STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335834	A. Building B. Wing	09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highpointe on Michigan Health Care Facility	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 39086 Based on observation, interview and record review conducted during an Extended survey completed on 9/16/24, the facility did not ensure the resident's representative was notified immediately of a change of condition for one (Resident #267) of two residents reviewed for notification of change. Specifically, Resident #267's representative was not notified of the resident's tracheostomy (opening into the trachea) tube being removed. The finding is: Resident #267 had diagnoses that included traumatic subdural hemorrhage (bleeding in the brain), acute kidney failure, and depression. The Minimum Data Set (a resident assessment tool) dated 8/11/24 documented Resident #267 was moderately cognitively impaired, usually understood and sometimes understands. The comprehensive care plan dated 5/11/24 documented Resident #267 had a tracheostomy related to impaired breathing mechanics. The comprehensive care plan documented the resident had a knowledge deficit related to their medical condition and/or plan of care. Review of Resident #267's Admission Record, with a printout date of 9/9/24, documented Resident #267s family member was their Health Care Proxy (a person who can legally make medical decisions on behalf of another person if they are unable to communicate their wishes). Review of Family Health Care Decision Act Consent Form dated 5/16/24, documented Resident #267 was determined to lack capacity to make medical decisions. This form documented Resident #267s family member was activated as their Health Care Proxy by the Medical Director. A nursing progress note for Resident #267 dated 8/28/24 at 2:55 PM, Registered Nurse #10 documented trach discontinued, tolerate well spo2 (oxygen saturation in the blood) 98% on room air. resident had appointment today for CT (computed tomography) scan and no issues or concerns noted return from appointment. There was no documentation that the resident's Health Care Proxy was updated. Further review of nursing progress notes dated 8/29/24-9/6/24 revealed no documentation that Resident #267's Health Care Proxy was updated on the removal of the tracheostomy tube. (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: 335834	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/16/2024
NAME OF PROVIDER OR SUPPLIER Highpointe on Michigan Health Care Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 1031 Michigan Ave Buffalo, NY 14203	

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 9/3/24 at 10:54 AM, Resident #267 was sitting in the common area, there was no tracheostomy tube present. During a telephone interview on 9/3/24 at 11:56 AM, Resident #267's Health Care Proxy stated they had been asking staff about when they would be attempting to remove Resident #267s tracheostomy tube and was upset because facility staff have not contacted them regarding the matter. During an interview on 9/6/24 at 10:25 AM, Registered Nurse #10 stated they believed Resident #267 was their own responsible party, but their family member was their Health Care Proxy. Registered Nurse #10 stated they believed Resident #267s Health Care Proxy was updated on the removal of their tracheostomy. Registered Nurse #10 stated it was the charge nurse's responsibility to update responsible parties on any changes in condition. Registered Nurse #10 stated there were three different Registered Nurses who worked on the unit as charge nurses, and they could not remember who was in charge the day the resident's tracheostomy tube was removed. During an interview on 9/6/24 at 10:27 AM, Registered Nurse #11, who was working as charge nurse on this date, reviewed the progress notes for Resident #267 and stated that based on the progress notes there was not any documentation that Resident #267s Health Care Proxy was updated on the removal of their tracheostomy tube. Registered Nurse #11 stated Resident #267s family member was their Health Care Proxy, and they should have been updated on the removal of the tracheostomy on the day it was removed. During an interview on 9/9/24 at 3:42 PM, the Director of Nursing stated Resident #267 lacked capacity and they expected staff to update their Health Care Proxy on any change in condition, and the removal of a tracheostomy tube was a change in condition. During an interview on 9/10/24 at 1:07 PM, the Social Worker stated Resident #267 had a Health Care Activation Form in their chart that documented Resident #267 lacked capacity and their family member was their Health Care Proxy. The Social Worker stated Resident #267s Health Care Proxy should be updated on any change in condition, and the removal of a tracheostomy tube was a change in condition. During an interview on 9/11/24 at 12:39 PM, the Director of Nursing and Administrator both stated there was not a policy for notification of change in the facility. 10 NYCRR 415.3 (f)(2)(b)

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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 0600

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Many

Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 39086

Based on observations, interviews and record reviews conducted during a complaint investigation (#NY00330798 and #NY00325133) during an extended standard re-certification survey from 9/3/2024 to 9/16/2024, the facility failed to protect the residents' right to be free from sexual abuse by a resident for three (Residents #33, #50, #208) of ten residents reviewed. Specifically, the facility failed to implement safeguards that resulted in repeated instances of sexual abuse with residents that had impaired cognitive status and lacked the ability to consent. This resulted in and had the likelihood for psychosocial harm that is Immediate Jeopardy and Substandard Quality of Care for Residents #33, #50, #208 with the likelihood to affect all residents (census 265) in the facility.

The findings are:

The policy and procedure titled Identification and Reporting of Abuse, Neglect, Exploitation, or Mistreatment of a Skilled Nursing Facility Resident revised on 9/12/2024 documented any resident abuse will not be tolerated. When a suspicion of abuse, mistreatment, or neglect becomes known, necessary steps will be taken to protect the residents involved and any other vulnerable residents in the facility.

Resident #226 had diagnoses of stroke (loss of blood flow to part of the brain or bleeding in the brain) and type 2 diabetes mellitus. The Minimum Data Set (a resident assessment tool) dated 9/24/2023 documented Resident #226 was cognitively intact.

The comprehensive care plan dated 7/21/2023 documented staff should check Resident #226's whereabouts on rounds, change of shift, and after meals due to wandering behaviors.

Resident #208 had diagnoses of Alzheimer's disease and depression. The Minimum Data Set, dated dated dated [DATE] documented Resident #208 was severely cognitively impaired.

The comprehensive care plan dated 4/5/2024 documented Resident #208 had impaired cognitive function, was non-verbal and dependent on staff for meeting emotional, intellectual, physical, and social needs. Review of the care plan revealed there were no revisions documented since August of 2022.

A nursing progress note dated 9/3/2023 written by Licensed Practical Nurse #3 documented Resident #226 was in the common area rubbing the leg of Resident #208.

During a telephone interview on 9/9/2024 at 8:18 AM, Licensed Practical Nurse #3 stated they heard an aide say, uh, uh, don't do that, looked over and Resident #226 was rubbing Resident #208's lower leg. They reported it to Registered Nurse Unit Manager #7 and was told to keep Resident #226 and Resident #208 apart. Licensed Practical Nurse #3 stated they were not instructed to put Resident #226 on 1:1 supervision or to put Resident #226 on 15-minute visual checks.

A nursing progress note dated 9/24/2023 written by Licensed Practical Nurse #1 documented Resident #226 was observed crawling under a table by Resident #208's knees. Resident #208 was moved to another area away from Resident #226.

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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 09/16/2024
NAME OF PROVIDER OR SUPPLIER: Highpointe on Michigan Health Care Facility		STREET ADDRESS, CITY, STATE, ZIP CODE: 1031 Michigan Ave Buffalo, NY 14203	

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During a telephone interview on 9/6/2024 at 9:01 AM, Licensed Practical Nurse #1 stated they had witnessed Resident #226 on 9/24/2023 trying to crawl under the table and was by Resident #208's knees. Licensed Practical Nurse #1 stated they had asked Resident #226 what they were doing and documented the behavior in the progress notes. They stated they had reported Resident #226's behavior to the former Unit Manager, Registered Nurse #7. Review of an investigation and witness statements dated 9/29/2023 documented Licensed Practical Nurse #16 was answering a call light in Resident #208's room when they found Resident #226 in Resident #208's room standing next to the bed with their arms at their side Resident #208's breasts were exposed, and Resident #226 was staring at Resident #208. Resident #226 had denied touching Resident #208. When asked what they were doing, Resident #226 responded nothing, nothing and walked out of the room. It was documented that Resident #208 was asked what happened but did not respond. Resident #81 (roommate of Resident #208) stated that someone had come into the room, but the curtain was pulled so they could not see what had happened and did not hear any noises from Resident #208's side of the room. Review of security video footage dated 9/29/2023 revealed that at 3:49 PM Resident #226 went into Resident #208's room. At 4:04 PM, the call light began to blink outside Resident #208's room. At 4:12 PM, Licensed Practical Nurse #16 entered Resident #208's room and Resident #226 was then seen leaving the room. Review of the 24-Hour Nursing Reports dated 9/29/2023, 9/30/2023, 10/1/2023, 10/2/2023, and 10/3/2023 documented staff were to watch Resident #226 to keep them away from Resident #208. There was no documented evidence indicating specific instructions for watching Resident #226. During a telephone interview on 9/6/2024 at 9:01 AM, Licensed Practical Nurse #1 stated they regularly worked on the unit and saw Resident #208 after the incident on 9/29/2023. They stated Resident #208 had tears in their eyes and would open their mouth and cry out, so Licensed Practical Nurse #1 stated they knew there was something wrong. Licensed Practical Nurse #1 stated Resident #226 did not have a room change right away and they were not put on 1:1 supervision. During a telephone interview on 9/9/2024 at 10:18 AM, Registered Nurse Supervisor #1 stated they had notified Assistant Director of Nursing #1 of the 9/29/2023 incident. Registered Nurse Supervisor #1 stated the Assistant Director of Nursing did not instruct them to put Resident #226 on a 1:1 supervision or to initiate 15-minute checks. During an interview on 9/9/2024 at 3:06 PM, Social Worker #1 stated Resident #226 was moved to the dementia unit four days after the 9/29/2023 incident with Resident #208 because there was not a long term care room available. Social Worker #1 stated they spoke with Resident #226 after the incident and educated them to keep their hands to themselves and not to make inappropriate comments to females. There was no documented evidence of a medically necessary reason to move Resident #226 to the dementia unit. (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 0600

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Many

During an interview on 9/10/2024 at 4:55 PM, Assistant Director of Nursing #1 stated Resident #226 was moved to the dementia because there was not another room available. Assistant Director of Nursing #1 stated no one witnessed Resident #226 touching Resident #208 so Resident #226 was not put on 1:1 supervision or 15-minute visual checks.

During a telephone interview on 9/10/2024 at 6:23 PM, Licensed Practical Nurse #17 stated after the 9/29/2023 incident they were told by Registered Nurse Unit Manager #7 to keep Resident #226 away from Resident #208. They were supposed to keep Resident #226 in sight while they were awake but there was no official documentation, and the resident was not on 1:1 supervision.

During an interview on 9/11/2024 at 8:07 AM, the Director of Nursing stated Resident #226 was moved to the dementia unit because there was not another room available, and they increased monitoring of Resident #226 whereabouts. The Director of Nursing stated the nurses should have documented Resident #226's whereabouts but there was not a formal 15-minute check started or 1:1 supervision.

The facility daily census reports dated 9/29/2023 through 10/3/2023 revealed available beds within the facility:

-Rehabilitation Unit - 3 empty beds available on 9/29/2023 and 9/30/2023

5 empty beds available on 10/1/2023 and 10/2/2023.

