a Standard survey completed 8/14/24, the facility did not ensure that a resident with pressure ulcers receives necessary treatment and services consistent with professional standards of practice to promote healing for one (Resident #38) of three residents reviewed. Specifically, there was a delay in an assessment from a qualified individual of the resident's newly identified right buttock pressure ulcer to include a description, stage, location, and measurements. The finding is: The policy and procedure titled Pressure Ulcer, Pressure Injury, and other Skin Conditions: Initial Assessment, Care Planning, Ongoing Evaluation and Management last modified 2/27/23, documented that all staff interacting with the resident daily, including nursing assistants, will conduct skin observations and report any changes in skin condition to ensure timely evaluation and assessment. Any new skin conditions are communicated during shift-to-shift report and/or to the supervisor for further evaluation, as necessary. The policy documented that upon the identification of a new skin condition, an assessment will be completed. Finding will be recorded in the medical record, the care plan will be reviewed and /or revised, the medical provider will be notified, appropriate treatments implemented, and applicable notifications made. The policy documented that the assessment would include characteristics of the wound and surrounding tissue, measurements, stage, presence of exudates, tissue and evidence of erythema. The policy and procedure title Perineal, Incontinence Care last modified 5/3/18 documented that after (perineal/penis/scrotum area, groin and thigh areas were wash, rinsed, and dry the staff member was to apply protective ointment if indicated. The policy documented that nursing assistant was to report to immediate supervisor (at appropriate time) that procedure was completed and any pertinent problems or observations. Resident #38 had diagnoses which included chronic kidney disease, overactive bladder, and anxiety. The Minimum Data Set (a resident assessment tool) dated 5/15/24, documented Resident #38 was understood, understands and was cognitively intact. The assessment tool documented Resident #38 was at risk for the development of pressure ulcers and had no pressure ulcers present. The comprehensive care plan revised 12/29/23 documented that Resident #38 was at very high risk for impaired skin integrity related to 5 or more medications, hypertension, incontinence, and a history of Stage II (2) pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer) on the sacral (area above the tailbone) area and heel. Interventions included to provide clean, dry, wrinkle-free linens; monitor skin condition daily and report any signs of skin break down; encourage frequent position changes; provide timely toileting/incontinent care; apply treatments and barrier creams; and pressure re-distribution mattress. During an interview on 8/8/24 at 11:06 AM, Resident #38 stated that they felt like their buttocks were irritated and that the certified nursing assistants had been using the green tube of ointment on their buttocks after they provided incontinent care. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation of care provided by Certified Nursing Assistant #4 on 8/8/24 at 11:54 AM, an approximated 0.5 centimeter round open area was observed to Resident #38's right buttock. Resident #38 stated that the area hurt when Certified Nursing Assistant #4 touched the area. Certified Nursing Assistant #4 replied to Resident #38 that they would apply ointment to the area. During an interview on 8/8/24 at 5:05 PM, Certified Nursing Assistant #4 stated that they notified Licensed Practical Nurse #5 about the open area noted to Resident 38's buttocks. Certified Nursing Assistant #4 stated that they also put the ointment on the area that they used after providing incontinent care to the residents. During an observation on 8/12/24 at 10:20 AM, Certified Nursing Assistant #18 provided incontinent care to Resident #38. It was observed that an approximated 0.5 centimeter round open area remained to Resident #38's right buttocks. Review of the electronic medical record including progress notes and skin assessments from 8/8/24 to 8/12/24 revealed no documented evidence that Resident #38's right buttock open area was assessed, measured, or monitored. During an interview on 8/13/24 at 7:00 AM, Licensed Practical Nurse # 5 stated they were not notified on 8/8/24 of an area of skin concern on Resident #38's buttocks. They stated they had not seen Resident's #38's buttocks and would need to look at it. During an interview on 8/13/24 at 8:22 AM, Certified Nursing Assistant #18 stated that they did not notify anyone of the open area that was noted to Resident #38's buttock on 8/12/24. They stated that they should have told the nurse. Certified Nursing Assistant #18 stated 8/12/24 was the first time they saw the area on Resident #38's buttocks, and they put incontinent barrier cream on it. They stated they should have notified the nurse on 8/12/24 because it was the right thing to do and because the area could have gotten worse. During an observation on 8/13/24 at 9:02 AM, with the Acting Unit Manager/Assistant Director of Nursing and Certified Nursing Assistant #4 present, an open area remained to Resident #38's right buttock. Certified Nursing Assistant #4 stated they had not noted the area to be open prior to their first observation of it on 8/8/24. Resident #38 stated that the area remained tender. During an interview after the observation with the Acting Unit Manager/Assistant Director of Nursing they stated that the observed open area to Resident #38's right buttock was a Stage II pressure area that measured 1 centimeter by 0.2 centimeters. The Acting Unit Manager/Assistant Director of Nursing stated that when a new area of skin concern was noted by a certified nursing assistant, they should have notified a charge nurse. They stated the charge nurse should have then reported it to them so the wound could be assessed and measured. The Acting Unit Manager/Assistant Director of Nursing stated then the medical provider should have been notified for a new treatment. The Acting Unit Manager/Assistant Director of Nursing stated they were not notified of an open area on Resident #38's right buttock prior to today and they should have been. They stated some of the potential risks of the noted area not being assessed and monitored were that the area could have progressed to a higher stage and possibly became infected. Review of Resident #38's SNF Skin Assessment-V1 dated 8/13/24 at 9:26 AM, the Acting Unit Manager/Assistant Director of Nursing documented that Resident #38 was observed to have a right buttock Stage II pressure ulcer that measured 1 centimeter by 0.2 centimeter by 0.1 centimeter. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Elderwood at Wheatfield		STREET ADDRESS, CITY, STATE, ZIP CODE 2600 Niagara Falls Boulevard Niagara Falls, NY 14304	

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/14/24 at 10:22 PM, the Physician Assistant stated they were notified 8/13/24 of Resident #38's Stage II pressure area on their right buttock. They stated their expectation would have been that the Assistant Director of Nursing be notified at first observation of the open wound and would consider it a delay in measuring, assessment and monitoring of a pressure wound. During an interview on 8/14/24 at 12:10 PM, the Director of Nursing stated they expected that when a new open area was noted on a resident, the certified nursing assistant report it to the team leader and a registered nurse assessment would need to be completed. They stated they were not aware Resident #38 had an observed open area on their buttocks noted on 8/8/24 and would consider the situation a delay in notification and assessment. During an interview on 8/14/24 at 12:52 PM, the Administrator stated that once an open area was noted on a resident's skin it should be reported to the team leader. They stated that they would not consider the Assistant Director of Nursing not being notified of Resident #38's open area on their buttock on 8/8/24 or again on 8/12/24 a lack of assessment because the resident was getting a barrier cream to protect the area. The Administrator stated they would consider it a miscommunication. 10 NYCRR 415.12 (c)(2)

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F 0689

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 43802

Based on interview and record review conducted during a Complaint investigation (#NY00321764) during the Standard survey completed on 8/14/24, the facility did not ensure that each resident receives adequate supervision to prevent accidents for one (Resident #84) of one resident reviewed for elopement. Specifically, Resident #84 was found in the parking lot by a visitor on 8/9/23.

