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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION     | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>335816 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing  | (X3) DATE SURVEY COMPLETED<br><br>01/08/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Canterbury Woods |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>725 Renaissance Drive<br>Williamsville, NY 14221 |  |

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

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| (X4) ID PREFIX TAG  | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |
| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>43785</p> <p>Based on observation, interview, and record review conducted during a Complaint investigation (Complaint #NY00362317) completed on an Extended Recertification survey with an exit date of 1/8/2025, the facility failed to protect the residents rights to be free from verbal and physical abuse by a Companion Aide for one (Resident #22) of six residents reviewed for abuse. Specifically, a Companion Aide was witnessed by facility staff being verbally and physically abusive towards Resident #22. The facility did not review/revise abuse processes/protocols since 2016. In addition, the facility did not consistently implement their protocols regarding Companion Aides. They did not have an effective system to ensure background checks were verified as completed for all Companion Aides prior to starting at the nursing home; lacked an effective system to communicate with the residents/families, and Companion Aides the nursing home policy included Companion Aides were not to provide hands on care; lacked a system to monitor Companion Aides to ensure their specific policies were followed to ensure resident safety. This resulted in no actual harm with the potential for more than minimal harm with the likelihood to affect all residents and is substandard quality of care.</p> <p>The finding is:</p> <p>The policy and procedure titled, Abuse Prevention Program dated 11/28/16 documented the residents have the right to be free from abuse, neglect, mistreatment, corporal punishment. The facility is committed to protecting our residents from abuse by anyone including, but not necessarily limited to, staff, other residents, consultants, volunteers, staff from other agencies providing services to our residents, family members, companion aides, legal guardians surrogates, friends, visitors, or any other individual.</p> <p>The policy and procedure titled Companion Aide with a revision date of 10/01/2020 documented the facility recognizes a resident's right to hire or engage the services of a Companion Aide. The Social Worker was listed as responsible for the implementation of this policy and the facility established guidelines. To ensure resident safety and security, Companion Aides must provide certain background information to the facility prior to beginning service, permit the facility to conduct a criminal background check and complete an Authorization for Release Information form. Companion Aides are subject to all the policies, guidelines, rules, and regulations in effect at the facility. Companion Aides providing services to residents residing in the Assisted Living &amp; Skilled Nursing settings are not permitted to perform hands on care, this includes assisting residents with personal care or activities of daily living.</p> <p>(continued on next page)</p> |

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

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p> | <p>An undated Private Hire Agreement provided by Social Worker #1, documented that all Companion Aides were to complete the agreement prior to their hire date. In consideration for access to the community for the purpose of performing personal care services to resident(s) they were to sign they understand and agree to the following: a criminal background check, validate any certifications or licenses as may apply or perform reference checks if deems necessary to ensure the safety of its residents. The form documents by signing they agree to assume all risks associated with or resulting from the performance of my services to residents. Additionally, by signing they agree to abide by all policies, procedures, rules, guidelines, and regulation of the community. Understands that our facility assumes no responsibility for supervising or monitoring the work of the companion aide engaged or employed by the resident. The Private Hire Agreement did not include the nursing home's specific policy which documented that Companion Aides were not to provide hands on care and they were subject to all to all the policies, guidelines, rules, and regulations in effect at the nursing home.</p> <p>1. Resident #22 had diagnoses of Alzheimer's disease, heart failure, and displacement fracture of left femur. The Minimum Data Set (a resident assessment tool) dated 11/15/24 documented Resident #22 had severe cognitive impairments. Resident #22 required substantial/maximal assistance for toileting, toileting transfer, upper body dressing, lower body dressing, and for personal hygiene.</p> <p>The Comprehensive Care Plan dated 11/25/24 documented Resident #22 had severe dementia, was alert and oriented to person only. Interventions included to provide comfort and reassurance when resident was confused. Resident #22 had behavioral problems related to dementia which included resistive to hands on care, hitting/slapping/kicking staff members, verbally aggressive, and yelling at staff. Interventions included to give positive feedback and reinforcement for resident's compliance, reapproach resident as needed in a calm manner. The care plan did not address Resident #22 had a Companion Aide.</p> <p>The Accident and Incident Report signed by the Administrator and the Assistant Administrator documented on 11/26/24 between the hours of 8:00 AM and 9:00 AM Activities Aide #1 reported to the Licensed Practical Nurse Supervisors they heard screaming and thumping sounds coming from Resident #22's room. The Licensed Practical Nurse Supervisors went to Residents #22's room and the resident was receiving care at the bedside from CNA (Certified Nurse Aide #1) and a private companion aide. The report also documented the resident was restrained by Companion Aide#1, their arms were grabbed, crossed, and held to the resident's chest. The Accident and Incident Report included a Management Investigation Report that documented the event occurred because Resident #22 did not want to get out of bed and the hired Companion Aide #1 did not respect the resident's wishes. The Accident and Incident Report/ Management Investigation Report had four employee written statements, but did not include a written statement from Companion Aide #1 and Activities Aide #1.