3 empty beds available on 10/3/2023.

-Long-Term Care Unit had one bed available on 9/29/2023 and 9/30/2023, 2 beds available on 10/1/2023, 10/2/2023 and 10/3/2023.

In addition, the facility had a closed (POD, unit) leaving the following beds empty 480 - 490 9/29/2023 through 10/3/2023.

During an interview on 9/11/2024 at 10:11 AM, the current Administrator stated they did not know why Resident #226 was not moved sooner to another room after the incident on 9/29/2023. They stated Resident #226 should have been placed on 1:1 supervision at that time to ensure they did not go into Resident #208's room or anyone else's room.

During an interview on 9/12/2024 at 8:55 AM, Medical Doctor #1 stated the incident on 9/29/2023 was highly suspicious and could have been abuse. Resident #226 should have been put on 1:1 supervision on 9/29/2023.

2. Resident #226 was moved to the dementia unit on 10/3/2023.

Resident #50 had diagnoses of dementia, arthritis, and seizure disorder. The Minimum Data Set, dated dated dated [DATE] documented Resident #50 was severely cognitively impaired.

The comprehensive care plan dated 9/10/2019 and in place in 11/2023 documented Resident #50 was cognitively impaired, preferred to be in bed after dinner, and staff were to check at least every 2-3 hours for incontinence.

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Resident #33 had diagnoses of dementia and anxiety disorder. The Minimum Data Set, dated dated dated [DATE] documented Resident #33 was severely cognitively impaired. The comprehensive care plan dated 3/15/2017 and in place 11/2023 documented Resident #33 had dementia. The 24-Hour Nursing Reports dated 11/10/2023, 11/11/2023, and 11/12/2023 documented Resident #226 was found in Residents #50 and #33's shared room. Review of Resident #226 nursing progress notes revealed the following: 11/9/2023 at 10:57 PM, Registered Nurse Nursing Supervisor #1 documented resident was observed by staff standing in the common area with their genitals out of their pants. Resident #50 and another resident (#33) were in the common area. Resident #226 denied that they had their genitalia exposed. 11/10/2023 at 8:22 PM, Licensed Practical Nurse #5 documented resident was found by staff in Resident #50's room. 11/11/2023 at 9:22 PM, Licensed Practical Nurse #6 documented resident was found in Resident 50's room again and this was the third instance. 12/11/2023 Licensed Practical Nurse #18 documented resident was in Resident 50's room. The Nursing Supervisor and the Nurse Practitioner were notified. Review of security video footage dated 11/10/2023 revealed Resident #226 entered Resident 50's room at 7:19 PM and was spotted by Certified Nurse Aide #3 at 7:23 PM and was removed from the room. Review of security video footage dated 11/11/2023 at 7:28 PM revealed Resident #50 was brought by a staff member to their room. At 7:53 PM, Resident #226 entered Resident #50's room and left the room at 8:19 PM. At 8:39 PM, Resident #226 re-entered Resident 50's room. At 8:56 PM, Certified Nurse Aide #3 ran into Resident #50's room and left. At 9:16 PM, Certified Nurse Aide #3 re-entered Resident 50's room. At 9:18 PM, an unidentified nurse entered Resident 50's room. At 9:20 PM, Certified Nurse Aide #3 and Resident #226 left Resident 50's room. During an interview on 9/11/2024 at 1:27 PM, Certified Nurse Aide #3 stated on 11/11/2023 they saw Resident #50 had thrown up on themselves and Certified Nurse Aide #3 ran to get the nurse. They stated they were so focused on Resident #50 throwing up that they did not see Resident #226 in the room the first time. Certified Nurse Aide #3 stated they removed Resident #226 from Resident #50's room after discovering the resident in that room. They stated Resident #50 was dressed in a hospital gown but was not exposed in any way. Review of security video footage dated 12/11/2023 revealed Resident #226 entered Resident #50's room at 7:16 PM. At 7:22 PM, Certified Nurse Aide #1 walked by Resident 50's room, looked in, walked away, and returned to the room and entered. At 7:23 PM, Resident #226 was seen leaving Resident #50's room. Review of the 24-Hour Nursing Reports for December 2023 revealed there was no documentation regarding Resident #226 being in Resident #50's room. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of an investigation along with Licensed Practical Nurse #13 and Certified Nurse Aide #4 witness statements dated 12/29/2023 documented Resident #226 was found kneeling at the bedside of Resident #50. Resident #226 was fondling their own genitals and had their other hand in the incontinence brief of Resident #50. Review of security video footage dated 12/29/2023 revealed at 9:47 PM, Resident #226 walked around the corner with their incontinence brief around their ankles. At 9:48 PM, Resident #226 walked into Resident #50's room wearing only a hospital gown. From 9:48 PM to 11:23 PM, Resident #226's walker and brief were observed on the floor outside of Resident 50's room. At 11:23 PM, Certified Nurse Aide #4 entered Resident 50's room and hurriedly left the room. At 11:24 PM Licensed Practical Nurse #13 entered Resident #50's room and Resident #226 was removed from the room. During a telephone interview on 9/6/2024 at 8:18 AM, Certified Nurse Aide #4 stated they witnessed Resident #226 in Resident 50's room fondling themselves and their other hand was inside Resident #50's brief. Certified Nurse Aide #4 stated they ran to get the nurse. During a telephone interview on 9/9/2024 at 4:57 PM, Certified Nurse Aide #1 stated approximately two weeks before the 12/29/2023 incident they had found Resident #226 in Resident #50's room. Resident #226 had their pants and their incontinence brief down. Certified Nurse Aide #3 stated they got the nurse and Resident #226 was removed from the room. During a telephone interview on 9/16/2024 at 2:04 PM, Licensed Practical Nurse #13 stated they found Resident #226 next to Resident #50's bed masturbating and their other hand was inside Resident #50's incontinence brief. During an interview on 9/10/2024 at 9:26 AM, Licensed Practical Nurse #18 stated the aides had reported Resident #226 was found in Resident #50's room on 12/11/2023. Licensed Practical Nurse #18 stated they documented it in the progress notes and had reported it to the nursing supervisor and a nurse practitioner but, did not recall which supervisor or which nurse. They stated they were asked by Assistant Director of Nursing #1 to write a witness statement and to initiate an investigation. During an interview on 9/10/2024 at 10:04 AM, Assistant Director of Nursing #2 stated there were no other investigations for any incidents between Resident #226 and Resident #50 and #33. During an interview on 9/10/2024 at 12:07 PM, Nurse Practitioner #1 stated they were never notified of any allegations of abuse between Resident #226 and Resident #50. Nurse Practitioner #1 stated they did not think Resident #226 was appropriate for a dementia unit. During an interview on 9/10/2024 at 12:31 PM, Nurse Practitioner #2 stated they were never notified about Resident #226 exposing themselves or any type of sexual abuse between residents. During an interview on 9/11/2024 at 1:00 PM, the Director of Nursing stated that what happened to Resident #50 was abuse. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 9/11/2024 at 2:43 PM, the [NAME] President of Long-Term Care (former Administrator) stated it was not an effective plan to move Resident #226 to another unit. The [NAME] President stated they were not aware Resident #226 was entering other resident rooms and if they had been aware, they would have initiated 1:1 supervision earlier to prevent any events and protect all vulnerable residents. The [NAME] President of Long-Term Care stated this situation should have risen to the administrative level for further review. During an interview on 9/12/2024 at 10:07 AM, the Director of Nursing stated they should have been notified by staff of Resident #226's behavior so that additional interventions could have been put into place to prevent sexual abuse. I believe we were not as prudent as we should have been to maintain the safety of all our residents. During an interview on 9/12/2024 at 8:55 AM, Medical Doctor #1 stated they were not aware of any incidents between Resident #226, Resident #50, and Resident #33 that occurred in November 2023. They would have expected staff to report any incidents of possible sexual abuse to themselves and the Director of Nursing. After the incident on 12/29/2023 they called the Special Victims Unit because this was sexual abuse. Medical Doctor #1 stated they assessed both Resident #50 and #226. Resident #226 was assessed for insight, judgement, and determined that Resident #226 was alert and oriented. Medical Doctor #1 stated, had Resident #226 been placed on 1:1 supervision on 9/29/2023, then any other incidents of sexual abuse could have been prevented. They stated there was room for improvement when it comes to sexual abuse education for staff. Based on observations, staff interviews, and record review the facility removed the immediacy as of 9/13/2024 at 11:15 PM: 12/29/2023 the facility placed Resident #226 on 1:1 supervision and remains on 1:1. 9/11/2024 the facility conducted a Quality Assurance and Performance Improvement meeting; completed a root cause analysis; conducted record reviews and resident interviews and began staff education with a specific focus on sexual abuse, recognition, prevention, and reporting. 9/12/2024 the facility conducted a second Quality Assurance and Performance Improvement meeting, reviewed the facility abuse policies, and education continued for all staff with a focus on sexual abuse. The Director of Nursing, Assistant Directors of Nursing and Registered Nurse Supervisors were educated on conducting abuse investigations. As of 9/13/2024 at 11:15 PM 86 % (percent) of all staff were educated. NYCRR 10 415.4(b)(1)(ii)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39086 Based on interview and record review conducted during a Complaint investigation (#NY00330798 and #NY00325133) during an extended standard survey on 9/16/24, the facility did not ensure that all alleged violations of abuse were thoroughly investigated for four (Resident #33, Resident #50, Resident #208, Resident #226) of ten residents reviewed. Specifically, facility investigations lacked interviews with potential witnesses and other potential victims (Resident #50, Resident #208, and Resident #226). Also, there was lack of an investigation when Resident #226 exposed their genitals in front of Resident #33 and Resident #50 in a common area. The findings are: The policy and procedure titled Identification and Reporting of Abuse, Neglect, Exploitations, of Mistreatment of a Skilled Nursing Facility Resident revised on 9/12/24, it documented that the facility begins an investigation immediately upon discovery of an incident, gather statements from the resident who is the suspected victim of abuse, gather statements from the resident's roommates, gather statements from staff including staff who work with the resident over the prior day, weeks, or months, and other witnesses who may have firsthand knowledge of the events. Resident #226 had diagnoses of stroke (loss of blood flow to part of the brain or bleeding in the brain) and type 2 diabetes mellitus. The Minimum Data Set (a resident assessment tool) dated 9/242023 documented Resident #226 was cognitively intact. The comprehensive care plan dated 7/21/2023 documented staff should check Resident #226's whereabouts on rounds, change of shift, and after meals due to wandering behaviors. Resident #208 had diagnoses of Alzheimer's disease and depression. The Minimum Data Set, dated dated dated [DATE] documented Resident #208 was severely cognitively impaired. The comprehensive care plan dated 4/5/2024 documented Resident #208 had impaired cognitive function, was non-verbal and dependent on staff for meeting emotional, intellectual, physical, social needs. Review of the care plan revealed there were no revisions documented since August of 2022. Review of an investigation dated 9/29/23 at 4:00 PM, completed by Registered Nurse Nursing Supervisor #1, and witness statements dated 9/29/2023 documented that Resident #226 was found by Licensed Practical Nurse #16 in Resident #208's room standing next to #208's bed with their arms at their side when answering a call light. Resident #208's breasts were exposed, and Resident #226 was staring at Resident #208. Resident #226 had denied touching Resident #208. When asked what they were doing, Resident #226 responded nothing, nothing and walked out of the room. It was documented that Resident #208 was asked what happened but did not respond. Resident #81 (roommate) stated that someone had come into the room, but the curtain was pulled so they could not see what had happened and did not hear any noises from Resident #208's side of the room. There were no additional potential witness statements from residents and staff members obtained. There were no interviews conducted with potential other victims. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Highpointe on Michigan Health Care Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 1031 Michigan Ave Buffalo, NY 14203	