The finding is:

The policy and procedure titled Elopement-Wandering-Missing Resident last modified 10/11/2018, documented all residents are assessed as needed to determine risk level for unsafe wandering/elopement. In the event a resident successfully leaves the facility undetected and unsupervised, the Missing Resident procedure will be put into place immediately.

1.Resident #84 had diagnosis including dementia, cognitive communication deficit, and anxiety disorder. The Minimum Data Set (a resident assessment tool) dated 6/13/23 documented the resident had severe cognitive impairment and exhibited no wandering behaviors.

The comprehensive care plan revised 6/10/23 documented Resident #84 was severely impaired with decision making related to dementia. Interventions included to encourage to make decisions as able. Additionally, Resident #84 had a deficit in activities of daily living function/mobility initiated on 6/8/23. Interventions included for wheelchair mobility; they required an extensive assist of one person.

Review of an Elopement incident report dated 8/9/23 at 6:37 PM prepared by Registered Nurse #2 Unit Manager, documented Resident #84 was found wandering the parking lot in their wheelchair looking for their car. Resident #84 was promptly brought back into the facility.

Review of Witness Account of Accident/Incident dated 8/9/23 at 6:37 PM, Receptionist #1 documented that Resident #84 rolled themselves out the front door and sat on the front patio. Resident #84 was sitting in front of the window, so they were able to see them. Receptionist #1 didn't realize Resident #84 moved until a family member of another resident came in and told them Resident #84 was in the parking lot.

Review of the Elopement assessment dated [DATE] at 8:45 PM, completed by Director of Nursing #2 documented Resident #84 had no risk for elopement.

Review of a progress note dated 7/25/23 at 1:04 PM, documented Resident #84 was wandering throughout the hallways and off the unit looking for their room.

Review of a progress note dated 8/9/23 at 5:49 PM by Director of Nursing #2, documented they received a call from the nursing supervisor that Resident #84 was in the parking lot in their wheelchair self-propelling looking for their car. According to the receptionist, Resident #84 was out on the front patio and a short time later a visitor alerted them that the resident was in the parking lot. Nursing supervisor brought resident back in and did an assessment, baseline confusion was noted.

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	335790	A. Building B. Wing	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elderwood at Wheatfield	2600 Niagara Falls Boulevard Niagara Falls, NY 14304

