

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335834	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/22/2024
NAME OF PROVIDER OR SUPPLIER Highpointe on Michigan Health Care Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 1031 Michigan Ave Buffalo, NY 14203	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>39086</p> <p>Based on interview and record review conducted during an Abbreviated survey (Complaint #NY00342510) completed on 5/22/24, the facility did not ensure that all alleged violations including abuse, neglect, exploitation, or mistreatment were reported immediately, but not later than two hours after the allegation is made. If the events that caused the allegation do not involve abuse or result in seriously bodily injury not later than 24 hours to the facility's Administrator and to other officials (including to the State Survey Agency) for one (Resident #1) of three residents reviewed. Specifically, facility staff did not report an allegation of resident neglect to the Director of Nursing or the Administrator which resulted not reporting to the State Survey Agency as required.</p> <p>The finding is:</p> <p>The policy and procedure titled Identification and Reporting of Abuse, Neglect, Exploitation, or Mistreatment of a Skilled Nursing Facility Resident, as per Public Health Law Section 2803-d dated 8/30/99 documented any nursing home employee who becomes aware of abuse, mistreatment, neglect shall immediately report their concerns to the Nursing Home Administrator or designee and to other officials in accordance with State law.</p> <p>Resident #1 had diagnoses which included congestive heart failure, orthostatic hypotension (low blood pressure), and history myocardial infarction (heart attach). The Minimum Data Set (a resident assessment tool) dated 5/5/24 documented the resident was cognitively intact.</p> <p>The comprehensive care plan dated 2/9/24 documented Resident #1's medical conditions included congestive heart failure. Interventions included vital signs, weights, medications, treatments, labs, and diagnostic tests per doctor/nurse practitioner orders.</p> <p>Review of the investigation file revealed a form titled An investigation of an Incident dated 5/13/24. A statement signed by Certified Nurse Aide #1 on 5/17/24 documented, On Monday (5/13/24) aide notified nurse twice before they told them that the resident was in distress, when they told the nurse the resident could not breathe the nurse on duty said; 'take them this dinner and I can't leave dining room during meals'. They told the nurse 'No, you need to go see her' nurse gave them back talk so they took the food and went to resident's room and seen that the resident was changing colors. They yelled 8 times for help and grabbed the cart to take their vitals and their oxygen sats were 38% (percent) and they screamed more, nurse eventually came, they left the room and did not return.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 5/21/24 at 12:24 PM, Certified Nurse Aide #3 stated that Certified Nurse Aide #1 asked them to go get Licensed Practical Nurse #1 for Resident #1. When I spoke to Licensed Practical Nurse #1, they stated they were unable to leave the dining room because residents were eating. They went back to Resident #1's room to let Certified Nurse Aide #1 know what Licensed Practical Nurse #1 had said. At that time Certified Nurse Aide #3 stated Certified Nurse Aide #1 had the pulse oximeter (electronic device that measures the saturation of oxygen carried in your red blood cells) on Resident #1 and it was low. Certified Nurse Aide #3 stated they went back to the dining room to notify Licensed Practical Nurse #1 that the resident was in respiratory distress. Licensed Practical Nurse #1 then responded to Resident #1's room.</p> <p>During a telephone interview on 5/21/24 at 12:46 PM, Certified Nurse Aide #2 stated they asked Certified Nurse Aide #1 to get Licensed Practical Nurse #1 from the dining room because Resident #1 was requesting them by name and was having trouble breathing. Certified Nurse Aide #1 returned to Resident #1's and told them Licensed Practical Nurse #1 stated they couldn't leave the dining room. Certified Nurse Aide #2 stated they believe Licensed Practical Nurse #1 should have responded quicker and believed Licensed Practical Nurse #1 was neglectful. Certified Nurse Aide #2 stated they informed Nursing Supervisor Registered Nurse #1 that Licensed Practical Nurse #1 did not respond immediately but had not reported negligence. Certified Nurse Aide #2 stated they expected Certified Nurse Aide #1 to have reported the allegation of neglect to the Nursing Supervisor.</p> <p>During a telephone interview on 5/21/24 at 1:29 PM, Certified Nurse Aide #1 stated they believed Licensed Practical Nurse #1 had not responded fast enough to Resident #1's medical needs. On 5/21/24 at 3:40 PM, Certified Nurse Aide #1 stated they had not reported the allegation of neglect until 5/16/24 and had reported it to Licensed Practical Nurse Unit Manager #2.</p> <p>During a telephone interview on 5/21/24 at 2:31 PM, Licensed Practical Nurse #1 stated Certified Nurse Aide #1 informed them Resident #1 was having some breathing difficulty and asked if the resident was short of breath or couldn't breathe. Certified Nurse Aide #1 didn't look anxious or act like it was an emergent situation. A few minutes later Certified Nurse Aide #3 approached them in the dining room and stated Resident #1 was having trouble breathing. Licensed Practical Nurse #1 stated they transported a resident out of the dining room and responded to Resident #1's room. At that time, they observed Resident #1 to be in respiratory distress.</p> <p>During an interview on 5/21/24 at 4:04 PM, Licensed Practical Nurse Unit Manager #2 stated that Certified Nurse Aide #1 reported to them on 5/16/24 they believed that Licensed Practical Nurse #1 was neglectful on 5/13/24 because they had not responded fast enough to Resident #1's requests for medical assistance. Licensed Practical Nurse Unit Manager #2 stated they had not immediately reported the allegation of neglect to the Interim Director of Nursing (Registered Nurse #2). They had requested the camera footage from the Security Manager and wanted to verify the actions of Licensed Practical Nurse #1 before the reported the allegation. Licensed Practical Nurse Unit Manager #2 stated the reported the allegation the next day (5/17/24). Licensed Practical Nurse Unit Manager #2 stated, looking back they should have informed the Interim Director of Nursing immediately.</p> <p>During an interview on 5/22/24 at 2:10 PM, the Interim Director of Nursing (Registered Nurse #2) stated there was a delay in reporting allegation of neglect. Certified Nurse Aide #1 should have reported the allegation on immediately 5/13/24.</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>During an interview on 5/22/24 at 3:22 PM, the Assistant Administrator stated they would have expected Certified Nurse Aide #1 to have reported the allegation of neglect immediately on 5/13/24 to the Nursing Supervisor. The allegation should have been reported accordingly to the New York State Department of Health.</p> <p>10 NYCRR 415.4(b)(2)</p>		