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a telephone interview on 9/9/24 at 10:18 AM, Registered Nurse Nursing Supervisor #1 stated they did not recall who the Assistant Director of Nursing was at the time but would have done what they told them them to do. During an interview on 9/9/24 at 10:55 AM, current Registered Nurse Unit Manager #4 stated that staff should get witness statements from all the staff that were working the day of the incident. During an interview on 9/11/24 at 8:07 AM, the Director of Nursing stated that they would expect written and signed witness statements from all staff who were working on that shift when an incident occurred. During an interview on 9/11/24 at 10:11 AM, the current Administrator stated that there should be witness statements from staff that worked the shifts when incidents occurred. During an interview on 9/12/24 at 8:55 AM, Medical Doctor #1 stated that an investigation should be started with witness statements from other residents, staff who worked that day, and anyone else who may have been on the unit at that time. Medical Doctor #1 stated the incident on 9/29/23 was highly suspicious and could have been abuse. 2. Resident #50 had diagnoses of dementia, arthritis, and seizure disorder. The Minimum Data Set, dated dated dated [DATE] documented Resident #50 was severely cognitively impaired. The comprehensive care plan dated 9/10/2019 and in place in 11/2023 documented Resident #50 was cognitively impaired, preferred to be in bed after dinner, and staff were to check at least every 2-3 hours for incontinence. Resident #33 had diagnoses of dementia and anxiety disorder. The Minimum Data Set, dated dated dated [DATE] documented Resident #33 was severely cognitively impaired. The comprehensive care plan dated 3/15/2017 and in place 11/2023 documented that Resident #33 had dementia. The 24-Hour Nursing Reports dated 11/10/2023, 11/11/2023, and 11/12/2023 documented that Resident #226 was found in Resident's #50 and #33's room. Review of Resident #226 nursing progress notes revealed the following: 11/9/2023 at 10:57 PM, Registered Nurse Nursing Supervisor #1 documented resident was observed by staff standing in the common area with their genitals out of their pants. Resident #50 and another resident (#33) were in the common area. Resident #226 denied that they had their genitalia. 11/10/2023 at 8:22 PM, Licensed Practical Nurse #5 documented resident was found by staff in Resident #50's room. 11/11/2023 at 9:22 PM Licensed Practical Nurse #6 documented resident was found in Resident 50's room again and this was the third instance. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	12/11/2023 at Licensed Practical Nurse #18 documented resident was in Resident 50's room. The Nursing Supervisor and the Nurse Practitioner were notified. Review of the 24-Hour Nursing Reports for December 2023 revealed no there was documentation regarding #226 being in Resident #50's room. During an interview on 9/10/2024 at 9:26 AM, Licensed Practical Nurse #18 stated the aides had reported that Resident #226 was found in Resident #50's room on 12/11/2023. Licensed Practical Nurse #18 stated they documented it in progress notes and had reported it to the nursing supervisor and a nurse practitioner. Licensed Practical Nurse #18 stated they did not recall which supervisor or which the nurse. They stated they were asked by Assistant Director of Nursing #1 to write a witness statement and to initiate an investigation. During an interview on 9/10/24 at 10:04 AM, Assistant Director of Nursing #2 stated there were no other investigations for any incidents between Resident #226 and Resident #50 and #33. During an interview on 9/10/2024 at 12:07 PM, Nurse Practitioner #1 stated they were never notified of any allegations of abuse between Resident #226 and Resident #50. During an interview on 9/10/2024 at 12:31 PM, Nurse Practitioner #2 stated they were never notified about Resident #226 exposing themselves or any type of sexual abuse between residents. During an interview on 9/10/24 at 5:57 PM with Registered Nurse Nursing Supervisor #5 stated that they don't recall being notified about Resident #226 genitals being exposed in the common area. They stated they would expect staff to report this to them right away. Registered Nurse Nursing Supervisor #5 stated they would have notified the Director of Nursing, family, and the physician right away and initiated an investigation. They stated they would have gotten witness statements from all the staff that were working on that shift. During an interview on 9/11/2024 at 2:43 PM, the [NAME] President of Long-Term Care (former Administrator) stated they were not aware Resident #226 was entering other resident rooms. The [NAME] President of Long-Term Care stated this situation should have risen to the administrative level for further review. During an interview on 9/12/2024 at 10:07 AM, the Director of Nursing stated they should have been notified by staff of Resident #226's behavior so that additional interventions could have been put into place to prevent sexual abuse. I believe we were not as prudent as we should have been to maintain the safety of all our residents. During an interview on 9/11/24 at 8:07 AM, the Director of Nursing stated that they would expect written and signed witness statements from all staff who were working on that shift when an incident occurred. During an interview on 9/11/24 at 10:11 AM, the current Administrator stated that there should be witness statements from staff that worked the shifts when incidents occurred. They stated they would expect the nursing supervisors to put things into place to prevent any more incidents. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 9/12/24 at 8:55 AM, Medical Doctor #1 stated they were not aware of any incidents between Resident #226, Resident #50, and Resident #33 that occurred in November 2023. They would expect any instances of abuse to be reported immediately to the nurses and proceed up the chain of command. They stated that an investigation should be started with witness statements from other residents, staff who worked that day, and anyone else who may have been on the unit at that time. 10 NYCRR 415.4(b)(3)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39086 Based on record review and interview conducted during an extended standard survey completed on 9/16/24, the facility did not ensure that the resident or resident representative was notified in writing, of the transfer and the reason for hospitalization for three (Resident #91, #222 and #250) of three residents reviewed. Specifically, Resident #91 was sent to the hospital on 8/30/24 and Resident #222 had multiple hospitalization s (4/14/24, 5/16/24, 5/23/24 and 8/13/24) with no written notification to the resident or their representative of the Notice of Transfer or Discharge. Resident #250 was transferred to the hospital on 3/20/24 with no written notification to the resident or their representative of the Notice of Transfer or Discharge and facility did not send a copy of the Transfer or Discharge notice to the Office of the State Long Term Care Ombudsman. The findings are: The facility policy titled Transfer, Resident Discharge revised 8/2023 documented, it was the policy of this facility that each resident has the right to remain in the facility and not be transferred or discharged unless a transfer or discharge is necessary for the resident's welfare and resident's needs, including urgent medical needs, that cannot be met in the facility. The transfer/discharge notice will be issued with a discharge date at least thirty days before the resident is transferred or discharged in a language and manner that the resident can understand. If the transfer/discharge is necessary due to an emergency, the notice will be issued as soon as practicable when an immediate transfer or discharge is required by the resident's urgent medical condition. The Social Worker will review and explain the notice to the resident and their representative and discuss the resident's right to appeal the discharge. At a minimum, the notice will include: the reason for transfer/discharge, the effective date of the transfer/discharge, location to which the resident will be transferred. The Social Worker or designee will complete the form, Notice of Resident Transfer or Discharge. The facility form titled Notice of Transfer or discharge date d 12/12/18 revealed fillable areas for resident's name, resident representative, date of notice, location to which resident is to be transferred or discharged and reasons for proposed transfer or discharge under 10 NYCRR 415.3(h) including but not limited to, an immediate transfer or discharge is required by the resident's urgent medical needs. 1. Resident #91 had diagnoses including displaced intertrochanteric fracture of left femur (break of long bone in the thigh), diabetes mellitus, and chronic kidney disease. The Minimum Data Set (a resident assessment tool) dated 7/22/24 revealed the resident was cognitively intact. Review of progress notes dated 8/1/24 - 9/11/24 revealed Resident #91 was transferred to the hospital on 8/30/24 and returned from the hospital on 9/6/24. Review of the resident's entire medical record dated 8/1/24 - 9/11/24 revealed there was no evidence that Notice of Transfer or Discharge form was completed and provided to the resident or resident's representative. (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 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	2. Resident #222 had diagnoses including chronic respiratory failure with hypoxia (low oxygen level), epilepsy (seizure disorder), and spastic quadriplegic cerebral palsy (stiff, jerky movements of all extremities due to damage to the brain). The Minimum Data Set, dated dated dated [DATE], 5/16/24, and 8/13/24 revealed the resident was severely cognitively impaired. Resident #222 progress notes dated 4/1/24 - 9/9/24 documented the following: -4/14/24 transferred to the hospital and readmitted on [DATE]. -5/16/24 transferred to the hospital and readmitted on [DATE]. -5/23/24 transferred to the hospital and readmitted on [DATE]. -8/13/24 transferred to the hospital and readmitted on [DATE]. Review of the Resident #222's entire medical record dated 4/1/24 - 9/9/24 revealed there was no documented evidence the Notice of Transfer or Discharge form was completed and provided to the resident's representative. 3. Resident #250 had diagnosis including chronic respiratory failure, tracheostomy status (an opening created in the trachea (windpipe) that provides an alternative airway for breathing), and gastrostomy status (an opening into the stomach from the abdominal wall, for the placement of a feeding tube). The Minimum Data Set, dated dated dated [DATE] documented Resident #250 was rarely/never understood, and rarely/never understands others. Review of progress notes dated 2/26/24 - 4/1/24 revealed resident was transferred to the hospital on 3/20/24 for an emergency visit and returned from the hospital on 3/20/24. Review of the resident's electronic medical record 3/20/24 - 9/9/24 There was no documented evidence the Notice of Transfer or Discharge form was completed and provided to the resident or resident's representative and a copy provided to the Office of the State Long-Term Care Ombudsman. During an interview on 9/10/24 at 9:13 AM, Social Worker #2 stated they do not complete a Notice of Transfer or Discharge form and provide to the resident or their representatives. They stated they had not completed and provided the form for Residents #222 and #250. They stated they believe the nursing department completes the information and provides it to the resident's representative when a resident is transferred to a hospital. During an interview on 9/10/24 at 9:24 AM, the Long Term Care Health Information Manager #1 stated they had not notified the Office of the State Long-Term Care Ombudsman of Resident #250's transfer to the hospital because they were not discharged to the hospital and was listed on the discharge list. They stated they generate a discharge list from the facility's computerized system and send a list of resident's names that were discharged to the hospital monthly via e-mail to the Office of the State Long-Term Care Ombudsman. They stated they do not receive a form titled Notice of Transfer or Discharge for any residents sent to a hospital / acute care setting from nursing or Social Work department to send to family or their representatives or the Office of the State Long-Term Care Ombudsman. (continued on next page)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	During an interview on 9/10/24 at 10:10 AM, Executive Secretary #1 stated they used to be responsible to complete the Notice of Transfer or Discharge form and the process was to complete and mail the forms to the resident or representatives for transfers and discharges and then send a copy to the Office of the State Long-Term Care Ombudsman. They stated the task was transferred to the Long-Term Care Health Information Manager over a year ago and does not know who provided the training and what their process has been since they were no longer responsible. During an interview on 9/10/24 at 10:27 AM, Long Term Care Health Information Manager #1 stated they were educated by Social Worker #1 that the facility Social Workers would be completing and providing the Notice of Transfer or Discharge forms for only residents who are discharge to home or another facility, but not residents transferred or discharged to a hospital setting. During an interview on 9/10/24 at 10:47 AM, Social Worker #2 stated they had not completed the Notice of Transfer or Discharge forms for residents sent to the hospital and stated the [NAME] President of Long Term Care (former Administrator) confirmed this was a Nursing Department's job to complete the form, and send it to Long Term Health Information Manager #1. The Long Term Health Information Manager was responsible to send the form to the resident or resident's representative and the Office of the State Long-Term Care Ombudsman. During an interview on 9/10/24 at 10:56 AM, Social Worker #1 stated they provided education to Social Worker #2 and Long Term Care Health Information Manager #1 that the Notice of Transfer or Discharge form was to be completed only for residents who were going home or community and was not completed for any residents transferred or discharged to a hospital setting. They stated they had not completed the Notice of Transfer or Discharge from and provided it to Resident #91's or their family. They stated they do not know who was responsible to complete the Notices of Transfer or Discharge form for those residents hospitalized . During an interview on 9/10/24 at 11:03 AM, The [NAME] President of Long Term Care (former Administrator) stated discussion were had with Social Worker #1, #2 and Long Term Care Health Information Manager #1 and they had identified the Notice of Transfer or Discharge form and notification process to residents or representatives in writing was not being completed for any resident's transfer to an acute or hospital setting. They stated they do not know how long the facility had not been completing this process as required. During an interview on 9/10/24 at 12:11 PM, the Ombudsman stated they have been receiving Notices of Transfer or Discharge for residents except had not received notification of Resident #250's transfer. They stated even though the resident was in the emergency room for hours and not admitted they should have been notified. 10 NYCRR 415.3(i)(1)(iii)(a-c)