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Elopement assessment dated [DATE] at 10:18 PM completed by Registered Nurse #2 Unit Manager, documented Resident #84 was at high risk for elopement. During an interview on 8/14/24 at 11:15 AM, Registered Nurse #2, Unit Manager stated an elopement assessment should be completed quarterly, annually, and when there was a change in condition. Upon review of the progress note dated 7/25/23 at 1:04 PM, Registered Nurse #2 Unit Manager stated they would have been concerned about elopement and that would have prompted them to re-evaluate Resident #84's elopement assessment due to exit seeking. During a telephone interview on 8/14/24 at 12:56 PM, the Administrative Assistant stated residents should always be stopped prior to going outside if they were by themselves. They stated residents were usually accompanied by family or staff outside. They stated there was a binder and pictures posted that was located at the reception desk of residents that are an elopement risk. They stated nursing staff should be contacted to verify if a resident was safe to be outside alone prior to exiting. During a telephone interview on 8/14/24 at 12:24 PM, Receptionist #1 stated they recalled the incident with Resident #84. They stated Resident #84 went out on the patio in their wheelchair, they then got talking to some visitors at the desk until they were notified by another visitor that a resident was in the parking lot. They then instantly alerted the Nursing Supervisor (at that time), Registered Nurse #2, Unit Manager. The Receptionist stated they weren't aware at that time; Resident #84 wasn't allowed outside alone. If a resident was an elopement risk, they would have a bracelet on that would have automatically locked the door. They stated Resident #84 was outside for 15 to 20 minutes. Attempt made on 8/14/24 at 12:52 PM to contact Director of Nursing #2 with no response or call back. During an interview on 8/14/24 at 1:23 PM, The Administrator stated Resident #84 got outside and the receptionist wasn't aware Resident #84 got from one area to the next. They stated Resident #84 shouldn't have gone outside by themselves and wasn't provided with adequate supervision. Resident #84 was able to get to the parking lot off the patio. 10NYCRR 415.12 (h)(2)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43802 Based on observation, interview, and record review conducted during complaint investigations (NY00344374, NY00348550, and NY00347789) conducted during the Standard survey completed on 8/14/24, the facility did not ensure sufficient nursing staff to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident for one of one facility. Specifically, the facility did not meet their established minimum number of staff for each shift. Additionally, there was a lack of sufficient nursing staff to get residents out of bed and provide appropriate care according to residents' care plans and preferences. Resident #'s 1, 13, 15, 32, 55, 56, 76, 82, 86, 89 and 91 were involved. The findings are: Refer to F561 Resident Choices, scope and severity = D 1. The Facility assessment dated [DATE], documented the facility's bed capacity was 123 and their average daily census at the time of the assessment was 107. The facility assessment documented the minimum number of staff required to meet the needs of the residents was determined based on total resident population, resident acuity, and facility physical plan layout. The master staffing plan documented the minimum staff required for each unit and each shift was: 6:00 AM to 2:00 PM, 1 Nurse and 2 Certified Nurse Aides; 2:00 PM to 10:00 PM, 1 Nurse and 2 Certified Nurse Aides; 10:00 PM to 6:00 AM, 1 Nurse and 1 Certified Nurse Aide. The policy and procedure titled Labor Disruption, dated 6/19/23 documented, in the case of a labor shortage such as, unavailability of appropriate/qualified persons to work, the Nursing Supervisor would notify the Administrator and other administrative personnel and they would mobilize staff and services from outside sources: off duty staff, health care agencies. The Director of Nursing would be required to enlist the help from departments other than nursing. The daily staffing sheets, reviewed from 7/8/24 through 8/14/24, documented the facility did not meet their minimum number of staff on the following dates: -7/14/24 10:00 PM to 6:00 AM, down 1 Certified Nurse Aide -7/22/24 6:00 AM to 2:00 PM, down 1 Certified Nurse Aide -8/1/24 6:00 AM to 2:00 PM, down 0.5 Certified Nurse Aide -8/7/24 6:00 AM to 2:00 PM, down 0.5 Certified Nurse Aide, 2:00 PM to 10:00 PM down 0.5 Certified Nurse Aide -8/9/24 2:00 PM to 10:00 PM, down 1 Certified Nurse Aide -8/11/24 2:00 PM to 10:00 PM, down 0.5 Certified Nurse Aide (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-8/12/24 6:00 AM to 2:00 PM, down 0.5 Certified Nurse Aide -8/13/24 6:00 AM to 2:00 PM, down 0.5 Certified Nurse Aide During an interview on 8/14/24 at 11:06 AM, the Scheduling Specialist stated they thought they had been meeting their minimum staffing levels. After reviewing the dates listed above, the Scheduling Specialist stated they did not meet their minimum staff levels on those dates. The Scheduling Specialist stated their ideal staffing level would be 5 Certified Nurse Aides and 2 nurses on every unit for day and evening shifts, and 2 nurses and 2 Certified Nurse Aides for night shift. During an interview on 8/14/24 at 12:24 PM, the Director of Nursing #1 stated staff made them aware they could not get all their work done because of staffing. They stated they had developed a plan that nurses were to assist with resident care to ensure all residents care plans were followed when there were only 2 aides scheduled and they expected certified nurse aides to report to their Unit Manager if they were unable to provide care according to the care plans. The Director of Nursing #1 stated if the nurses were not helping with care, then it would be very difficult for the certified nurse aides to complete their assignments and provide care to all residents according to the care plans. They stated they had not verified if the nurses were assisting the aides when the facility had 2 aides scheduled on each unit on the day shift. The Director of Nursing #1 stated managers told them they had complaints from family and residents about not getting their requests met in a timely manner, and they complained it was because of staffing. The Director of Nursing #1 stated they were aware there were times they did not meet their minimum staffing levels. They themselves have come in to work as the supervisor when a nurse was unavailable. During an interview on 8/14/24 at 1:00 PM, the Administrator stated they felt the staff should be able to get all their work done and follow the residents' care plans with their minimum staffing levels if there was a team approach and they all worked together, such as nurses and therapists assisting with resident care. They expected the nursing staff to provide care to all residents according to their care plans and if they were unable to follow the care plan, they would expect the nursing department to let them know. The Administrator was aware they had not met their minimum staffing levels for the listed dates. They stated that management would have stepped up to help the staff complete their work. 2. Review of the Resident Council minutes dated 6/6/24, revealed that several residents from Unit 2 reported concerns of late get ups and the nursing department was to be invited to the July 2024 meeting. During the meeting on 7/2/24 the council was updated on the concern from June. The completed concern form for the reported concerns from the 6/6/24 meeting documented that the late get up concern was shared by 4 of 10 residents who attended the meeting, and the specific concern was that recently, they had not been gotten up until after lunch. The response, documented by the Director of Nursing, was: Director of Nursing to talk with staff and unit managers to re-enforce early get ups to prevent any delays of morning get ups for all residents. During the meeting on 8/1/24 residents were informed by the Administrator that many staff were being cross trained to help, when there were shortages in various departments, to ensure the best possible care was provided. The residents did not respond. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During Resident Council interviews on 8/9/24 from 11:09 AM to 12:00 PM, residents stated that low staffing caused the staff to ignore residents and shut off call lights and say they would be right back, but staff did not return. Residents had to re-activate their call lights to get assistance from staff. One resident reported they sometimes get passed over in the mornings, when staff were assisting residents with getting up. The resident required the assistance of two staff with personal care and transfers. Residents also reported they could not get assistance with getting out of their wheelchair during the day, could not get their water and ice pitchers filled and experienced long waits for anything they may have requested. 3. Observation and interviews with residents, Ombudsman, family members and staff revealed the following: During an interview on 8/8/24 at 9:17 AM, Resident # 91 stated the facility did not have enough staff and some nights they had to wait up to an hour for pain medication. During an observation and interview on 8/8/24 at 10:13 AM, Resident #76 was observed in bed with a gown on and stated they had not been out of bed yet today and didn't like eating breakfast in bed. Resident #76 stated the facility did not have enough staff, therefore they had to eat breakfast in bed 1 to 2 times a week and they didn't like it. During an interview on 8/8/24 at 10:26 AM, Certified Nurse Aide #19 stated the facility didn't have enough staff, and often the unit was scheduled with 2 aides. Today the unit had a census of 40, therefore they had 20 residents on their assignment. Certified Nurse Aide #19 stated there was not enough staff to provide all the care necessary according to the resident's care plans such as showers, incontinent care, getting residents out of bed according to their preferences and toileting. They stated often residents waited up to an hour for toileting and then sometimes they were incontinent because they couldn't provide the care timely. During an additional interview on 8/8/24 at 11:05 AM, Certified Nursing Assistant #19 stated sometimes residents were not gotten out of bed the entire day shift because of short staffing and they didn't know if the residents left in bed were gotten out of bed on the evening shift. They stated some nurses would help with resident care and others would not. They stated Resident #76 was not provided care today until 10:45 AM because they did not have time. They stated Licensed Practical Nurse #8 knew they couldn't provide care according to the care plan for all residents. During an observation and interview on 8/8/24 at 11:10 AM, Resident #82 was observed being transferred out of bed by Certified Nurse Aide #19 with a stand lift, Resident #82's brief was saturated with urine and feces oozing out of the edges of the brief, the bed sheet and draw sheet were saturated with urine and feces. Resident #82 stated they had been waiting for a while but would not provide specifics of how long. Certified Nurse Aide #19 stated they had started at 6 AM today and that was the first time they had been able to provide care to Resident #82 because they were short staffed. During an interview on 8/8/24 at 11:13 AM, Activities Aide #1 stated they were also a Certified Nurse Aide and helped with resident care because of short staffing. They stated they often couldn't do activities with the residents because they were busy helping the Certified Nurse Aides. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation and interview on 8/8/24 at 11:40 AM, Resident #56 was lying in bed. They stated they were waiting for staff to get them out of bed. During an additional interview on 8/9/24 at 8:48 AM, Resident #56 stated that they were lucky if they got a shower once a week. They stated they like to be out of bed by 10:00 AM and they mostly never were. Resident #56 stated they got out of bed right before lunch on 8/8/24 and they minded. They stated there was usually only one certified nurse aide for that wing of the unit. During an interview on 8/8/24 at 11:48 AM, Certified Nurse Aide #1 stated they had been working at the facility for thirty-three years and staffing was currently at its worst. They stated they were uncertain if they were offering sign on bonuses, but they were offered $100.00 to stay late. They often declined due to exhaustion. During an interview on 8/8/24 at 11:52 AM, Resident #86 stated the facility did not have enough staff to provide them with two showers a week and they received only one shower since they were admitted last month. During a family interview on 8/8/24 at 12:22 PM, Resident #32's spouse stated the facility did not have enough staff because the resident often had to wait up to an hour to be changed after having a bowel movement. They stated that the staff were very good, they just didn't have enough help, and it was not intentional, but it was neglect due to insufficient numbers. During a telephone interview on 8/8/24 at 12:29 PM, the Ombudsman stated they had received concerns recently about short staffing, and that it's gotten worse. The Ombudsman did not reveal resident information as they did not give them permission to act on the information. During an observation and interview on 8/8/24 at 12:38 PM, a family member was assisting Resident #46 with their meal and stated there just wasn't enough help. They stated there weren't enough aides to care for the residents and a family member was often there to assist the resident with their meals. During an interview on 8/8/24 at 1:18 PM, Certified Nurse Aide #3 stated they were not always able to get all their work done and follow the resident's care plans, including showers and changing incontinent residents every 2- 4 hours, because they did not have enough staff, they were often the only aide on the rehab unit for that shift. They stated, if they couldn't get something done, they passed it on to the next shift and told the nurse. Certified Nurse Aide #3 stated that the nurses would help if they had time, but with only one nurse on the unit they were usually unable to help. They stated that if they had 3 or 4 aides, on Unit 4, they would be able to get all their work done and complete their documentation as they should. During an interview on 8/8/24 at 4:31 PM, Resident #13 stated they were not getting their scheduled showers on Fridays mornings due to low staffing numbers. They stated that the staff did not offer to give them a shower at a different time or different day, and they wanted a shower at least once a week. Resident #13 also stated there were times they were not out of bed or back to bed as they preferred due there not being enough staff. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 8/8/24 at 5:05 PM, Certified Nurse Aide #4 stated Unit 2 was usually staffed with just two aides on the day shift. They stated that once a month the units would hold town hall meetings and staff would express their low staffing concerns. Certified Nurse Aide #4 stated they got Resident #56 out of bed prior to the resident's lunch, and they knew Resident #56 requested to be gotten out of bed earlier than that. They stated they could not get Resident #56 out of bed at their preferred time because there were only two aides on the floor. Certified Nurse Aide #4 stated they did not provide any showers that were scheduled on 8/8/24 due to staffing issues, passing trays and they were still getting residents out of bed. During a further interview on 8/13/24 at 4:11 PM, Certified Nurse Aide #4 also stated they had not been able to get to Resident #55's shower due to staffing. During an interview on 8/9/24 at 7:55 AM, Resident #1 stated sometimes they were not gotten out of bed before breakfast, and they wanted to be. They were not provided showers two times a week per their preference and sometimes their showers were skipped an entire week because there was not enough staff. During an additional interview on 8/12/24 at 10:47 AM, Resident #1's Health Care Proxy stated the resident did not receive their showers as scheduled and sometimes they did not get a shower for a week or longer because there was not enough staff. During an interview on 8/9/24 at 12:02 PM, Resident #15 stated they were usually late getting out of bed for breakfast due to low staffing. They stated they needed to be out of bed around 8:30 AM to eat their meal in the dining room and were usually not out of bed until 9:30 AM. Resident #15 stated that did not always get their scheduled shower on Tuesdays and Saturdays and staff did not have time to wash them when they got them up for the day. Resident #15 stated there were never any staff on Saturdays to give them their showers. They stated that staff would, at times, enter their room, turn off their call light and then not return to assist them. During an interview on 8/12/24 at 11:39 AM, Resident #89's family member stated the biggest problem with the understaffing was when residents had to go to the bathroom. Resident #89 was a two assist, and the aide would have to find someone to help, and that could take hours. During a telephone interview on 8/12/24 at 4:38 PM, Certified Nurse Aide #7 stated when they worked the 2:00 PM-10:00 PM shift there were usually just two aides on Unit two and they did not have time to complete all their work. Certified Nurse Aide #7 stated they told the nurses and the unit manager they could not complete all their work due to low staffing. Certified Nurse Aide #7 stated they normally worked Unit one on the 10:00 PM-6:00 AM shift with no other scheduled aide. They stated they usually only have time to get one incontinent care round completed because they would need to be with the residents that were having behaviors. Certified Nurse Aide #7 stated they let the nurse, or the supervisor know they could not complete all their duties, and many times the nurse was also the building supervisor. During an interview and observation on 8/12/24 at 5:31 PM, Resident #55 was out of bed in their wheelchair visiting with their family member. Resident #55's family member stated that it had been three weeks since the resident had a shower. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 8/13/24 at 1:04 PM, Licensed Practical Nurse #9 stated they were the only nurse on their unit that shift, and they knew they would not be able to complete all their work. They stated that some of the treatments wouldn't get done but they would tell their manager before they left. They stated they were asked to stay for the evening shift today and if they refused, they might get mandated to stay. They stated they would make sure all the medications were passed before they left, but they could not stay. They stated they felt that the residents were being unintentionally neglected because of the lack of staff. During an interview on 8/13/24 at 1:19 PM, Certified Nurse Aide #10 stated that if a resident's shower was not signed off in the electronic medical record, then it was not completed. They stated when they worked alone on one wing of Unit two, they could not get all their work done. They stated they prioritized incontinent care over showers and let the nurses and unit manager know what work was not completed. During a telephone interview on 8/13/24 at 1:28 PM, Certified Nurse Aide #9 stated they worked on Unit two from 6:00 AM-7:00 PM and when they were the only aide on a wing, they did not complete their showers due to staffing. They stated they would either let their nurses know or report off to the oncoming shift which showers did not get done. During an interview on 8/13/24 at 1:45 PM, Certified Nurse Aide #18 stated they could not get all their work done when there were only two aides on unit two. They stated there were times when they were the only aide working the whole unit with two nurses. Certified Nurse Aide #18 stated the nurses knew they could not get their work done and they were told to do their best to keep the residents dry and fed. During an interview on 8/14/24 at 8:32 AM, Certified Nurse Aide #4 stated that staffing was not where it should be in the facility. They stated that getting the residents up, providing incontinent care and meals were their priorities, but they were not always able to follow the care plans and get everything done. Certified Nurse Aide #4 stated that the residents could be being unintentionally neglected due to the lack of staff. They stated they were asked to come in for extra shifts at least a couple times every week. During interviews on 8/14/24 at 9:33 AM and 11:24 AM, the Acting Unit Manager/Assistant Director of Nursing stated the facility would benefit from more staff. They stated that staff did tell them they couldn't get their work done because they were short staffed. They stated when staff came to them, they would try to help them with whatever tasks they can't complete. The Acting Unit Manager/Assistant Director of Nursing stated they thought the minimum staff should be 2 nurses per unit and at least 3 aides. They stated 2 nurses and 2 certified nursing assistants for Unit 2 was not enough staff to provide adequate care to all residents due to the high acuity of the unit. They stated the Director of Nursing and Administrator knew there was not enough staff to provide showers to the residents when there were only 2 certified nursing assistants scheduled. They stated it was the Administrator's responsibility to ensure there was enough staff to provide care to all residents according to the care plan. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 8/14/24 at 9:51 AM, Certified Nurse Aide #1 stated there was not enough staff, and the unit manager on Unit 1, had to be the cart nurse as well as perform their other duties. They stated there were only two aides, on Unit 1, with approximately 20-24 residents per aide. They stated that was not enough staff to get their work done. Certified Nurse Aide #1 stated it was the facility's responsibility to ensure they had enough staff to provide adequate care to the residents. During an interview on 8/14/24 at 10:17 AM, the Registered Nurse #2 Unit Manger (on Unit 4) stated that they were aware staff were not always able to get their work done, and at times they themselves have given a resident a shower. When they have staff call off, they call other staff and offer bonuses. They felt their minimum staff on their unit should be 2 nurses and 2 aides. Registered Nurse #2 Unit Manager stated the Director of Nursing and the Administrator knew they needed more staff. They stated they sometimes stayed late and worked the unit when they didn't have enough staff. During an interview on 8/14/24 at 10:39 AM, Licensed Practical Nurse #7 stated at times for eight hours of their shift, there was no other nurse working with them on the unit. They stated they would give medications and do vital signs, but they have to prioritize their treatments to just complete the worst ones. Licensed Practical Nurse #7 stated they usually only work with two certified nurse aides and the certified nurse aides cannot get to all of their showers and cannot get all the resident out of bed for the day. Licensed Practical Nurse #7 stated it was especially hard on the weekends because if they were having a resident with behaviors, they do not have enough staff to sit with that resident. During an interview on 8/14/24 at 12:19 AM, Certified Nurse Aide #9 stated they often work with only 2 aides on Unit 2, therefore they had an assignment of 19 - 21 residents and were unable to provide care according to the care plan for all residents because there was not enough staff; they reported it to the nurses, and they stated the facility has had meetings concerning the staffing shortages. They stated it was the Administrator's responsibility to ensure there was enough staff for the resident population. 415.13 (a)(1)(i)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 43802 Based on observation, interview, and record review conducted during the Standard survey completed on 8/14/24, the facility did not post, on a daily basis, the staff total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift. Specifically, the facility's posted staffing was not updated at the beginning of each shift and/or reflected changes in the schedule. Additionally, the facility did not have a policy for completing the DOH Staffing Report. The finding is: During observations from 8/8/24 through 8/14/24 from 7:45 AM through 5:00 PM, the DOH Staffing Report was posted at the front desk of the facility, however it did not include an updated total number of actual licensed and unlicensed nursing staff for each shift. Review of the last 30 days of the documents titled DOH Staffing Report revealed that the forms were not updated with the total number of actual licensed and unlicensed nursing staff for each shift. During an interview on 8/14/24 at 11:06 AM, the Scheduling Specialist stated they were responsible for completing the DOH Staffing Report and they did not update the report with actual numbers of licensed and unlicensed nursing staff for each shift. They stated they did not know the purpose of the form, but thought it was specifically for the New York State Department of Health to see when they visited the facility. The Scheduling Specialist stated they were not given formal training on how to complete the form but thought there was a policy on it. They stated they would look for the policy. During an interview on 8/14/24 at 12:24 PM, the Director of Nursing stated they knew the DOH Staffing Report was used to show the public how many staff were in the building, but they didn't think it should be updated to show actual numbers of licensed and unlicensed nursing staff for each shift, because that would be a lot of work, with no call no shows and staff calling off, it sometimes takes a while for supervisors to realize someone didn't show up. They stated they thought there was a policy, and they would look for it. During an interview on 8/14/24 at 1:00 PM, The Administrator stated they did not know the DOH Staffing Report should be updated to show actual numbers of licensed and unlicensed nursing staff for each shift. They thought it was to be completed at the beginning of each day. They thought there was a policy for completing the report and they would look for it. During an interview on 8/14/24 at 3:30 PM the Administrator stated they did not have a policy for the DOH Staffing Report. 10NYCRR 415.13