</p> <p>Review of Certified Nurse Aide #1's statement dated 11/26/24 revealed Resident #22 did not want to get up, so they stated to the resident they would come back later. The Companion Aide was in the room at the time and said they were going to get the resident dressed. The Companion Aide moved the resident's blanket and the resident hit the Companion Aide with their legs. The Companion Aide grabbed both of Resident #22's hands, crossed them and pushed their arms towards the resident's chest. The Companion Aide told Resident #22 to stop, and they were going to get dressed. Certified Nurse Aide #1 documented they told the Companion Aide to stop, that we don't do that. Certified Nurse Aide #1 also documented the resident was scared.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Review of Licensed Practical Nurse Supervisor #1's statement dated 11/26/24 revealed they responded to the reported situation, upon entering Certified Nurse Aide #1 was providing care and Companion Aide #1 was attempting to clean the resident. The resident was agitated but calmed after the Companion Aide walked away.</p> <p>Review of Licensed Practical Nurse #3's statement dated 11/26/24 revealed Certified Nurse Aide #1 was doing care and Companion Aide #1 was assisting with care and Resident #22 was visibly agitated.</p> <p>During an observation on 1/6/24 at 8:01 AM Resident #22's room door was closed. Post knocking, Companion Aide #3 opened the door and Resident #22 was lying in bed resting with no distress noted. During an interview at this time Companion Aide #3 stated they provided hands on care for Resident #22 and they were also aware that Companion Aide #1 had provided hands on care. Companion Aide #3 stated the facility nurses and CNA's (certified nurse aides) were aware Companion Aides provided hands on care and were happy because it was less work for them. Companion Aide #3 also stated they were in charge of the hiring Companion Aides for Resident #22, and they performed the duties of a Case Manager for the family. Companion Aide #3 stated they were informed by Social Worker #1 of Companion Aide #1's inappropriate behavior towards Resident #22 that occurred 11/26/24 and that Companion Aide #1 no longer worked for the family and was not allowed in the facility. Companion Aide #3 stated Social Worker #1 did a background check on Companion Aide #1 but did not validate their licensure because Social Worker #1 told them (meaning themselves) Companion Aides were not allowed to perform hands on care. Companion Aide #3 stated the family representative was aware they were providing hands on care for Resident #22 in the nursing home and the staff in the nursing home never told them to stop.</p> <p>During an interview on 1/6/25 at 8:19 AM, Certified Nursing Aide #1 stated Resident #22 could be combative while providing care. They stated the morning of 11/26/24, Companion Aide #1 insisted that Resident #22 got up and dressed; and had stated they were tired of (facility) staff not getting the resident out of bed and would do it themselves. Certified Nurse Aide #1 stated they told Companion Aide #1 the resident could not be forced to get up. Companion Aide #1 insisted, pulled the residents blankets back and Resident #22 kicked Companion Aide #1. Companion Aide #1 then forcefully grabbed the residents' arms and crossed them across the resident's chest to restrain them as they yelled, Stop, you will get dressed now! Certified Nursing Aide #1 told Companion Aide #1 to stop. Resident #22 was screaming and crying. Licensed Practical Nurse Supervisor #1 and Licensed Practical Nurse #3 entered the room. Certified Nurse Aide #1 stated they would consider this abuse because they should not force a resident to do anything they don't want to. Certified Nurse Aide #1 stated they were aware Companion Aides were not allowed to provide hands on care and were to socialize with the residents only. They stated all facility staff were trained yearly on abuse but the Companion Aides were not employed by the facility, so they were not certain of what training they received.</p> <p>During an interview at 1/6/25 at 9:17 AM, Licensed Practical Nurse #3 stated Activities Aide #1 had told Licensed Practical Nurse Supervisor #1 they heard a thump and yelling in Resident #22's room, so they went to see what had happened. Certified Nurse Aide #1 was at the foot of the bed and Companion Aide #1 was trying to assist them with care, Resident #22 was screaming, distressed and agitated. They stated they did not see any bruises on Resident #22 and did not see Companion Aide #1 touch the resident, so they were not certain if this was abuse, but the resident was upset and agitated.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p> | <p>During an interview on 1/6/25 at 9:24 AM, Licensed Practical Nurse Supervisor #1 stated Activity Aide #1 reported they had heard screams and a thump in Resident #22's room and they went to the Resident's room with Licensed Practical Nurse #3. Upon entering the room Certified Nurse Aide #1 and Companion Aide #1 were at the bedside, Resident #22 was screaming and agitated. Companion Aide #1 had blamed the resident's distress on the amount of people in the resident's room. Licensed Practical Nurse Supervisor #1 stated Companion Aide #1 overstepped their boundaries and were not to provide hands on care. There was no bruising noted on Resident #22, but they considered this abuse and reported the incident to the Assistant Administrator.</p> <p>During an interview on 1/6/25 10:27 AM, Activities Aide #1 stated during their rounds on the morning of 11/26/24, they passed Resident #22's room and heard a thump and someone yelled, Stop kicking me. They reported the concern Licensed Practical Nurse Supervisor #1 and Licensed Practical Nurse #3. They stated they were uncertain if the Companion Aides were allowed to perform hands on care.</p> <p>During a telephone interview on 1/6/25 at 11:06 AM, Companion Aide #1 stated they worked with Resident #22 on 11/26/24 until 9:00 AM and they worked for the family of Resident #22 not the facility. They stated Resident #22 was combative and their behavior had declined since their transfer to the nursing home from independent living. Resident #22 would call them trash, hit them. Companion Aide #1 stated they had to provide hands on care to Resident #22 because the facility aides would never come when they pressed the call bell, and facility staff did not like to provide care because Resident #22 was so behavioral. Companion Aide #1 stated on 11/26/24 they asked Certified Nurse Aide #1 if they needed help with care and they replied yes. Companion Aide #1 stated they did not yell at Resident #22; the resident did not have their hearing aide in and had to talk loudly. Companion Aide #2 stated they never grabbed the resident's arms or restrained them. They stated they were not asked to leave the facility, it was the end of their shift and that was why they left. They stated they no longer provided companion care for Resident #22 and was asked not to return to the building by the Case Manager (Companion Aide #3).