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Many	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39086 Based on record review and interview conducted during an extended standard survey completed on 9/16/24, the facility did not ensure that the resident or resident representative was notified in writing of the bed hold policy for three (Resident #91, #222 and #250) of three residents reviewed for hospitalization . Specifically, Resident #91 was sent to the hospital on 8/30/24, Resident #222 had multiple hospitalization s (4/14/24, 5/16/24, 5/23/24 and 8/13/24) and Resident #250 was transferred to the hospital on 3/20/24 with no written notification to the resident or their representative of the facility's bed hold policy. The findings are: Review of facility Resident Handbook undated documented; Bed Reservation Policy as follows: Residents hospitalized paying with private funds - Residents privately paying for basic services with private funds may reserve their room at the facility by continuing to pay the basic daily service rate while they are in the hospital. The resident / representative will be contacted with the current daily rate. Notification of bed reservation cancellation must be given by resident or resident representative. Residents hospitalized receiving Medicare, Other Insurance (HMO) assistance - Bed reservations are not covered by Medicare or other private insurance carriers. If a resident would like to reserve their bed they can opt to pay using private funds. Residents hospitalized receiving Medicaid assistance - New York State Department of Health regulations are amended to provide a bed reservation for nursing home patients [AGE] years of age or older and are hospitalized on ly if the resident is receiving hospice in the facility. The bed reservation is limited to an aggregate of 14 days in any 12-month period. Review of facility form titled Notice of Transfer or discharge date d 12/12/18 revealed fillable areas of the facility's Bed Hold Policy with a fillable area of the facility rate of money per day for the length of the hospital stay or up to the maximum days allowable by current Medicaid guidelines. 1. Resident #91 had diagnoses including displaced intertrochanteric fracture of left femur (break of long bone in the thigh), diabetes mellitus, and chronic kidney disease. The Minimum Data Set (a resident assessment tool) dated 7/22/24 revealed the resident was cognitively intact. Review of progress notes dated 8/1/24 - 9/11/24 revealed resident was transferred to the hospital on 8/30/24 and returned from the hospital on 9/6/24. There was no documented evidence the Notice of Transfer or Discharge form was completed which included the bed hold policy notification was provided to the resident or resident's representative. Review of the resident's entire medical record dated 8/1/24 - 9/11/24 There was no documented evidence the Notice of Transfer or Discharge form was completed which included the bed hold policy notification was provided to the resident or resident's representative. (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 0625 Level of Harm - Potential for minimal harm Residents Affected - Many	2. Resident #222 had diagnoses including chronic respiratory failure with hypoxia (low oxygen level), epilepsy (seizure disorder), and spastic quadriplegic cerebral palsy (stiff, jerky movements of all extremities due to damage to the brain). The Minimum Data Set, dated dated dated [DATE], 5/16/24, and 8/13/24 revealed the resident was severely cognitively impaired. Resident #222 progress notes dated 4/1/24 - 9/9/24 documented the following: -4/14/24 transferred to the hospital and readmitted on [DATE]. -5/16/24 transferred to the hospital and readmitted on [DATE]. -5/23/24 transferred to the hospital and readmitted on [DATE]. -8/13/24 transferred to the hospital and readmitted on [DATE]. Review of the resident's medical record dated 4/1/24 - 9/9/24 revealed there was no documented evidence the Notice of Transfer or Discharge form was completed which included the bed hold policy notification and provided to the resident or resident's representative. 3. Resident #250 had diagnosis including chronic respiratory failure, tracheostomy status (an opening created in the trachea (windpipe) that provides an alternative airway for breathing), and gastrostomy status (an opening into the stomach from the abdominal wall, for the placement of a feeding tube). The Minimum Data Set, dated dated dated [DATE] documented Resident #250 was rarely/never understood, and rarely/never understands others. Review of progress notes dated 2/26/24 - 4/1/24 revealed resident was transferred to the hospital on 3/20/24 for an emergency visit and returned from the hospital on 3/20/24. Review of the resident's electronic medical record 3/20/24 - 9/9/24 revealed there was no documented evidence the Notice of Transfer or Discharge form was completed which included the bed hold policy notification and provided to the resident or resident's representative. During an interview on 9/10/24 at 9:13 AM, Social Worker #2 stated they do not complete a Notice of Transfer or Discharge form and stated the facility doesn't allow residents to hold beds. During an interview on 9/10/24 at 10:27 AM, the Long-Term Care Health Information Manager #1 stated they were educated by Social Worker #1 the facility Social Workers would be completing and providing the Notice of Transfer or Discharge forms for only residents who are discharge to home or another facility, but not residents transferred or discharged to a hospital setting. During an interview on 9/10/24 at 10:56 AM, Social Worker #1 stated they provided education to Social Worker #2 and Long-Term Care Health Information Manager #1 that the Notice of Transfer or Discharge form was to be completed only for residents who are going home or community and is not completed for any residents transferred or discharged to a hospital setting. They stated they do not know who was responsible to complete the Notice of Transfer or Discharge form for residents hospitalized . (continued on next page)

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Many	During an interview on 9/10/24 at 11:03 AM, the [NAME] President of Long-Term Care (former Administrator) stated after discussions with Social Worker #1, #2 and Long-Term Care Health Information Manager #1 they had identified the Notice of Transfer or Discharge form and bed hold policy notification process to residents or representatives in writing was not being completed for any resident's transfer to an acute or hospital setting. They stated they do not know how long the facility had not been completing this process as required. 10 NYCRR 415.3(i)(3)(i)(a)

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 39086 Based on observation, interview, and record review conducted during a complaint investigation (#NY00324941) during an Extended survey completed on 9/16/24, the facility did not ensure that each resident who was unable to carry out activities of daily living received the necessary services to maintain grooming and personal hygiene for one (Residents #20) of two residents reviewed. Specifically, Resident #20 had greasy, disheveled hair, with matting and knots to the back of their head. The finding is: Resident #20 had diagnoses that included multiple sclerosis (disease central nervous system), age-related physical debility, and epilepsy (seizure disorder). The Minimum Data Set (a resident assessment tool) dated 7/7/24 documented the resident was understood, understands, and had severe cognitive impairment. The Minimum Data Set documented Resident #20 did not exhibit rejection of care behaviors and they required substantial/maximal assistance for personal hygiene. Review of the facility Orientation Checklist for Long Term Care Certified Nursing Assistant revealed technical skills included they implemented a plan of care to include personal care, including hair care. The comprehensive care plan dated 4/19/22 documented Resident #20 had an activity of daily living self-care performance deficit related to weakness. Interventions revised 8/2023 documented the resident required extensive assist of one person for personal hygiene, bathing and showering. The Kardex (resident care guide) dated 9/11/24 documented Resident #20 required extensive assist of one person for personal hygiene, bathing and showering. The skin inspection record dated 8/1/24-8/29/24 documented Resident #20 received a bed bath or shower. There was no documented evidence that Resident #20 refused their hair to be washed. There were no skin inspection records for 9/1/24-9/9/24 that verified a shower or bed bath was given as scheduled. The last documented shower was given on 8/22/24. The nursing progress notes dated 7/31/24-9/10/24 revealed no documented refusals of care for Resident #20. Additionally, nursing progress notes dated 9/1/23-10/28/23 revealed no documented refusals of care. During observations on 9/3/24 at 10:14 AM, 9/4/24 at 3:12 PM, 9/5/24 at 8:43 AM and 10:45 AM, 9/6/24 at 7:52 AM, 9/9/24 at 8:21 AM, 9/10/24 at 10:04 AM, and 9/12/24 at 10:37 AM, Resident #20's hair was greasy in appearance. During the observations on 9/5/24, 9/6/24, 9/10/24 and 9/12/24, Resident #20's hair was uncombed, and disheveled. During an interview on 9/6/24 at 10:50 AM, Certified Nursing Assistant #15 stated they always tried to brush Resident # 20's hair, but their hair is in knots, nurse usually cuts the knots out. They stated the brushes at the facility don't work on Resident #20's hair. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Highpointe on Michigan Health Care Facility		STREET ADDRESS, CITY, STATE, ZIP CODE: 1031 Michigan Ave Buffalo, NY 14203	