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. 43802 Based on observation, interview, and record review conducted during a Standard survey completed on 8/14/24, the facility did not ensure that each resident was provided special eating equipment and utensils for residents who need them while consuming meals for one (Resident #85) of one resident reviewed. Specifically, Resident #85 was not provided bowls for solid foods or mugs for liquid beverages as care planned. The finding is: The policy and procedure titled Meal Serving-Resident dated 9/24/2018, documented that designated dietary staff will be responsible for ensuring that the necessary items are present at mealtime, or are obtained immediately upon request, for the consumption of food. Nursing staff or other appropriately trained staff will be responsible for fulfilling all non-food requests of residents, feeding of resident if needed, and for other dietary services that are part of the resident's care plan. Resident #85 had diagnoses that included Alzheimer's disease, unspecified dementia, senile degeneration of brain (loss of intellectual ability of the brain). The Minimum Data Set (a resident assessment tool) dated 7/7/24 documented Resident #85 had severe cognitive impairment. Resident #85 required supervision or touching assistance for eating and helper cues as resident completes activity. Review of the comprehensive care plan dated 5/17/24 documented that Resident #85 required limited assist while eating, supervision to ensure consumes food and not food packaging and other paper products, mugs for all beverages, bowls for food. Date of initiation was 7/20/23. Review of the occupational therapy notes dated 9/7/23 documented that Resident #85 was referred for an occupational screening for self-feeding skills, patient demonstrated pouring behaviors, usage of fingers to bring food to mouth instead of utilizing utensils functionally, resulting with patient requiring increased assistance and cueing for self-feeding skills to maximize independence. Review of an occupational therapy treatment encounter dated 9/8/23, documented that Resident #85 was assessed with bowls to trial an increase in nutritional intake, maximize independence in self-feeding tasks, and decrease pouring behaviors. The writer provided one food at a time presented in bowls with appropriate utensils to promote functional use of utensils and to maximize independence. Resident #85 required moderate verbal cues for initiation to enhance nutritional intake. Review of an occupational therapy treatment encounter dated 9/22/23 documented that Resident #85 spilled milk in mug, food spillage from plate. Only oatmeal provided in bowls. The writer cleared residents' visual field of cluttered area, while cleaning spillage as resident was noted to utilize utensils and attempted to grab food that had spilled on table tray and themselves. Resident utilized utensils functionally without using fingers to completed self-feeding 90% of the time, as resident noted to use fingers to gather food from spillage. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 8/9/24 at 8:51 AM Resident #85 meal slip stated liquids were to be placed in mugs and food in bowls. Resident #85's orange juice was served in a cup (not a mug) and breakfast meal was served on a plate not in bowls. There were no staff members assisting the resident and food had been pushed off the plate and onto the tray. During an observation on 8/9/24 at 12:26 PM, Resident #85's lunch was served on a plate and beverages were served in cups, not mugs. There were no staff members assisting the resident and food had been pushed off the plate and onto the tray. During an observation and interview on 8/12/24 at 12:55 PM, Certified Nurse Aide #1 stated that Resident #85's beverages should be in mugs. They stated the beverages were not in mugs and they were not certain why they were not. During an observation and interview on 8/12/24 at 12:58 PM, Certified Nurse Aide #2 reviewed the meal slip and stated the meal slip for Resident #85 documented mugs for beverages, Certified Nurse Aide observed cups on their tray. They stated it was important that residents had the correct adaptive equipment for meals to prevent spills and possible burns to the residents' skin if the beverage or food was hot. During an interview on 8/14/24 at 10:35 AM, the Food Service Director, stated it was the entire kitchens responsibility to ensure the correct adaptive utensils were on trays before they left the kitchen. They stated they were unaware Resident #85 received their meal tray without the appropriate adaptive equipment on 8/9/24 for breakfast and lunch, and on 8/12/24 for lunch. They stated it was important for the quality-of-life sustainability and ensured the residents maintained as much independence as possible. During an interview on 8/13/24 3:59 PM with the Director of Rehabilitation stated they completed the assessments to determine what adaptive equipment was needed for meals and the resident's care plan was updated. They stated the bowls were easier to manage for Resident #85 and promoted an increase in independence and food consumption. They stated this resident also had a lot of pouring behavior's and would pour liquids all over their food and was care planned for mugs for all liquids. During an interview on 8/14/24 9:45 AM, Certified Nursing Assistant #1 stated Resident #85 often spilled food on themselves, and that was why they needed to feed them. They stated supervision with touch assistance meant when the tray arrives, they were trained to look at the tray and ensure adaptive equipment was provided if indicated. They stated they supervised the resident while eating and cued them when not. They stated they did not notice that Resident #85 was not being provided the correct adaptive equipment but did not give Resident #85 any hot beverages because they might pour it on their food. During an interview on 8/14/24 at 11:08 AM, the Registered Dietician stated adaptive equipment was provided to residents to increase their independence and to not hinder their progress in getting the appropriate calories and nutrition. The entire kitchen staff should look at the meal slips, and down to the last person who provided the tray to the resident. The staff should have verified the meal slip was accurate. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/14/24 at 1:30 PM, the Director of Nursing stated, they expected the staff to review the meal slips prior to giving the resident their meal tray. This was important to ensure residents had the right equipment and to ensure they were safe from hot foods and were able to eat the food provided to them. 10 NYCRR 415.14 (g)