</p> <p>During an interview on 1/6/25 at 11:38 AM, Resident #22's family member stated they were told by Certified Nurse Aide #1 that Companion Aide #1 physically grabbed their family member by the arms, put them across the resident's chest and yelled at them that they needed to get dressed. The family member stated they reported the incident to Social Worker #1. The family member stated Companion Aides were not allowed to perform hands on care, but were aware the Companion Aides would provide incontinent care and change Resident #22's brief when needed but deferred to the nursing home staff for anything else. They stated they were never provided the nursing home policy and procedures regarding Companion Aides.</p> <p>During an observation and an interview on 1/6/25 at 2:43 PM, Resident #22's room door was closed, Companion Aide #2 responded to the knock at the door. The resident was lying in bed and appeared comfortable without agitation. Companion Aide #2 stated their duties were to perform hands on care for Resident #22. Personal care included washing the resident and providing incontinence care, changing incontinence briefs, and providing oral care. They stated they shadowed Companion Aide #3 for a day, and this was what they were told to do. They stated they observed Companion Aide #3 perform a sponge bath, changed the residents' briefs, and applied zinc oxide to the residents' buttocks. They stated the only thing they were told not to do was to shower Resident #22. They stated the facility itself had not provided them information on what they could or could not do for residents and they had never met with Social Worker #1 prior to their hire date.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p> | <p>During an interview on 1/6/25 at 2:59 PM and 1/7/25 at 10:31 AM, Social Worker #1 stated they were responsible for the Companion Aide program at the skilled nursing home level. Social Worker #1 stated they were uncertain how many Companion Aides were currently working within the nursing home and were uncertain how many current residents had Companion Aides. Social Worker #1 stated they were not verifying that background checks were completed for Companion Aides because they assumed if the resident was transferred from within the community (campus) it was completed at the other levels of care. They stated they had performed a background check on Companion Aide #1 prior to their hire date but did not check their licensure because they were not to perform hands on care. Social Worker #1 stated they had not completed a background check on Companion Aide #2 because they were unaware, they acted as both a Companion Aide and as the Case Manager for the family. During the interview Social Worker #1 reviewed the Private Hire Agreement and stated the agreement did not specify that hands on care could not be provided by the Companion Aide once a resident reached the skilled nursing level of care. Social Worker #1 stated the campus utilized the same Private Hire Agreement for Companion Aides across all levels of care throughout the campus even though the expectations were different. Social Worker #1 stated the nursing home does not provide education for the Companion Aides regarding the of rules and regulations they were expected to adhere to. The Companion Aides did not receive a copy of the nursing homes policy titled Companion Aide and they do not verbally tell the Companion Aides they cannot provide hands on care in the nursing home. Social Worker #1 stated to protect the resident's safety the facility monitored the Companion Aides the same way they would monitor any visitor; they relied on the staff to inform them of any inappropriate behavior.</p> <p>During an interview on 1/6/25 at 3:14 PM, the Administrator stated the Companion Aide program was the responsibility of the Social Worker in the nursing home; and Companion Aides were told they were not to perform hands on care verbally when they met with Social Worker #1. The expectations of the Companion Aide would include taking residents to the library, scheduling appointments, or anything the family would ask them to do as long as it was not hands on care. The Administrator stated the incident that occurred on 11/26/24 with Resident #22 would not be considered abuse because the police did not get involved, the resident did not get hurt, and there was no psychological harm. They stated it was an isolated event and it was wrong but would not consider this abuse. They stated the facility reported the incident; Companion Aide #1 was no longer allowed in the facility and this was an adequate resolution to the incident. The Administrator deferred to Social Worker #1 questions regarding how many residents had Companion Aides and how many Companion Aides were working within the nursing home.</p> <p>During a follow up telephone interview on 1/7/25 at 11:53 AM, Companion Aide #1 stated they did provide hands on care for Resident #22 all the time and usually with a staff member of the facility but did recall twice they had to do care themselves because no one came when they pressed the call bell. They stated they assisted Resident #22 with eating, made sure they were hydrated, assisted with dressing, helped them to the toilet, changed soiled briefs and applied zinc oxide to their buttocks. They stated they never met with anyone from the facility about orientation or training but did sign paperwork and dropped it off to the receptionist when it was completed. They stated all the facility staff were aware they provided hands on care for Resident #22 and liked that they did because the resident was behavioral, and it was less work for them.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p> | <p>During an interview on 1/7/25 at 3:24 PM, Social Worker #1 stated the facility had a responsibility to ensure a resident was not being abused. They stated there was no formal process for monitoring the Companion Aides except as if they were any other visitor. Staff were to check in with the resident, observe and intervene if there was anything inappropriate happening. Social Worker #1 stated they were unaware that Resident #22's Companion Aides were providing hands on care. Social Worker #1 stated that from their understanding of the situation that occurred on 11/26/24, they felt Resident #22 was restrained by Companion Aide #1 and that would be considered abuse.</p> <p>During an interview on 1/8/25 at 10:44 AM, Companion Aide #3 stated they were not provided with the nursing home's Companion Aide policy. The Private Hire Agreement did not specify the different levels of care and restrictions on care in the nursing home. Companion Aide #3 stated the facility could not ensure the residents safety if the Companion Aides were not informed on what care they could or could not do for the residents.</p> <p>During an interview on 1/8/25 at 11:28 AM, the Administrator stated it was the facilities responsibility to provide a safe environment to protect the residents from abuse, and assumed the responsibility when a resident was admitted . They stated the facility management did not do any unannounced visits or monitoring of the Companion Aides before or after the incident that occurred on 11/26/24. They stated they monitored the Companion Aides the same way they would monitor any other visitor, they relied on staff to inform them of any inappropriate behavior. They stated no corrective actions were needed following the investigation because the alleged suspect was not permitted in the facility any longer.</p> <p>10 NYCRR 415.4(d)(1)(vii)</p> |   |  |