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 9/10/24 at 10:04 AM, Resident #20 was in bed with hair disheveled, uncombed, and greasy. Resident #20 stated they could not recall the last time their hair was washed. Resident #20 stated it was important to them to have their hair brushed and washed, as it made them feel better. During a follow up interview on 9/10/24 at 10:10 AM, Certified Nursing Assistant #15 stated resident's hair should be combed every day, so the resident looked presentable. They stated Resident #20 was unable to brush their own hair, they're dependent on staff to complete. Certified Nursing Assistant #15 stated Resident #20's hair was knotted up very badly and it was uncomfortable for Resident #20 to have their hair combed. During an interview on 9/10/24 at 10:24 AM, Licensed Practical Nurse #15 stated resident's hair should be combed during morning care and is usually washed during showers by the Certified Nursing Assistants. They stated if a shower was refused the Certified Nursing Assistant should make the nurse aware and indicate the refusal on the skin inspection record. Licensed Practical Nurse #15 stated residents' hair should be washed and combed for hygiene purposes and dignity. During an observation and interview on 9/10/24 at 10:34 AM, Registered Nurse #4, Unit Manager, stated residents' hair should be combed daily, just like us we comb our hair every day. They stated grooming was part of a resident's activities of daily living for dignity, and self-worth and should be completed by the certified nursing assistant. Registered Nurse #4, Unit Manager stated Resident #20's hair was thick, matted, and difficult to comb. They stated Resident #20's hair should be washed on their shower days, twice a week by the certified nursing assistants. Registered Nurse #4 observed Resident #20's hair, and stated their hair looked greasy and uncombed. As Registered Nurse #4, attempted to untangle the matted hair, Resident #20 expressed discomfort. During a telephone interview on 9/10/24 at 11:50 AM, Certified Nursing Assistant #14 stated they did not give Resident #20 a shower or wash their hair on 9/9/24 as scheduled. They stated there was so much going on and they forgot to tell the nurse. They stated they combed Resident #20's hair into a ponytail yesterday and didn't think Resident 20's hair was really greasy, but their hair was matted in the back. During an interview on 9/11/24 at 12:39 PM, the Administrator stated they did not have a facility policy for activities of daily living or provision of personal care including hair care. During an interview on 9/12/24 at 9:45 AM, the Director of Nursing stated they expected resident's hair to be, ideally, combed daily with activities of daily living care. They stated hair style was resident dependent, but that it was not acceptable for residents' hair to be knotted, it should be combed though. They stated if a resident refused care, it should be documented. 10 NYCRR 415.12(a)(3)

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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 - 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 39086

Based on observations, interviews, and record review completed during complaint investigations (Complaint #NY00345300 and #NY00324827) during an extended recertification survey, the facility failed to ensure that each resident received adequate supervision to prevent accidents and elopement for two (Resident #20 and #228) of ten residents reviewed. Specifically, Resident #228 required 1:1 (one to one) supervision for safety and had an unwitnessed fall, sustaining a right hip fracture. In addition,

on 9/24/2023 at 1:25 PM Resident #189 eloped through the front door of the facility. This resulted in actual harm to Resident #228 that was not Immediate Jeopardy.

The findings are:

1. During an interview on 9/11/2024 at 12:39 PM both the Director of Nursing and the Administrator stated there was no policy for 1:1 supervision.

Review of the Role of the Sitter and Sitter Safety in the Acute Healthcare Setting education revealed the definition of 1:1 is constant observation, meaning a situation in which a staff member is responsible for maintaining continuous watch of a single patient, with eyes on the patient at all times and within arm's length of the patient.

Resident #228 had diagnoses including unspecified dementia with agitation, delirium (confused thinking, with reduced awareness of surroundings), and history of traumatic fracture to their left hip. The Minimum Data Set (a resident assessment tool), dated 4/26/2024, documented Resident #228 was moderately cognitively impaired, usually understood, and sometimes understands. Resident #228 was dependent for bed mobility and transfers and used a wheelchair. Resident #228 had a fall prior to admission and two or more falls with injury since admission which included surgery (fractured left hip repair) requiring active skilled nursing care.

Review of the Comprehensive Care Plan dated 5/3/2024 revealed Resident #228 required 1:1 supervision around the clock for safety; was a fall risk due to recent frequent falls and delirium; required their bed in the lowest position with fall mats to both sides of their bed. In addition, Resident #228 had behaviors such as rolling out of bed and attempting to self-ambulate.

Review of the Kardex (a resident care guide) dated 5/24/2024 revealed Resident #228 required 1:1 supervision around the clock for safety.

Review of the nursing progress notes from 4/19/2024 - 5/3/2024 revealed Resident #228 had multiple unwitnessed falls with minor injuries.

The Internal Quality Review/Investigation Worksheets dated 4/19/2024, 4/20/2024 and 4/23/2024 revealed multiple falls on the floor. On 4/23/2024, one-to-one observation was initiated for the resident, which was not placed on their comprehensive care plan until 5/3/2024.

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F 0689

Level of Harm - Actual harm

Residents Affected - Few

The Internal Quality Review/Investigation Worksheet dated 5/24/2024 documented at 8:45 AM Resident #228 was found sitting on their buttocks on their roommate's side of the room. No injuries noted. The form documented the 1:1 had been discontinued on 5/24/2024 by the Physician. Review of the attached Kardex dated 5/24/2024 documented Resident #228 required 1:1 observation around the clock for safety. The attached assignment sheet labeled [NAME] Park, the resident's unit, dated 5/24/2024 for 7:00 AM- 3:00 PM shift documented there was no aide assigned as a 1:1 for Resident #228 that shift.

The Physician/Nurse Practitioner/Physician Assistant note dated 5/24/2024 at 8:57 PM completed by Medical Director #1 documented 1:1 supervision was reinstated for Resident #228 due to recent frequent falls.

The Internal Quality Review/Investigation Worksheet dated 5/26/2024 documented at 1:10 PM Resident #228 was found on the floor in the common area lying on their right side. Staff were attending to other residents at the time. An X-ray was ordered, and results showed a fractured right hip. The attached Kardex dated 5/24/2024 documented Resident #228 required 1:1 observation around the clock for safety. The attached assignment sheet labeled [NAME] Park dated 5/26/2024 for 7:00 AM- 3:00 PM shift documented there were two residents requiring 1:1 that shift. Only one aide was assigned as a sitter (staff assigned to 1:1 for a resident) but was not assigned to Resident #228.

During an observation on 9/6/2024 at 10:30 AM with Security Officer #1 present, the facility video surveillance footage for 5/26/2024 at 12:46 PM revealed Resident #228 was left unattended in the common area on the [NAME] Park unit. At 12:46 PM, Resident #228 stood up and fell to the floor onto their right side. At 12:48 PM Licensed Practical Nurse #11 came into view, saw the resident, and went to the telephone.

The Ultrasound Report dated 5/26/2024 documented an exam of the right hip with pelvis X-ray which revealed an acute right hip fracture.

The Radiology Results Report dated 5/26/2024 documented an acute intertrochanteric (upper part of the thigh bone between the two ends that stick out, where the muscle is attached) hip fracture.

The hospital Discharge Summary dated 6/4/2024 documented Resident #228 had a closed reduction internal fixation (surgical repair) of the right hip intertrochanteric fracture on 5/28/2024.

During an interview on 9/6/2024 at 8:57 AM, Licensed Practical Nurse #10 stated 1:1 supervision meant a staff member would be assigned to the resident and they would be with that resident the entire shift, getting relieved for breaks. They should stay close enough to the resident so they could catch them if they were to try to stand and fall.

During a telephone interview on 9/9/2024 at 9:52 AM, Certified Nurse Aide #8 stated Resident #228 was made a 1:1 because they were always trying to get themselves up and they fell a lot. Certified Nurse Aide #8 stated they know if a resident is 1:1 by checking the care plan, and they check that every day in case there are changes.

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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 - Actual harm Residents Affected - Few	During an interview on 9/9/2024 at 10:20 AM, Certified Nurse Aide #10 stated they were assigned as a sitter on [NAME] Park on 5/26/2024 for the 7:00 AM-3:00 PM shift, but not for Resident #228. They recalled they were in the other resident's room who was a 1:1 for that shift. They looked at the assignment sheet for [NAME] Park unit dated 5/26/2024 for 7:00 AM-3:00 PM shift and noted there were two residents on 1:1, but they were the only sitter assigned. Certified Nurse Aide #10 stated that by not providing Resident #228 with a sitter, it was a break in their care plan. They stated Resident #228 was a 1:1 because they tried to stand and fell a lot. During an interview on 9/9/2024 at 2:34 PM, Assistant Director of Nursing #4 stated they did not know why Resident #228 was not assigned a sitter on 5/26/2024. Resident #228's care plan and Kardex documented they required 1:1 supervision, around the clock, for safety. By not having an assigned 1:1 sitter, and the resident falling and breaking their hip, it was a break in their care plan that led to harm to the resident. During an interview on 9/9/2024 at 3:09 PM, the Director of Nursing stated according to their care plan and Kardex, Resident #228 should have been assigned a sitter on 5/26/2024, but they were not, and they fell and fractured their hip. By not assigning a sitter, it was a break in the resident's care plan that led to harm of the resident. During an interview on 9/10/2024 at 10:03 AM, Medical Director #1 stated Resident #228 was put on 1:1 because they were very active and difficult to redirect. Resident #228 was always trying to get up on their own. Medical Director #1 stated it was possible the fall could have been prevented if they were provided the 1:1 at the time of the incident. The fall resulted in a fractured hip, which was a major injury that did result in harm to the resident. During an interview on 9/10/2024 at 12:42 AM the Administrator stated, if Resident #228 was care planned to have 1:1 supervision around the clock and they were not provided 1:1 supervision, had a fall, and fractured their hip, then that was a break in the care plan that led to harm to the resident. During an interview on 9/11/2024 at 9:05 AM the Clinical Educator stated that 1:1 meant there should always be an aide with the resident within arm's reach. 1:1 supervision was not taught during orientation nor during annual in-services. The Clinical Educator stated they should probably include that in their orientation because they did have residents that required 1:1 supervision. During an interview on 9/11/2024 at 9:06 AM, Physical Therapist #1 stated the therapy department is not involved in 1:1 education or recommendations, but it is the nursing department's responsibility. They stated 1:1 meant an aide should be no more than 6 feet away from the resident and always have them in site. Physical Therapist #1 stated 1:1 in the nursing home was usually used for safety of residents that tried to stand and fell a lot. 2. The policy titled Elopement Long Term Care/Missing Person last revised 10/27/2022 documented resident elopement is defined as when a cognitively impaired resident leaves a facility without staff observation or knowledge of the resident's departure. Any staff member observing a confused or previously identified wandering resident attempting to leave the premises, shall attempt to redirect the resident to the facility. Upon notification that a resident is missing, a thorough search of the facility and the premises for the missing resident will be conducted. Outside search will be coordinated with Site Leadership, Nursing Supervisor, and Security. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The policy titled Wander Guard last revised on 10/27/2022 documented the wander guard system alarms when residents wearing a bracelet signaling device attempts to pass through a monitored area. Residents identified as at risk for elopement will have a bracelet signaling device applied to their wrist. Resident #189 had diagnoses that included unspecified dementia, polyneuropathy (damaged peripheral nerves) and type 2 diabetes mellitus (problem with the way the body regulates the uses of sugar as a fuel). The Minimum Data Set, dated dated dated [DATE] documented Resident #189 was severely cognitively impaired, understood and understands. Additionally, Resident #189 had a wander/elopement alarm. The comprehensive care plan dated 2/9/2023 documented Resident #189 required supervision with ambulation with a rolling walker on and off the unit. Resident #189 was at risk for elopement and had a wander guard (device that alarms if the resident leaves a designated area) in place and may not leave the floor unaccompanied. The Kardex dated 2/9/2023 documented staff were to check the whereabouts of Resident #189 on rounds, after meals and at change of shift. Review of the active Physician Orders dated 9/9/2024 revealed to check Resident #189's wander guard on right ankle every shift for safety. Review of the facility investigation dated 9/24/2023 at 2:00 PM, documented Registered Nurse/Nursing Supervisor #9 was notified by Licensed Practical Nurse #14 at 1:30 PM that Resident #189 may have gone out on pass without signing out. Registered Nurse/Nursing Supervisor #9 was then informed 10 minutes later that Resident #189 had eloped by following another resident's family out of the building. Security was alerted and the grounds of the facility were immediately searched. The Director of Nursing and 911 was called. The search continued off facility grounds by staff members. Resident #189 was brought back to the facility at 2:30 PM by a family friend who saw Resident #189 walking down a sidewalk. Resident #189 was assessed for any injuries, no injuries documented. Resident #189 stated I just wanted to go see my family member. I didn't know I couldn't leave the building. Resident #189 was placed on 15-minute checks for 48 hours, then 30-minute checks for 24 hours, 1-hour checks for 24 hours, and 4-hour checks for 24 hours without any elopement attempts. A new protocol was established for out on pass monitoring after review and a larger picture of Resident #189 was posted at the security desk. Additionally, the investigation file revealed two in-servicing sheets titled 4th Floor Resident dated 9/24/2023 and Resident Out on Pass Process dated 11/23/2023 with signatures identifying 51 staff members were educated that residents on the 4th floor must be at all times accompanied by a staff member off the floor. Review of the Employee Roster detail report provided by the facility revealed a list of 445 employees and their titles. (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 0689