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F 0842

Level of Harm - Potential for minimal harm

Residents Affected - Some

Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 43802

Based on interview and record review conducted during a Standard survey completed on 8/14/24, it was determined that the facility did not ensure that in accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are complete; accurately documented; readily accessible; and systematically organized. Specifically, three of five residents (Residents #1, #12, #59) reviewed for complete immunization records had issues with no documented evidence of signed consents or declinations for the 2023 influenza vaccine.

The findings are:

The policy and procedure titled Influenza Immunization (Residents) dated 7/19/22 documented that at the appropriate time of year to determine eligibility for the influenza immunization will be indicated on the Influenza Vaccination Consent Declination Resident form.

1. Resident #1 was admitted to the facility with diagnoses of left sided hemiplegia (paralyzed on the left side), type 2 diabetes mellitus, and asthma. Review of the Minimum Data Set (a resident assessment tool) dated 7/17/24 documented that the resident was cognitively intact, usually understands others, usually understood by others. The Minimum Data Set documented that the resident received an influenza immunization on 10/20/23.

Review of the medication administration record for October 2023 documented the resident received the Flu zone High Dose Quadrivalent influenza vaccine 10/20/23.

Review of the vaccine screening prior to the vaccine dated 10/20/23 documented that Resident #1 was screened prior to receiving the influenza shot.

Review of the update immunization tab in the electronic medical record dated 11/6/23 documented that a consent was obtained for the influenza immunization for Resident #1. Further review of the chronological electronic medical record revealed no scanned copy of the signed consent form for influenza immunizations.

During an interview on 8/14/24 at 10:00 AM, Resident #1 stated that they don't remember if they signed a consent form, nor do they remember if they received an influenza vaccine.

2. Resident #12 was admitted to the facility with diagnoses of type 2 diabetes mellitus and atrial fibrillation (irregular rhythm of the heart). The Minimum Data Set, dated dated dated [DATE] documented that the resident is cognitively impaired, understands others, and is understood by others. Further review of the Minimum Data Set documented that the resident received an influenza immunization on 10/20/23.

Review of the medication administration record dated October 2023 documented that the resident received the influenza vaccination on 10/20/23.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elderwood at Wheatfield	2600 Niagara Falls Boulevard Niagara Falls, NY 14304