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| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>43785</p> <p>Based on interview, and record review conducted during a Complaint investigation (Complaint #NY00362317) completed on an Extended Recertification survey with an exit date of 1/8/2025, the facility did not ensure that all alleged violations involving abuse, neglect, and mistreatment, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse to the administrator and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for one (Resident #22) of six reviewed. Specifically, the facility did not report to the State Agency allegations of abuse within the two-hour required time frame. In addition, the facilities abuse reporting protocols have not been reviewed/revised since 2016.</p> <p>The finding is:</p> <p>The policy and procedure titled Abuse Reporting revised 11/28/16 documented the Director of Nursing and Administrator will be called and notified immediately, but not later than two hours after the allegation is made if the events of the allegation involve abuse or result in serious bodily injury. Verbal/written notices to agencies will be made within 24 hours of the occurrence and such notice may be submitted electronically via the NYSDOH (New York State Department of Health) Health Commerce System. The policy did not include the required 2-hour timeframe.</p> <p>1. Resident #22 had diagnoses of Alzheimer's disease, heart failure, and displacement fracture of left femur. The Minimum Data Set (a resident assessment tool) dated 11/15/24 documented Resident #22 had severe cognitive impairments. Resident #22 required substantial/maximal assistance for toileting, toileting transfer, upper body dressing, lower body dressing, and for personal hygiene.</p> <p>The Accident and Incident Report signed by the Administrator and the Assistant Administrator documented on 11/26/24 between the hours of 8:00 AM and 9:00 AM Activities Aide #1 reported to the Licensed Practical Nurse Supervisors they heard screaming and thumping sounds coming from Resident #22's room. The Licensed Practical Nurse Supervisors went to Residents #22's room and the resident was receiving care at the bedside from CNA (Certified Nurse Aide #1) and a private companion aide. The report documented the resident was restrained by Companion Aide #1, their arms were grabbed, crossed, and held to the resident's chest. The Accident and Incident Report included a Management Investigation Report that documented the event occurred because Resident #22 did not want to get out of bed and the hired Companion Aide #1 did not respect the resident's wishes. The report documented the event was suspected abuse/mistreatment/neglect of the resident and the Regulatory Agency was notified on 11/27/24.</p> <p>Review of Social Worker #1's written statement attached to the Accident and Incident report dated 11/26/24 documented that Resident #22's family member reported to them at 2:00 PM on 11/26/24 that Certified Nurse Aide #1 reported to the family member that Companion Aide #1 was using inappropriate behavior towards Resident #22.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>During an interview on 1/6/25 at 8:19 AM, Certified Nursing Aide #1 stated on the morning of 11/26/24, Companion Aide #1 insisted that Resident #22 got up and dressed; they pulled the residents blankets back and Resident #22 kicked Companion Aide #1. Companion Aide #1 then forcefully grabbed the resident's arms and crossed them across the resident's chest to restrain them as they yelled, Stop, you will get dressed now! Resident #22 was screaming and crying. Licensed Practical Nurse Supervisor #1 and Licensed Practical Nurse #3 entered the room. Certified Nurse Aide #1 stated they would consider this abuse because they should not force a resident to do anything they don't want to.</p> <p>During an interview at 1/6/25 at 9:17 AM, Licensed Practical Nurse #3 stated Activities Aide #1 had told Licensed Practical Nurse Supervisor #1 they heard a thump and yelling in Resident #22's room, so they went to see what had happened. Resident #22 was screaming, distressed, and agitated. They stated they did not see any bruises on Resident #22 and did not see Companion Aide #1 touch the resident, so they were not certain if this was abuse.</p> <p>During an interview on 1/6/25 at 9:24 AM, Licensed Practical Nurse Supervisor #1 stated Activity Aide #1 reported they had heard screams and a thump in Resident #22's room. Upon arrival to the room, Resident #22 was screaming and agitated. Licensed Practical Nurse Supervisor #1 stated Companion Aide #1 overstepped their boundaries and were not to provide hands on care. There was no bruising noted on Resident #22, but they considered this abuse and reported the incident to the Assistant Administrator.</p> <p>During an interview on 1/6/25 10:27 AM, Activities Aide #1 stated during their rounds on the morning of 11/26/24, they passed Resident #22's room and heard a thump and someone yelled, Stop kicking me. They reported the concern to Licensed Practical Nurse Supervisor #1 and Licensed Practical Nurse #3.</p> <p>During an interview on 1/6/25 at 11:38 AM, Resident #22's family member stated they were told by Certified Nurse Aide #1 that Companion Aide #1 physically grabbed their family member by the arms, put them across the resident's chest and yelled at them that they needed to get dressed. The family member stated they reported the incident to Social Worker #1 in the afternoon on 11/26/24.</p> <p>During an interview on 1/6/25 at 3:14 PM, the Administrator stated the incident that occurred on 11/26/24 with Resident #22 would not be considered abuse because the police did not get involved, the resident did not get hurt, and there was no psychological harm. They stated it was an isolated event and it was wrong but would not consider this abuse. The Administrator stated the facility reported the incident.</p> <p>During an interview on 1/7/25 at 3:24 PM, Social Worker #1 stated based on their understanding of the situation that occurred on 11/26/24, they felt Resident #22 was restrained by Companion Aide #1 and that would be considered abuse.</p> <p>Review of an email provided by the Administrator on 1/8/2025 dated 11/27/24 at 3:07 PM revealed the email was addressed to the Administrator and documented the Nursing Home Facility Incident Report was successfully submitted on 11/27/24 at 15:06 (3:06 PM). The report was not submitted within two hours of the alleged abuse.</p> <p>NYCRR 415.4(b)(4)</p> |   |  |