Level of Harm - Actual harm

Residents Affected - Few

Review on 9/9/2024 at 9:36 AM of facility surveillance video footage dated 9/24/2023 revealed at 1:25 PM Resident #189 was observed walking with their walker through the lobby. Resident #189 was to the left of a visitor. Two children were to the right of the visitor. The door opened as the visitors approached and Resident #189 walked up and around the left side of the visitor at a fast pace. Resident #189 exited the building, walking alongside the visitor and the children. At 1:27 PM, when Resident #189 and visitors reached the middle of the parking lot, Certified Nursing Aide #16 was observed exiting the building and started following Resident #189 and the visitors. At 1:28 PM the visitors and Resident #189 were observed walking across the street, then Resident #189 was observed walking down the side street adjacent to the facility, alone, then goes off camera view. Certified Nursing Aide #16 proceeded to go in the direction of Resident #189. At 1:31 PM Certified Nursing Aide #16 was seen reentering the parking lot. At 1:33 PM Certified Nursing Aide #16 re-enters the facility.

During an interview on 9/5/2024 at 1:21 PM, the Director of Nursing stated there was a facility wide education done on the elopement policy, and it should be in the investigation file.

During an interview on 9/5/2024 at 1:32 PM, Licensed Practical Nurse #14 stated on 9/24/2023 Security Officer #2 informed them Resident #189 went out with family and did not sign out. When the visitors came back to the facility 10 minutes later without Resident #189, Security Officer #2 alerted Licensed Practical Nurse #14, who then updated Registered Nurse Supervisor #9 of Resident #189's elopement. Staff then began searching for Resident #189. Resident #189 was brought back to the facility about an hour later. Licensed Practical Nurse #14 stated the resident was found on [NAME] and [NAME] (according to map [NAME] approximately a 40-minute walk from the facility). Licensed Practical Nurse #14 stated they were not sure how Resident #189 was able to get down to the lobby because the elevator should not have moved when the wander guard alarms.

During an interview on 9/5/2023 at 4:00 PM, Security Officer #2 stated a blue line will pop up and flash on the wander guard system when a resident with a wander guard goes near an exit or elevator. The Security Officer must clear it with the floor and then clears it in the system before the exit can open, or elevator can move. Security Officer #2 stated it was a busy day with a lot of visitors coming and going. Security Officer #2 stated during the incident on 9/24/2023 with Resident #189, there were multiple alerts going off at the same time, and it is possible that they cleared the alert for Resident #189 on the elevator mistakenly. That is how Resident #189 was able to get on the elevator and make it to the lobby. Security Officer #2 stated when Resident #189 arrived in the lobby, the door had already started opening when the wander guard alarm sounded, and Resident #189 was able to exit with the visitors they were walking with. Security Officer #2 stated they realized Resident #189 had not signed out on pass, called up to the unit and confirmed they had not. Security Officer #2 had Certified Nurse Aide #16, who was in the lobby at the time of elopement with a different resident, go out and attempt to flag down the visitors and Resident #189. Certified Nurse Aide #16 was unsuccessful and returned to the facility. Security Officer #2 stated they went out to the parking lot and could not visualize Resident #189 or the visitors, so they returned to the facility. About 10 minutes later the visitors returned and stated they had not been with Resident #189. This is when the elopement procedures began.

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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 - Actual harm Residents Affected - Few	During a telephone interview on 9/8/2024 at 9:52 AM, Certified Nurse Aide #16 stated they were in the lobby helping one of their residents get ready to leave when another resident (Resident #189) was seen exiting the facility with people. Certified Nurse Aide #16 stated they weren't sure if that resident (Resident #189) was allowed to leave so they attempted to catch up to the visitors and ask. Certified Nurse Aide #16 stated they were unable to catch up to them and went back into the facility. Certified Nurse Aide #16 stated they did not continue perusing Resident #189 and the visitors because they were unfamiliar with Resident #189. Certified Nurse Aide #16 thought they just forgot to sign out. Certified Nurse Aide #16 stated upon return to the facility, Security Officer #2 stated Resident #189 went out with family and it was no big deal. During an interview on 9/9/2024 at 3:34 PM, the Director of Nursing stated Certified Nursing Aide #16 should have continued to trail Resident #189 and kept eyes on them or ask for assistance out in the community if there was someone nearby. 10 NYCRR 415.12(h)(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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 39086 Based on observation, interview, and record review conducted during an extended standard survey completed on 9/16/24, the facility did not ensure residents were assessed for risk of entrapment from bed rails prior to installation, review the risks and benefits of bed rails with the resident or resident representative, and obtained informed consent prior to the installation of bed rails for one (Resident # 20) of one resident reviewed for bed rails. Specifically, Resident #20 was not assessed for risk of entrapment from bed rails, there was no documented evidence the risks and benefits of bed rails were reviewed and that consents were obtained prior to bed rail use. Additionally, there was lack of maintaining the bed rails in proper working order. The finding is: The policy and procedure titled Transfer/Bed Mobility Bar revised 10/25/22 documented the goal is always to maintain the highest practical functional status for our residents. The use of a transfer/bed mobility bar facilitates this commitment and promotes functional mobility for our residents with optimal bed safety achieved. The policy and procedure titled Side Rail Policy revised 10/27/22 documented side rails may be utilized as an enabler to improve or maintain a resident's functionally independent status in moving to and from a lying position, turning side-to-side, re-positioning in bed, and transferring in/out of bed. When side rails are used, continuous evaluation of their appropriateness is expected to be part of an ongoing assessment. This evaluation is to be done quarterly, annually and with significant change in the resident's condition. Resident's and families should be actively involved in deciding whether to use side rails. The interdisciplinary care team is still responsible to determine whether their use is contraindicated to the health care and safety of the resident. The User-Service Manual, copyright 2013 for bed series utilized in facility documented, Warning: Possible Injury or Death. Do not use any assist device until you verify it is locked in place. Failure to lock assist devices may result in injury; An optimal bed system assessment should be conducted on each resident by a qualified clinician or medical provider to ensure maximum safety of the resident. The assessment should be conducted within the context of, and in compliance with, the state and federal guidelines related to the use of restraints and bed system entrapment guidance. Entrapment zones involve the relationship of components often directly assembled by the healthcare facility rather than the manufacturer. Therefore, compliance is the responsibility of the facility. Resident #20 had diagnoses that included multiple sclerosis (disease central nervous system), age-related physical debility, epilepsy (seizure disorder), and depression. The Minimum Data Set (a resident assessment tool) dated 7/7/24 documented resident was understood, understands, and had severe cognitive impairment. Resident #20 required partial/moderate assistant with rolling left to right. No bed rail use indicated on the assessment. (continued on next page)

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 09/16/2024
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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Kardex (guide used by staff to provide care) dated 9/11/24 documented staff were to to anticipate and meet safety needs; bed mobility extensive assist of one staff member for rolling side to side with bed assist bars. The comprehensive care plan initiated 4/19/22 documented Resident #20 had limited physical mobility related to multiple sclerosis. Intervention revised 8/14/23 documented bed mobility as extensive assist of one for rolling side to side with bed assist bars. Additionally, revision dated 1/23/24 documented Resident #20 was at risk for falls related to confusion, deconditioning, incontinence, and immobility. Interventions initiated 1/23/24 included to anticipate and meet resident's needs. During observations on 9/3/24 at 10:19 AM and 3:32 PM, 9/4/24 at 3:12 PM, and 9/5/24 at 8:43 AM, 10:45 AM, and 3:26 AM Resident #20 was in bed with bed assist bar to right side of bed unlatched, unsecured from bed frame. Review of Plant Operations Bed Inventory was last completed 5/15/23-5/18/23 documented entrapment, compliance mattress/assist rail fit. During a continuous observation on 9/6/24 from 9:54 AM to 10:40 AM, Resident #20 was observed to utilize the bed assist bars during care when prompted by staff and encouraged by Certified Nurse Aide #15. During an interview on 9/5/24 at 3:46 PM, Certified Nurse Aide #13 stated all bed assist bars should be locked into place for safety. If they were not locked into place the resident may not be safe and could fall out of the bed. Certified Nursing Assistant #13 stated if there was an issue with a bed assist bar, they would let the nurse know and put a maintenance order in through the computer. During an interview on 9/5/24 at 3:55 PM, Certified Nursing Assistant #12 stated all residents had bed assist bars on their beds. They stated the bed assist bars can be unlatched and pulled away from the bed to boost a resident in bed or when transferring a resident out of or into the bed. They stated any staff member that moves the bed assist rail was responsible to make sure they are locked back into place after moving. Additionally, they stated that if the bed assist rail weren't locked into place the resident wouldn't be able to hold on to them, they could fall or slid out of the bed. During an observation and interview on 9/5/24 at 4:16 PM, Licensed Practical Nurse #2 stated that if the bed assist bars were left unlatched it would be a safety issue. Licensed Practical Nurse #2 checked the bed assist bars on Resident #20's bed and stated the bed assist rail to the right side of the bed was unlatched. Licensed Practical Nurse #2 attempted to latch the bed assist bar into place and was unable to do so. They stated the bed assist bar was supposed to lock. During an interview on 9/5/24 at 4:22 PM, the Registered Nurse #4, Unit Manager, stated there were no side rail assessment done for the bed assist bars, as they were on every bed and therapy makes the recommendations for use. Registered Nurse #4 stated handrails, side rails help residents with turning, positioning, sitting up and as a barrier to protect residents from falling out of bed. They stated the nursing staff were responsible for making sure the bed assist bars were secured during care. Additionally, they stated safety, maintenance concerns with the bed assist bars should be reported to them or environmental services. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highpointe on Michigan Health Care Facility	1031 Michigan Ave Buffalo, NY 14203