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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 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of the Vaccine Screening Prior to Vaccination form dated 10/20/23 documented that the resident was screened and able to receive the influenza vaccine. During an interview on 8/14/24 at 9:20 AM, the Assistant Director of Nursing stated that if the resident has capacity, the resident signs the declination or the consent for the influenza immunization. They also stated that the unit clerks would scan the consent forms into the electronic medical record after the vaccine was given. The Assistant Director of Nursing stated that the paper copy goes to medical records after it is scanned. 3. Resident #59 was admitted to the facility with diagnoses of chronic obstructive pulmonary (lung) disease and anxiety. The Minimum Data Set, dated dated dated [DATE] documented the resident was severely cognitively impaired, usually understood by others, and usually understands others. Further review of the Minimum Data Set documented that the resident did not receive the influenza immunization. Review of the immunization tab in the electronic medical record dated 10/19/23 documented that the resident declined the influenza vaccine. Review of the chronological electronic medical record for declinations of immunizations revealed that there was no scanned copy of a signed influenza immunization declination. During an interview on 8/14/24 at 9:28 AM, the Director of Nursing stated they typically get the signed consents or declinations at the same time. They stated that once the immunization was completed, it was expected that the unit clerk scanned the document into the electronic medical record. The Director of Nursing stated then the signed paper copy goes to medical records. During an interview on 8/14/24 at 10:39 AM, the Administrator stated they expected nursing staff to document immunizations accurately and for medical records to make sure signed consents or declinations were scanned into the resident's medical record. During an interview on 8/13/24 at 3:15 PM, the Unit Clerk stated that once the immunization was given, the form was scanned into the electronic medical record. They stated that they looked through the paper medical records and could not find the signed declinations or consents. NYCRR 10 415.22(a) (1-4)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43802 Based on observation, interview, and record review conducted during a Standard survey completed on 8/14/24, 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 two (Resident #15 and Resident #82) of eight residents reviewed for infection control processes during care. Specifically, Certified Nurse Aide #4 and Certified Nurse Aide #18 did not wear proper personal protective equipment for a resident requiring enhanced barrier precautions with a multidrug resistant organism infection while they emptied a catheter bag (urine collection bag), changed the catheter bag to a leg bag, and transferred the resident to a shower chair (#15). In addition, Certified Nurse Aide #5 did not use proper hand hygiene during incontinent care (Resident #82). The findings are: The policy and procedure titled Infection Prevention Control Program dated 7/15/24 documented that staff are responsible to wash their hands frequently especially after handling soiled or contaminated objects, before and after coming into contact with residents or residents' possessions and are to use protective equipment when coming into contact with a resident on transmission-based precautions. 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 include urinary catheters. The memo documented enhanced barrier precautions are employed for high contact resident care activities including the care or use of a urinary catheter. 1. Resident #15 was admitted to the facility with diagnoses of multiple sclerosis (an autoimmune disorder that affects the brain, spinal cord, and other nerves) and resistance to multiple antibiotics. The Minimum Data Set (a resident assessment tool) dated 6/19/24 documented Resident #15 was cognitively intact, understands others, and was understood by others. The assessment further documented the resident required substantial assistance for toileting and had a suprapubic urinary catheter (a thin tube inserted into the bladder to drain urine). The comprehensive care plan dated 7/1/24 documented the resident required substantial assistance of one staff member with toileting. The comprehensive care plan documented the resident had a neurogenic bladder (a condition where the bladder function is impaired due to nerve damage) that required a suprapubic catheter. Interventions included enhanced barrier precautions. Review of the Kardex (a guide for resident care) documented that Resident#15 was on enhanced barrier precautions because of their suprapubic catheter. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 8/13/24 at 8:45 AM outside Resident 15's room, a sign was posted that noted for direct care and transfers, enhanced barrier precautions were needed. Further observation of this sign revealed that staff were to wear a gown, gloves, and a mask for direct care of a resident. Outside the room there was a multi drawer bin that contained face masks, procedure gowns, and gloves. During a care observation on 8/13/24 at 10:23 AM Resident #15 was being prepared for transfer to a shower chair. Certified Nurse Aide #18 assisted the resident in their bed into a sitting position. Certified Nurse Aide #4 emptied the resident's catheter bag into a container and stated that the resident had approximately 550 milliliters of urine. Certified Nurse Aide #4 emptied the container into the toilet, washed their hands, and applied gloves. Certified Nurse Aide #4 then changed the catheter bag to a leg bag. Certified Nurse Aide #4 placed the catheter bag in Resident #15's bathroom. Certified Nurse Aide #4 washed their hands and changed their gloves. Certified Nurse Aide #18 and Certified Nurse #4 then assisted Resident #15 into a sit to stand lift. Resident #15 was then transferred from their bed into a shower chair. Neither certified nurse aide wore a gown and face mask during these direct care activites. During an interview on 8/13/24 at 10:35 AM, Certified Nurse Aide #18 reviewed the enhanced barrier precautions sign outside Resident #15's room and stated that they should have worn a mask and a gown when they provided care for Resident #15. Certified Nurse Aide #18 stated that they should have worn protective equipment to prevent any cross contamination with other residents. During an interview on 8/13/24 at 10:37 AM, Certified Nurse Aide #4 reviewed the enhanced barrier precautions sign outside Resident #15's room and stated that they should have worn a mask, a gown, and protective eyewear because there was a splash risk from changing the catheter bag to a leg bag. Certified Nurse Aide #4 stated there was a risk of cross contamination to other residents or contaminating Resident #15. During an interview on 8/13/24 at 10:47 AM, the Registered Nurse, Nurse Educator stated that if a resident has an open wound or a tube like a catheter, they expected staff to wear proper protective equipment. They stated that they had started in-services for enhanced barrier precautions for staff but did not get to all the employees. They stated that if there was a sign and a precaution set up outside the resident's room, staff should wear protective equipment. During an interview on 8/13/24 at 11:07 AM, the Director of Nursing stated they expected their staff to wear personal protective equipment when care was provided to residents on enhanced barrier precautions to prevent contamination. During an interview on 8/13/24 at 12:19 PM, the Assistant Director of Nursing stated they expected their staff to wear protective equipment when providing care for a resident on enhanced barrier precautions. During an interview on 8/13/24 at 1:01 PM, the Regional Registered Nurse Infection Preventionist stated that they would expect the staff to wear any protective equipment like gowns and gloves when they provide direct care to a resident on enhanced barrier protections. They stated that there could be a splash risk when changing a catheter bag to a leg bag. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident 82 was admitted to the facility with diagnoses of hemiplegia (paralysis on one side of the body) and dysphagia (a condition with difficulty in swallowing). The Minimum Data Set, dated dated dated [DATE] documented that Resident #82 was cognitively intact, understands others, and was understood by others. The Minimum Data Set documented the resident required maximal assistance for toileting of one staff member and always incontinent of urine. The comprehensive care plan revised on 4/23/24 documented Resident #82 was a maximal assist of one staff member for toileting hygiene. The Kardex documented the resident was always incontinent of urine and needed incontinent care every two to four hours or as needed. During an observation of incontinent care on 8/13/24 at 8:15 AM, Certified Nurse Aide #5 put a plastic barrier on the residents over the bed table and one on the floor next to the resident's bed. Certified Nurse Aide #5 washed their hands, put on gloves, and brought out wet washcloths and placed them onto the barrier on the over the bed table. They raised the bed of Resident #82 to perform incontinent care. Certified Nurse Aide #5 removed Resident #82's incontinence brief which was moderately wet with urine and placed the wet brief on the plastic barrier on the floor. Certified Nurse Aide #5 did not change their gloves or wash their hands after removing the wet brief. They then cleansed the front genital area of Resident #82 with one washcloth that had body wash on it then took another wet washcloth from the over the bed table and wiped off the body wash from the front genital area. They then dropped the washcloths onto the plastic barrier on the floor. Certified Nurse #5 then dried the resident with a towel. They folded the used part of the towel and placed the used towel on the over the bed table. The did not change gloves or wash hands after cleaning the front genital area. Certified Nurse Aide #5 asked Resident #82 to turn to their side so they could wash their buttocks and rear genital area. Certified Nurse Aide #5 took a clean washcloth with body wash on it and cleansed the resident's buttocks and rear genital area; wiped off the soap with another washcloth; and patted dry. Certified Nurse Aide #5 put all the used washcloths and towels on the plastic barrier on the floor. They did not change gloves or wash their hands. Certified Nurse Aide #5 then put a new brief on the resident and straightened out Resident #82 nightgown. Certified Nurse Aide #5 then discarded the used linens. During an interview on 8/13/24 at 8:31 AM, Certified Nurse Aide #5 stated they were not trained to change gloves or wash hands after changing a wet brief. They stated that there could be some contamination if you didn't wash your hands and change your gloves after changing a wet brief. During an interview on 8/13/24 at 10:47 AM, the Registered Nurse, Nurse Educator stated they expected staff when performing incontinence care for staff to wash their hands and change their gloves after handling a wet brief and before putting on a new brief. They stated staff were taught to do this. During an interview on 8/13/24 at 11:07 AM, the Director of Nursing stated they expected their staff to wash their hands and change their gloves after changing a brief and before they put a new brief on the resident. During an interview on 8/13/24 at 1:01 PM, the Regional Registered Nurse Infection Preventionist stated they expected the staff to change their gloves and wash their hands after a staff member changed a wet brief and before they put a clean one on a resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NYCRR 10 415.19(b)(4)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43802 Based on observation, interview, and record review during the Standard survey completed on 8/14/24, the facility did not maintain an effective pest control program so that the facility was free from insects for one (Unit 1) of three resident units. Specifically, flies were observed in resident rooms, dining rooms and common (lounge) area on Unit 1. The findings are: Refer to F 584 Safe clean and comfortable environment. Facility was unable to provide a policy and procedure for pest control. Review of work order dated 7/29/24, Resident room [ROOM NUMBER], documented the resident's family stating flies were coming in from around open, air conditioner. Work order indicated work order completed 7/29/24, seal around air conditioner. Review of work order dated 7/31/23, Resident Room's #100, #106, #107 noted reports of flies coming in from outside through gaps left by air conditioners. Work order documented completed, all three rooms sealed up air conditioners, done. Review of pest company National Accounts Service Report dated 6/20/24 and 7/18/24 commented fly lights were serviced. No fly lights on resident units. During an observation on 8/8/24 at 11:42 AM, 11:46 AM and 11:48 AM revealed multiple live small flies on the Side B lounge area landing on residents sitting in that area. Resident #45 heard saying Get that fly out of here, and Kill that fly. During an observation on 8/8/24 at 11:46 AM, Resident room [ROOM NUMBER] had strong urine odor and live small flies present. There was a resident in bed and flies were observed landing on the resident's bare skin of their leg and on the wheelchair in the room. At the time of the observation the resident stated there were flies all the time, especially in the dining room. The resident stated flies were terrible and were germ carriers. They stated they have reported the flies to staff and haven't heard back. During an observation on 8/8/24 at 12:31 PM and 12:48 PM, multiple small flies were observed in the Private dining room during meal service. Flies landed on resident's food. During observation on 8/9/24 at 10:42 AM Resident room [ROOM NUMBER] had a strong odor of urine, and live small flies were observed in the room. An interview this time with the resident that resided in the room stated there have been a zillion flies the last week or two. They stated when they are trying to sleep, they land on their face, they try to swat them away, but they were too fast for them. The resident stated they believed the staff were aware because they yell at the flies. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/12/24 at 11:37 AM, an visiting family member of Resident #63 on Unit 1 stated there have been a lot of flies. They stated it has been over two weeks and that they have spoken to the Administrator about it. They stated initially they thought it was from the gap between the window and air conditioning units the facility put in, but it's been over 2 weeks. During the interview, the family member swatted a fly away with their hand that was flying in front of their face. They stated the flies were unsanitary and that the unit smelt like urine. During an observation and interview on 8/12/24 at 5:35 PM, the Unit 1 Main Dining room had multiple flies, flying around residents' food while they were eating. Residents were observed swatting at flies while they were eating their food. Resident #26 stated, the Flies are eating more than I am. During an observation on 8/13/24 at 1:38 PM, there were a few flies flying around an unidentified resident consuming a sandwich in the Side B lounge area of Unit 1. The resident was unable to be interviewed. There was a strong urine odor presents in lounge area. During an interview on 8/13/24 at 1:47 PM, Licensed Practical Nurse #2 stated there had been a fly presence since they placed the air conditioning units in the resident's rooms. Licensed Practical Nurse #2 stated the air conditioning units were not sealed all the way around and felt the fly situation was circumstantial due to the air conditioning units. They stated flies were pests and were gross. They stated maintenance should be aware but wasn't sure if a work order had been submitted for the flies. During an interview on 8/14/24 at 8:26 AM, Registered Nurse #1, Unit Manager, stated there has been an increase in flies on Unit 1 since the air conditioning units were placed, at least two weeks ago. They stated maintenance and administration were aware and working on it. They stated the presence of flies was not homelike and this was there home. Additionally, they stated the urine odor may contribute to the flies. During an interview on 8/14/24 at 8:32 AM, Maintenance Assistant stated they have not received any work orders related to flies. They stated they were unaware of any fly issue on Unit 1. They stated resident units should be pest free and didn't think there should be a presence of flies on the unit. They stated flies were unsanitary; source of flies needed to be determined and eliminated. Additionally, they stated they would expect staff to notify the maintenance department of issues with pests. During an interview on 8/14/24 at 8:40 AM, Housekeeping Aide stated they have observed flies on the unit but haven't informed maintenance of the flies. During an interview on 8/14/24 at 8:47 AM, the Director of Facility Management stated they were unaware of any fly concerns in the last 2 weeks. They stated they had received a few calls related to gaps after air conditioning units were placed that were addressed. They stated they still wouldn't expect flies to be present today on unit from over 2 weeks ago. They stated flies shouldn't be to a point of swatting away, the environment should be comfortable and clean. They stated everyone has access to the work order system, and they would expect staff to inform them of fly issues. Additionally, they stated they have never had to call the exterminator related to flies on the unit. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/14/24 at 8:58 AM, Certified Nursing Assistant #6 stated there has been an increase in flies on Unit 1 in the resident rooms but mostly in the lounge area and dining rooms. They stated they reported it to a nurse last week and was told by the nurse it was being taken care of. Certified Nursing Assistant #6 stated the flies were gross, and not sanitary where residents were trying to eat their food. During an additional interview on 8/14/24 at 11:58 PM, Director of Facility Management stated they had not received any work orders related to flies since 7/31/24 and those work orders were addressed. During an interview on 8/14/24 at 1:23 PM, Administrator stated they weren't aware of there being a fly concern currently on Unit 1. They stated they would expect that if an issue were being identified staff would let maintenance and housekeeping know right away, so something can be done about it. 10NYCRR 415.29(j)(5)