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| <p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>43785</p> <p>Based on observation, interview and record review conducted during the Extended Recertification survey completed on 1/8/25, the facility did not ensure that a resident with pressure ulcers (ulcers on the skin due to prolong pressure) received necessary treatment and services, consistent with professional standards of practice, to promote healing, and prevent infection for one (Resident #13) of one resident reviewed. Specifically, there were lack of consistent weekly pressure ulcer assessments and ongoing monitoring for Resident #13's left heel and left buttock pressure ulcers, the assessments did not consistently include staging, measurements of size (length x width x depth), or a description of the wounds. Additionally, the assessments had conflicting documentation of treatment instructions and wound measurements for the pressure ulcers.</p> <p>The finding is:</p> <p>The undated facility policy titled Pressure Ulcer Prevention and Treatment documented that a complete wound assessment and documentation will be done upon initial finding then weekly on all pressure ulcers until they are healed or if there was a deterioration in the ulcer by the Skin team or designees. The policy documented the criteria to be included were site/location; stage; size to include length, width, and depth in centimeters; appearance of the wound bed; undermining/tunneling; surrounding skin; drainage; pain; and signs and symptoms of infection.</p> <p>Resident #13 had diagnoses including dementia, coronary artery disease and chronic obstructive pulmonary disease. The Minimum Data Set (a resident assessment tool) dated 10/11/24 documented Resident #13 had moderate cognitive impairment, was understood, and usually understands. The assessment tool documented the resident had one stage II (partial-thickness skin loss into but not deeper than the dermis) pressure ulcer that was not present upon admission.</p> <p>The Comprehensive Care Plan dated 10/24/24 documented Resident #13 had actual altered skin integrity related to a partial thickness wound on their left heel. Interventions included to monitor skin per protocol, preventive skin interventions as per resident care guide, encourage meal/fluid consumption, skin team referral as needed, notify the medical doctor for adverse changes, and left heel bootie on at all times. There was no documentation regarding the left buttock pressure ulcer.</p> <p>Review of the Treatment Record from October 1, 2024-January 8, 2025, revealed Resident #13 had a treatment order with start date of 10/31/24 to apply optifoam (a foam dressing designed to absorb wound drainage) bandage to their pressure ulcer on left buttock after cleansing with normal saline daily in the evening.</p> <p>Review of the untitled medical provider progress notes from 9/20/24- 11/12/24 the Medical Director documented on:</p> <p>-9/20/24, Resident #13 had an acute visit due to a new onset of an ulceration on their left heel in the medial aspect (the part that is closest to the body's midline). It was documented that the area was about 2.5 x 1 centimeters and crescent shaped.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>-9/24/24, Resident #13 had an ulceration on their left heel, measuring 2 x 0.5 centimeters, a quarter moon type shape with a clean wound bed.</p> <p>-11/12/24, Resident #13 was seen for a 60-day visit and they had a very superficial ulceration area 3 x 4 centimeters to their left heel.</p> <p>There was no further Medical Director documentation in the medical record regarding Resident #13's pressure ulcer of their left heel or left buttock.</p> <p>Review of the Interdisciplinary notes from 9/20/24-1/7/25 revealed on:</p> <p>-9/20/24 at 10:14 AM, Registered Nurse Manager documented Resident #13 was seen by the Medical Director due to a pressure injury to their outer aspect of the left heel. The area measured 2.5 x 1 centimeters and was crescent shaped. There was no mention of stage or wound bed description.</p> <p>-10/30/24 at 10:18 PM, Licensed Practical Nurse #5 documented that Resident #13 had a small 2-centimeter open area noted to their left buttock. It was documented that a new order was received to place optifoam dressing daily. There was no documented description of the wound.</p> <p>-12/11/24 at 2:22 PM, Licensed Practical Nurse #4 documented that Resident #13 presented with a left heel pressure injury that measured 3.5 x 3.6 centimeters with eschar (dead tissue usually black, brown, or tan in color) and slough (non-viable yellow, tan, gray, green or brown tissue).</p> <p>-12/18/24 at 12:22 PM, Licensed Practical Nurse #4 documented that Resident #13 was seen for skin rounds and was observed to have a stage II pressure ulcer on their left lower buttocks with scant serous drainage measuring 1 x 1.5 centimeters. It was documented that the treatment was for a hydrocolloid dressing (a gel-like dressing that promotes healing) to be changed every three days and as needed.</p> <p>-12/26/24 at 2:27 PM, Registered Nurse Manager documented that Resident #13 was seen for skin checks, their left heel remained with pressure injury and the left lower buttock was resolving.</p> <p>-1/1/25 at 2:47 PM, Licensed Practical Nurse #4 documented that Resident #13 was seen for skin rounds and presented with a pressure ulcer to the lower buttocks. It was documented that Resident #13 had an unstageable pressure ulcer on the left heel that was 95% slough and 5% granulation tissue (red healing tissue).</p> <p>Review of Resident #13's Skin Evaluation form from 10/20/24-1/1/25 revealed on:</p> <p>-10/20/24 at 2:37 PM, Licensed Practical Nurse #4 documented the resident had an area to their left heel measuring 1.5 x 3 centimeters with 25% slough and serosanguineous drainage (drainage containing both blood and serum). There was no documented stage of the left heel pressure ulcer.</p> <p>-11/21/24 at 2:24 PM, Registered Nurse Manager documented the resident had a pressure injury to their left heel measuring 1.5 x 3 centimeters with 25% slough and moderate amount of serosanguinous drainage. It was documented that the stage needed further assessment.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>-12/11/24 at 12:08 PM, Licensed Practical Nurse #4 documented the resident had a left heel unstageable pressure injury measuring 3.5 x 3.6 centimeters with eschar and slough. Licensed Practical Nurse #4 documented on a second form at 12:09 PM that the left heel pressure injury measured 1.5 x 3 centimeters with 25% slough and 75% granulation tissue. The form documented that the stage needed further assessment. There were conflicting measurements documented on two different forms for the same area on the left heel.