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/9/24 at 9:27 AM, Physical Therapist #2 stated bed assist rails shouldn't move if a resident reaches for it, they should be locked into place. They stated if a bed assist bar was unlatched it would be safety concern. The resident could have trouble using the bed assist rail or could fall from the bed. Additionally, they stated physical therapy makes recommendations for use of the bed assist bar for mobility purposes. During an interview on 9/9/24 at 9:57 AM, Therapy Manager stated bed assist bar assessments were completed with physical therapy evaluations, whether the resident can use the bed assist bars or not. They stated bed assist bars for each resident are care planned accordingly. They stated if there was a risk for use identified with the presence of bed assist bars it was discussed with the interdisciplinary team. The interdisciplinary teams determined if bed assist bars should be removed or padded if a resident has seizures, hypertonic (muscle-state of abnormally high tension) or have flailing arms that could cause injury or risk for entrapment with use of the bed assist bars. During an interview on 9/10/24 at 9:00 AM, Director of Environmental Services stated that all beds had bed assist bars, except for on the pediatric unit or if specified to remove per a resident's care plan. They stated they were not aware of any assessments for side rail use and that entrapment was highly unlikely. Director of Environmental Services stated there were no routine audits to check proper installment of the bed assist bars. They stated the only time there was an audit was when the beds were being placed into a room. During an interview on 9/10/24 at 9:33 AM, the Director of Nursing stated they did not not currently have any beds with side rails, they have bed assist bars. They stated all beds came equipped with the bed assist bars and there were no nursing evaluations for the bed assist bars. They stated there was no consent required with the use of bed assist rails because they weren't considered a restraint. Additionally, they expected anyone providing care to a resident to make sure the bed assist bars were latched, appropriately, in place for safety. During an interview on 9/10/24 at 9:43 AM, the current Administrator stated they did not know the definition of a bed rail specifically. They stated the facility utilized bed assist bars and that no consent for use was obtained. They stated the therapy department conducts quarterly and as needed assessments on the appropriateness of the bed assist bars. To their knowledge no education regarding entrapment with use of the bed assist rails was provided to the residents or families. They stated they had not been made aware of any risk for entrapment and did not know if there was a potential risk for entrapment with the use of the bed assist bars. 10 NYCRR 415.12 (h)(1)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 39086 Based on interview and record review conducted during a Complaint investigation (#NY00336618) during an Extended survey completed on 9/16/24, the facility did not ensure that residents are free of significant medication errors for one (Resident #250) of three residents reviewed. Specifically, on 3/20/24 Registered Nurse #3 erroneously administered Resident #247's morning medications to Resident #250 which resulted in a significant medication error. The finding is: The policy and procedure titled Medication Ordering, Interpretation and Administration Guidelines revised 10/3/22 documented prior to all medication administration, scanning both the patient's wristband and the medication barcode are required. The facility's Medication Administration Competency Assessment Tool revised 5/11/23 documented medications were administered using the right resident, right medication, right dose, resident route, right time, right reason/indication for medication, right documentation, and right response. Resident #250 had diagnoses including chronic respiratory failure, tracheostomy status (an opening created in the trachea (windpipe) that provides an alternative airway for breathing), and gastrostomy status (an opening into the stomach from the abdominal wall, for the placement of a feeding tube). The Minimum Data Set (a resident assessment tool) dated 10/24/23 documented Resident #250 was rarely/never understood, and rarely/never understands. The comprehensive care plan initiated 10/18/23 documented Resident #250 had global developmental delays secondary to bronchopulmonary dysplasia (a chronic lung disease which affects premature infants) originating in the prenatal period, resident was not able to make needs known, and staff would anticipate the resident's needs. Review of facility Medication Error Form documented on 3/20/24 a medication error was made by Registered Nurse #3 involving Resident #250. Registered Nurse #3 gave the medications Keppra (an anti-seizure drug), Onfi (used to treat seizures), Omeprazole (used to treat too much acid in the stomach) and a multivitamin to the wrong resident, then called Doctor #1 and pulled out most of the medications via the mic-key (a low-profile tube that allow children to receive nutrition, fluids, and medicine directly into the stomach) right after. Review of facility Long Term Care Transfer Form dated 3/20/24 at 9:30 AM documented Resident #250 was given the wrong medications including Keppra 5 milliliters, Onfi 4 milliliters, Omeprazole 9.5 milliliters and multivitamin 0.5 milliliters. Registered Nurse #3 pulled out most of the medications right after giving them. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review hospital emergency department note dated 3/20/24 at 5:10 PM documented Resident #250 presented with accidental ingestion of medication, earlier this morning at around 9 AM they were given by mistake other resident's medications which are as follows, Onfi 10 milligrams, Keppra 500 milligrams, omeprazole 19 milligrams and multivitamin. Facility managed to aspirate a lot of the medication but not all of, and they discussed the case with poison control who recommended transferring the resident to the emergency department for observation and further investigation. Resident #250 was observed for 6 hours as per poison control recommendations, no change in vitals or baseline clinical status, and resident was sent back safely to the facility with close observation. During an interview on 9/10/24 at 2:21 PM, Registered Nurse #3 stated it was their mistake and they realized they gave medication to Resident #250 that was intended for Resident #247 immediately after they exited Resident #250's room, therefore they immediately returned to Resident #250 and extracted gastric contents including the medications from Resident #250's stomach by the gastric tube. They stated they had the nurse who was working with them call Doctor #1 (the on-call doctor) immediately and they advised them to continue to monitor Resident #250. They stated Doctor #1 called back within 5 minutes and provided an order to send Resident #250 to the emergency room for evaluation. Registered Nurse #3 stated they were concerned for Resident #250 because of the medications that were given and they should have followed the 5 rights (right resident, right route, right medication, right dosage, right time) when administering medications. During an interview on 9/6/24 at 10:36 AM, Medical Director #2 stated Doctor #1 was on call on the date the medication error occurred and called New York State Poison Control and was informed of the risks of sedative/ hypnotic toxicity (drugs that cause central nervous system depression) and advised to monitor Resident #250's carbon dioxide levels. Medical Director #2 stated the facility was unable to monitor a resident's carbon dioxide levels therefore Resident #250 was sent to the emergency room for observation. Medical Director #2 stated Resident #250 did not have a seizure disorder diagnosis and received the medications Onfi (a prescription medicine used along with other medicines to treat seizures associated with Lennox-Gastaut syndrome (a complex, rare, and severe type of epilepsy) in people 2 years or age of older) which is the most concerning because of the central nervous system depression and they were only 10 months old at the time of the medication error. They also received Keppra 500 milligrams which was more than a loading dose (an initial higher dose given at the beginning of treatment) for this resident's age at the time of the medication error. Medical Director #2 stated this was a significant medication error. During an interview on 9/10/24 at 1:37 PM, Registered Nurse Unit Manager Assistant Director of Nursing #3 stated Registered Nurse #3 provided medications to Resident #250 that were intended for another resident and because of the medications provided they would consider this a significant medication error. During an interview on 9/10/24 at 1:48 PM, the Director of Nursing stated Resident #250 received medications that were not prescribed to them and considered this a significant medication error. During an interview on 9/10/24 at 2:12 PM, the facility's Pharmacy Consultant #1 stated they would consider this as a significant medication error because of the potential for sedation related to the medications provided and Resident #250's age. 10 NYCRR 415.12(m)(2)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39086 Based on interview and record review conducted during an extended standard survey completed from 9/3/2024 to 9/16/2024, the facility was not administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body is responsible and accountable for the Quality Assurance and Performance Improvement program. Specifically, the administration did not ensure policies and procedures were consistently implemented, and the administration was not aware of the extent of the deficient practices cited. The findings are: REFER TO: F 600 - Free from Abuse and Neglect F 610 - Investigation / Prevent / Correct Alleged Violation Review of the facility's undated Resident Handbook documented; in accordance with Federal and State regulation, each resident has the right to be free from verbal, sexual, physical, and mental abuse, or neglect. Any allegation regarding abuse, mistreatment, or neglect is immediately investigated. Review of facility's Abuse Policy and Procedure revised 12/2/22 documented; Resident abuse, neglect, exploitation, involuntary seclusion, or misappropriation of property will not be tolerated. This policy will be administered by the Long-Term Care Administrator and the Director of Nursing. A summary of the investigation shall be forwarded to the Administrator / designee for review and final decision regarding the allegation. a. Resident #226 had diagnoses of stroke (loss of blood flow to part of the brain or bleeding in the brain) and type 2 diabetes mellitus. The Minimum Data Set (a resident assessment tool) dated 9/242023 documented Resident #226 was cognitively intact. Resident #208 had diagnoses of Alzheimer's disease and depression. The Minimum Data Set, dated dated dated [DATE] documented Resident #208 was severely cognitively impaired. Review of an investigation and witness statements dated 9/29/2023 documented that Resident #226 was found by Licensed Practical Nurse #16 in Resident #208's room standing next to #208's bed with their arms at their side when answering a call light. Resident #208's breasts were exposed, and Resident #226 was staring at Resident #208. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 9/9/2024 at 3:06 PM, Social Worker #1 stated Resident #226 was moved to the dementia unit four days after the 9/29/2023 incident with Resident #208 because there was not an appropriate long term care room available. During an interview on 9/11/2024 at 8:07 AM, the Director of Nursing stated Resident #226 was moved to the dementia unit because there was not another room available. The Director of Nursing stated the nurses should have documented Resident #226's whereabouts but there was not a formal 15-minute check started or 1:1 supervision. The facility daily census reports dated 9/29/23 through 10/3/23 revealed available beds within the facility: Rehabilitation Unit there were 3 empty beds available on 9/29/23 and 9/30/23; 5 empty beds available on 10/1/23 and 10/2/23; and 3 empty beds available on 10/3/23. A Long-Term Care Unit had one bed available on 9/29/23 and 9/30/23, 2 beds available on 10/1/23, 10/2/23 and 10/3/23. In addition, the facility had a closed (POD) leaving the following beds empty 480 - 490 9/29/23 through 10/3/23. b. Resident #50 had diagnoses of dementia, arthritis, and seizure disorder. The Minimum Data Set, dated dated dated [DATE] documented Resident #50 was severely cognitively impaired. Resident #33 had diagnoses of dementia and anxiety disorder. The Minimum Data Set, dated dated dated [DATE] documented Resident #33 was severely cognitively impaired. The 24-Hour Nursing Reports dated 11/10/2023, 11/11/2023, and 11/12/2023 documented that Resident #226 was found in Resident's #50 and #33's room. Review of Resident #226 nursing progress notes revealed the following: 11/9/2023 at 10:57 PM, Registered Nurse Nursing Supervisor #1 documented resident was observed by staff standing in the common area with their genitals out of their pants. Resident #50 and another resident (#33) were in the common area. Resident #226 denied that they had their genitalia. 11/10/2023 at 8:22 PM, Licensed Practical Nurse #5 documented resident was found by staff in Resident #50's room. 11/11/2023 at 9:22 PM Licensed Practical Nurse #6 documented resident was found in Resident 50's room again and this was the third instance. 12/11/2023 Licensed Practical Nurse #18 documented resident was in Resident 50's room. The Nursing Supervisor and the Nurse Practitioner were notified. During an interview on 9/11/2024 at 10:11 AM the current Administrator stated, (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	that Resident #226 should have been placed on 1:1 supervision at that time to ensure they did not go into Resident #208's room or anyone else's room. During an interview on 9/10/2024 at 12:07 PM, Nurse Practitioner #1 stated they did not think Resident #226 was appropriate for a dementia unit. During an interview on 9/12/2024 at 10:07 AM, the Director of Nursing stated they should have been notified by staff of Resident #226's behavior so that additional interventions could have been put into place to prevent sexual abuse. The Director of Nursing stated when Resident #226 was moved to the dementia unit there should have been additional education provided to the staff to observe Resident #226's behaviors and report unusual behaviors to them but does not know if education was provided. The staff education may have fallen through the cracks because the Unit Manager was out on leave. Additionally, After reviewing the medical record the Director of Nursing stated, I believe we were not as prudent as we should have been to maintain the safety of all our residents. During an interview on 9/12/2024 at 8:55 AM, Medical Doctor #1 stated the incident on 9/29/23 was highly suspicious and could have been abuse. Resident #226 should have been put on 1:1 supervision on 9/29/2023. Medical Doctor #1 stated they were not aware of any incidents between Resident #226, Resident #50, and Resident #33 that occurred in November 2023. They would have expected staff to report any incidents of possible sexual abuse to themselves and the Director of Nursing. Medical Doctor #1 stated, had Resident #226 been placed on 1:1 supervision on 9/29/2023, then any other incidents of sexual abuse could have been prevented. During an interview on 9/11/24 at 2:43 PM, the [NAME] President of Long Term Care (former Administrator) stated moving Resident #226 to the dementia unit was not an effective plan. The [NAME] President of Long Term Care stated they would have expected to have been notified that Resident #226 was wandering into other resident's rooms as the progress notes documented in November 2023. The [NAME] President of Long-Term Care stated this situation should have risen to the administrative level for further review. If they had been informed they would have initiated 1:1 supervision earlier to prevent and protect all the vulnerable residents on the dementia unit. During interview on 9/13/24 at 11:36 AM, the Director of Nursing stated after the 9/29/23 sexual abuse allegation they discussed the room change with Assistant Director of Nursing #1 and decided to move Resident #226 to the dementia unit. They did not recall if the former Administrator or the Assistant Administrator were involved in the decision making. They stated they did not move the Resident #226 to the Rehabilitation Unit's open bed because the resident was a long-term care resident but could have; and doesn't recall why they did not move them to an open Long-Term Care bed. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 9/13/24 at 12:23 PM, the current Administrator (former Assistant Administrator) stated they were not directly involved in reviewing the incidents. The former Administrator at the time was responsible for reviewing the incidents and reviewing the interventions. The facility did not identify these were isolated incidents due to lack of investigations. The investigation should have included interviewing of staff, other residents and reviewing the videos on the unit. They stated psychiatry was available and the facility should have provided additional evaluation and resources to Resident #226, #208 and #50. They stated they do not believe they were part of the conversation to move Resident #226 to the dementia unit but expects the facility to be proactive and have appropriate interventions in place to prevent abuse. They stated moving Resident #226 to the dementia unit was not an effective intervention and would have expected the Unit Manager, Assistant Director of Nursing and Director of Nursing to have had additional interventions in place for resident safety. During an interview on 9/13/24 at 1:59 PM, the [NAME] President of Long Term Care (former Administrator) stated they believed the 9/29/23 reported sexual allegation was an isolated incident and that there was no evidence Resident #226 touched Resident #208. They stated they met with the Assistant Administrator and Director of Nursing and discussed Resident #226's behaviors and recalled being informed the resident had not been inappropriate to anyone else. They stated it was the facility's responsibility to maintain optimal psychosocial well- being and safety for all residents. 10 NYCRR 415.26