</p> <p>-12/18/24 at 12:16 PM, Licensed Practical Nurse #4 documented the resident had a stage II pressure injury to their left lower buttock measuring 4 x 3.9 centimeters with light serous drainage (clear or yellow fluid). The treatment was a hydrocolloid dressing every other day. There was no documented description of the wound. Licensed Practical Nurse #4 documented on a second form at 12:31 PM that the stage II pressure injury on the left lower buttock measured 1 x 1.5 centimeters with light serous drainage. The treatment was a hydrocolloid dressing every other day. There was no documented description of the wound. There were conflicting measurements documented on two different forms for the same area on the left lower buttock. Licensed Practical Nurse #4 documented a third form at 12:22 PM that the resident had a left heel unstageable pressure injury measuring 3.5 x 3.6 centimeters with eschar and slough.</p> <p>-12/26/24 at 2:25 PM, Registered Nurse Manager documented the resident had an unstageable pressure injury to their left heel that measured 5 x 3.9 centimeters with eschar and slough. At 2:26 PM Registered Nurse Manager documented the resident had a stage II pressure ulcer to their left lower buttock measuring 0.8 x 1 centimeters. There was no documented description of the wound and the treatment was a hydrocolloid dressing that was to be changed every other day.</p> <p>-1/1/25 at 2:57 PM, Licensed Practical Nurse #4 documented that Resident #13 had an unstageable pressure injury to their left heel that measured 6 x 4 centimeters with slough. The resident had a stage II pressure ulcer to their left lower buttocks measuring 1 x 1 centimeters. There was no documented description of the wound and the treatment was a hydrocolloid dressing to be changed every other day.</p> <p>There was no documented evidence that Resident #13's pressure ulcer to their left heel was monitored and/or observed by the skin team or Medical Director for the weeks of 10/27/24-11/2/24, 11/3/24-11/9/24 and 12/1/24- 12/7/24. There was no documented evidence that Resident #13's pressure ulcer to their left buttock was monitored and/or observed by the skin team or Medical Director from 11/1/24-12/17/24 (6 weeks missed).</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>During an observation and interview on 1/8/25 at 8:11 AM, Registered Nurse Supervisor #1 performed wound care on Resident #13 per medical provider orders. Registered Nurse Supervisor #1 stated that they were unsure how long Resident #13 had a pressure ulcer to their left heel and left buttock, but it was longer than two weeks. They stated both wounds were chronic wounds. Resident #13 was observed to have a quarter size open area to their left buttock. Registered Nurse Supervisor #1 placed an optifoam dressing to the area. Registered Nurse Supervisor #1 stated they would describe Resident #13's left buttock wound as a stage II pressure ulcer that was open, had slough to the wound bed and did not have any drainage. Resident #13 was observed to have a large open area to their left heel. Registered Nurse Supervisor #1 cleansed the area with normal saline and applied Medi honey (wound care dressing that uses medical-grade honey) and a dry clean dressing. Registered Nurse Supervisor #1 stated they would describe Resident #13's heel as an unstageable pressure ulcer that had slough, dark eschar to the wound bed, was moist with drainage and had a foul odor. They stated the area also appeared macerated (skin that has been softened due to prolonged exposure to moisture). [NAME] drainage was observed on the outside of the old dressing prior to removal and on Resident #13 fitted bed sheet. Registered Nurse Supervisor #1 did not measure any skin areas because they stated they did not bring in anything in the room to measure them with and would have to do so later.</p> <p>During an interview on 1/8/25 at 9:16 AM, Registered Nurse Manager stated the process for resident pressure ulcer monitoring was the wounds were to be observed weekly on Thursdays by themselves and/or Licensed Practical Nurse #4. They stated the Weekly Skin Care Report was the skin tracking log that was emailed to them weekly from the Administrator. The Registered Nurse Manager stated they completed the log after observation of the wound and emailed the log back to the Administrator. They stated they were notified over the summer that they were also to complete the Skin Evaluation Form in the electronic medical record, but it was hit and miss if they completed that form. Registered Nurse Manager stated it was the responsibility of Licensed Practical Nurse #4 or themselves to complete the Skin Evaluation Form. Registered Nurse Manager stated from October 2024 until December 23, 2024, Licensed Practical Nurse #4 was responsible for weekly skin monitoring and documentation because they had assumed the role of interim Director of Nursing.</p> <p>During an interview on 1/8/25 at 11:18 AM, Registered Nurse Manager stated on 9/20/24 they did document the initial skin note for Resident #13 pressure injury to their left heel. They stated they did not stage the wound because they were not comfortable staging any pressure ulcers. Registered Nurse Manager also stated that not all of their notes have descriptions of the wounds and/or staging because they needed more education on pressure ulcers. They stated upon hire and during their role of Registered Nurse Manager they had expressed their need to the Former Director of Nursing and the Administrator for more education and uncomfortableness of staging pressure ulcers. Registered Nurse Manager stated that Resident #13 should have had consistent weekly measurements, staging and description of their pressure ulcers because it was important for continual management of their wounds. After they reviewed the Skin Evaluation Form and the electronic Treatment record, Registered Nurse Manager stated they documented on the Skin Evaluation Form that Resident #13 was getting a hydrocolloid dressing to their left buttock pressure ulcer and that was inaccurate. They stated Resident #13 had an order to have optifoam to the left buttock daily and was unsure why they documented a hydrocolloid dressing every other day.</p> <p>A telephone interview was attempted on 1/8/25 at 11:43 AM, with Licensed Practical Nurse #4 and no return telephone call was received.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>During a telephone interview on 1/8/25 at 11:49 AM, the Medical Director stated Resident #13 had chronic pressure ulcers. The Medical Director stated their expectation for pressure ulcer documentation would be for staff to document Resident #13's wounds in their medical record and that the treatment information be accurate. They stated they would expect the wound documentation to include measurements with depth, description of the wound including what the surrounding tissue looked like and if there were any signs and symptoms of infection.</p> <p>During an interview on 1/8/25 at 2:48 PM, the Director of Nursing stated they expected that monitoring, and documentation of a pressure ulcer would be conducted weekly. They stated the documentation should be part of the medical record and include staging, measurements, and description of the wound. The Director of Nursing stated weekly skin monitoring was the responsibility of the Registered Nurse Manager and themselves. They stated that Licensed Practical Nurse #4 should have assessed Resident #13's pressure ulcers with a registered nurse present. The Director of Nursing stated they could not provide any further skin documentation for Resident #13 and the Weekly Skin Report was the facility's skin tracking log and was not part of a resident's medical record. The Director of Nursing reviewed Resident #13's treatment documentation on the Skin Evaluation Form and the electronic treatment records dated November 2024 and December 2024, and stated there was conflicting documentation. The Director of Nursing stated that optifoam and hydrocolloid were not a same treatment, and they were unsure what treatment Resident #13 should have had in place to their left buttock. They stated they would have followed the medical provider's order, but the documentation should be accurate. The Director of Nursing stated skin documentation should be descriptive and accurate for proper monitoring of improvement or worsening of a pressure ulcer.</p> <p>During an interview on 1/8/25 at 3:08 PM, the Administrator stated that their expectations for monitoring and documenting of pressure ulcers would be staff to follow the facility policy along with the regulatory requirements. They stated the skin team was handled by the Director of Nursing along with Registered Nurse Manager and Licensed Practical Nurse #4. The Administrator stated that they were unaware Registered Nurse Manager requested additional education for pressure ulcer staging and treatment.</p> <p>10NYCRR 415.12(c)(2)</p> |   |  |

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| <p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>                                   | <p>Post nurse staffing information every day.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43785</b></p> <p>Based on observation and interviews conducted during the Extended Recertification survey completed on 1/8/25, the facility did not ensure the nursing staff information was posted daily and contained the required information for three of five days reviewed. Specifically, the facility did not post daily the current resident census, the total number, and the actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift in a prominent place readily accessible to residents and visitors.</p> <p>The finding is:</p> <p>The policy titled Direct Care Daily Staffing Numbers dated 2/03, documented the facility will post on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents. Additionally, within two hours of the beginning of each shift, the number of licensed nurses and the number of unlicensed nursing personnel directly responsible for resident care will be posted in a prominent location (accessible to residents and visitors) and in a clear and readable format.</p> <p>Intermittent observations made on 1/2/25 at 8:40 AM, 1/3/25 at 8:25 AM, 1/6/25 at 9:46 AM and 1/6/25 at 3:05 PM, revealed there was no posting of the Report of Nursing Staff Directly Responsible for Resident Care form at the nurse's station of [NAME] Village, at the main reception area of the facility, or in any prominent place accessible to residents and visitors.</p> <p>The Skilled Nursing Assignment Sheet observed posted at the nurse's station on 1/2/25 at 8:40 AM, 1/3/25 at 8:25 AM and 1/6/25 at 9:46 AM, documented the current date, the name of the nursing supervisor, charge nurse, and certified nurse aides. The document did not include the resident census, or the total number and actual hours worked by licensed and unlicensed staff directly responsible for resident care.</p> <p>During an interview with Resident #18's family member on 1/3/25 at 2:30 PM, they stated that the actual staffing was never posted and was not visible to family members. Resident #18's family member stated that only the daily assignment sheet would be posted, and it did not accurately document what staff had showed up for work or who had called off.</p> <p>During an interview on 1/6/25 at 3:05 PM, the Staffing Coordinator #1 stated that they did not post the Report of Nursing Staff Directly Responsible for Resident Care form because they would post the daily Skilled Nursing Assignment Sheet.</p> <p>During an interview on 1/8/25 at 11:54 AM, the Staffing Coordinator #1 stated that it was the nursing supervisor's responsibility to complete the Report of Nursing Directly Responsible for Resident Care form within two hours of their shift starting and would be posted at the nurse's desk in a clear plastic stand next to the Daily Skilled Nursing Assignment Sheet.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>                                   | <p>During an interview on 1/8/25 at 1:17 PM, Licensed Practical Nurse Supervisor #1 stated that the nursing supervisors were responsible to complete the Report of Nursing Staff Directly Responsible for Resident Care form each shift and would adjust with any staff changes that occurred during their shift. Licensed Practical Nurse Supervisor #1 stated this form had not previously been posted at the nursing desk until 1/7/25. They stated that prior to 1/7/25 this form would be completed and placed in a binder that was behind the nurse's desk not accessible to residents or family. Licensed Practical Nurse Supervisor #1 stated that it would be important to have it posted to provide transparency for residents and families so that they knew how many staff members were present in the building to provide resident care. They were not aware that it should have been posted in an accessible.</p> <p>During an interview on 1/8/25 at 11:58 AM, the Director of Nursing #1 stated that it was the nursing supervisor's responsibility to complete and post the Report of Nursing Staff Directly Responsible for Resident Care form daily. They stated they would expect this form to be updated every shift with any call offs to reflect the actual staff in the building. The Director of Nursing #1 stated it was important to have this posted so that residents and family members would know how many staff members were present in the building providing care.</p> <p>10NYCRR 415.13</p> |   |  |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Provide and implement an infection prevention and control program.</p> <p>43785</p> <p>Based on observation, interview and record review conducted during an Extended Recertification Survey completed 1/8/25, the facility did not maintain an infection prevention and control program designed to provide a safe, sanitary, and a comfortable environment, to help prevent the development and transmission of communicable diseases and infections for one (Residents #13) of one resident reviewed. Specifically, enhanced barrier precautions (interventions designed to reduce transmission of multi-drug resistant organisms including gown and glove use during high contact resident care activities) were not initiated for a resident with pressure ulcers and staff did not wear appropriate personal protective equipment during pressure ulcer care.</p> <p>The finding is:</p> <p>The policy titled Enhanced Barrier Precautions dated 5/2024, documented enhanced barrier precautions are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms to residents. Enhanced barrier precautions employed targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. An example of high-contact resident care activity requiring the use of gown and gloves for enhanced barrier precautions would include wound care (any skin opening requiring a dressing). Signs were to be posted on the door or wall outside the resident room indicating the type of precautions and personal protective equipment required along with the personal protective equipment to be available outside of the resident room.</p> <p>Review of the enhanced barrier precaution signage (a sign used by the facility that was supposed to be posted outside a residents door to indicate they required enhanced barrier precautions) documented that providers and staff must wear gloves and a gown for the following high-contact resident care activities: wound care (any skin opening requiring a dressing).</p> <p>Resident #13 had diagnoses including dementia, coronary artery disease and chronic obstructive pulmonary disease. The Minimum Data Set (a resident assessment tool) dated 10/11/24 documented Resident #13 had moderate cognitive impairment, was understood, and usually understands. The assessment tool documented the resident had one stage II (partial-thickness skin loss into but not deeper than the dermis) pressure ulcer that was not present upon admission.</p> <p>The Comprehensive Care Plan dated 10/24/24 documented Resident #13 had actual altered skin integrity related to a partial thickness wound on their left heel. Interventions included to monitor skin per protocol, preventive skin interventions as per resident care guide, encourage meal/fluid consumption, skin team referral as needed, notify the medical doctor for adverse changes, and left heel bootie on at all times. The comprehensive care plan did not document that Resident #13 was on enhanced barrier precautions.</p> <p>During intermittent observations on 1/2/25 at 12:06 PM, 1/2/25 at 3:34 PM, 1/6/25 at 9:53 AM 1/6/25 at 3:16 PM and 1/8/25 at 8:11 AM, Resident #13 was in their room either in their recliner chair, wheelchair, or bed. There were no plastic precaution bins outside of their room and no enhanced barrier precaution signage on the door.</p> <p>(continued on next page)</p> |   |  |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>335816   | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing  | (X3) DATE SURVEY COMPLETED<br><br>01/08/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Canterbury Woods   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>725 Renaissance Drive<br>Williamsville, NY 14221 |  |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |   |  |
| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>During an observation and interview on 1/8/25 at 8:11 AM, Registered Nurse Supervisor #1 performed wound care to Resident #13 while the resident was in bed. Registered Nurse Supervisor #1 stated that they were unsure how long Resident #13 had a pressure ulcer to their left heel and left buttock, but it was longer than two weeks and they were chronic. The resident had an open area to their left buttock/hip area with slough (non-viable yellow, tan, gray, green or brown tissue) to the wound bed. Registered Nurse Supervisor #1 stated that they would describe the area as a stage II pressure ulcer that was open, had some slough to the wound bed but did not have any drainage. Registered Nurse Supervisor #1 cleansed the area with normal saline and applied any optifoam dressing. The resident had had a large open area to their left heel. Registered Nurse Supervisor #1 stated the area appeared to be an unstageable pressure ulcer that had slough with dark eschar (dead tissue usually black, brown, or tan in color) to the wound bed that was moist with a large amount of serosanguineous (blood mixed with yellow/clear drainage) drainage. [NAME] drainage was noted to the outside of the old dressing prior to removal and on Resident #13 fitted bedsheet. Registered Nurse Supervisor #1 did not wear a gown during this observation.</p> <p>During an interview on 1/8/24 at 10:43 AM, Registered Nurse Supervisor #1 stated that when a resident was on enhanced barrier precautions, plastic bins were placed outside of the resident's door, and a precaution sign was to be hung on their door. Registered Nurse Supervisor #1 stated the purpose of enhanced barrier precautions was to protect oneself from the possibility of spreading an infection to themselves or others. They stated that Resident #13 was not on enhanced barrier precautions, and they did not wear a gown when performing pressure ulcer care. Registered Nurse Supervisor #1 stated they were unsure if residents with a chronic pressure ulcer should be on enhanced barrier precautions and would need to look at the signage. After review of the facility's enhanced barrier precautions signage, Registered Nurse Supervisor #1 stated Resident #13 should have been on enhanced barrier precautions because the signage stated, wound care: any skin opening requiring a dressing.</p> <p>During an interview on 1/8/25 at 11:18 AM, Registered Nurse Manager stated that a resident with any skin wounds should be on enhanced barrier precautions. They stated that Resident #13 was not on enhanced barrier precautions, that they should have been, and there was no reason but it was not followed through. Registered Nurse Manager stated the purpose of enhanced barrier precautions was for the protection from the resident getting a further infection and protecting the staff as well.</p> <p>During an interview on 1/8/25 at 2:48 PM, the Director of Nursing stated they were the facility's Infection Preventionist and that enhanced barrier precautions should be utilized on residents that need wound care and when there was any high-risk contact with the area. They stated they were responsible for implementing and ensuring residents that needed them, had enhanced barrier precautions in place. The Director of Nursing stated they were unsure if Resident #13 had enhanced barrier precautions implemented and assumed they did because Resident #13 had chronic pressure ulcers for a while. The Director of Nursing stated the purpose of enhanced barrier precautions was to protect to the resident from obtaining an infection in their wound and protect other residents and staff.</p> <p>NYCRR 415.19(a)(2)</p> |   |  |