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39086 Based on interview and record review conducted during an extended survey completed on 9/16/24, the facility did not ensure a quality assurance and performance improvement (QAPI) program did not ensure the committee developed and implemented appropriate plans of action to correct quality deficiencies and regularly reviewed, analyzed and acted on available data to make improvements. Specifically, the facility quality assurance and improvement program did not identify, develop, and implement an appropriate plan to prevent and protect all residents from sexual abuse when repeated patterns of sexually inappropriate behaviors occurred. Additionally, when there was a change in the facilities processes for addressing hospital transfer/discharge notifications and bed hold policy notices; the facility quality assurance and performance improvement program did not identify they were not being completed as required. Refer to: F 600 - Free from Abuse and Neglect F 610 - Investigate/Prevent/Correct Alleged Violation F 623 - Notice Requirements Before Transfer/Discharge F 625 - Notice of Bed Hold Policy Before/Upon Transfer The findings are: Review of the policy and procedure titled Long-Term Care, Quality, Quality Assurance Performance Improvement (QAPI) revised 9/23/21 documented, the Quality Assurance Performance Improvement Plan provides guidance for our overall quality improvement program. Quality assurance performance improvement principles will drive decision making within Long Term Care. Decisions will be made to promote excellence in quality of care, quality of life, resident choice, person directed care and resident transitions. Focus areas will include all systems that affect resident and family satisfaction, quality of care and services provided, and all areas that affect the quality of life for persons living and working in our organization. The Administrator and/or [NAME] President of Long-Term Care has the responsibility and is accountable to the Board of Directors for ensuring that Quality Assurance Performance Improvement is properly implemented. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility's Long-Term Care Corporate Quality Management revised 12/2010 documented, the Long-Term Care Corporate Quality Management Committee is responsible for the oversight of the coordination, integration, and supervision of all aspects of the Long-Term Care services and functions. The committee meets on a quarterly basis and reviews the following by not limited to: Incidents reported to the New York State Department of Health/ and sentinel events. The scope of the Long-Term Care Corporate Quality Management committee is organization wide, and its components include Administrative Officers, Medical Directors, and the facility's departments. The mission of the Quality Management Program is to promote the delivery of resident care in keeping with the highest standards on outcomes and services valued by our customers, medical staff, employees, and payers/ its institutional relationships as the community which it services. The purpose of the program is to provide for overall vision, supervision, education, coordination and integration of the quality assessment and improvement functions. a. Review of an investigation and witness statements dated 9/29/2023 documented that Resident #226 was found by Licensed Practical Nurse #16 in Resident #208's room standing next to #208's bed with their arms at their side when answering a call light. Resident #208's breasts were exposed, and Resident #226 was staring at Resident #208. The 24-Hour Nursing Reports dated 11/10/2023, 11/11/2023, and 11/12/2023 documented that Resident #226 was found in Resident's #50 and #33's room. Review of Resident #226 nursing progress notes revealed the following: 11/9/2023 at 10:57 PM, Registered Nurse Nursing Supervisor #1 documented resident was observed by staff standing in the common area with their genitals out of their pants. Resident #50 and another resident (#33) were in the common area. Resident #226 denied that they had their genitalia. 11/10/2023 at 8:22 PM, Licensed Practical Nurse #5 documented resident was found by staff in Resident #50's room. 11/11/2023 at 9:22 PM Licensed Practical Nurse #6 documented resident was found in Resident 50's room again and this was the third instance. 12/11/2023 Licensed Practical Nurse #18 documented resident was in Resident 50's room. The Nursing Supervisor and the Nurse Practitioner were notified. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 9/12/24 at 10:07 AM, the Director of Nursing stated they review all incidents that were reported to the New York State Department of Health at the Quality Assurance Meetings for discussion and review of the specifics of the incident and interventions added. The Director of Nursing stated the September Quality Assurance Meeting was held prior to the 9/29/23 reported sexual abuse allegation involving Resident #226 and #208. Therefore, it would have been reviewed during the October 2023 meeting. The October meeting was canceled. Therefore, the sexual abuse allegation should have been discussed at the November Quality Assurance meeting with the committee, however it had not been added it to the November agenda. The December 2023 Quality Assurance Committee meeting was canceled. The 9/29/23 reported sexual abuse allegation involving Resident #226 and #208 was not discussed at a Quality Assurance meeting and it should have been to ensure the entire Quality Assurance Performance Improvement Committee was aware. The Committee should have reviewed the abuse allegation, what interventions were put into place and determined if the plan was appropriate or if the plan required additional interventions. They stated they reviewed the 12/29/23 reported sexual abuse Resident #226 was involved in during the January 2024 Quality Assurance Committee meeting and determined that 1:1 supervision was necessary to continue to ensure resident safety. During an interview on 9/12/24 at 11:19 AM, the [NAME] President of Long-Term Care (former Administrator) stated the reported sexual abuse allegation of 9/29/23 was not discussed at the Quality Assurance Committee meeting with all members and should have been. At the time it was believed to be an isolated incident. They stated they did meet as an informal team, the Director of Nursing, Assistant Director, and themselves and Resident #226 was moved to the dementia unit. They stated if they would have known Resident #226 was in other resident's rooms in November 2023, they would have had additional interventions such as 1:1 supervision to protect other residents. They stated sexual abuse doesn't necessary mean to touch someone, it includes exposing their private areas to someone or in a public area. During an interview on 9/13/24 at 1:01 PM, in the presence of the Director of Nursing, the current Administrator (previous Assistant Administrator), the [NAME] President of Long-Term Care (former Administrator) stated the Quality Assurance Committee was supposed to review all incidents reported to the Department of Health. They stated the purpose was to review the issue, the interventions, discuss the incident and determine if additional interventions were needed to promote quality of care and safety to residents and to improve outcomes. b. Review of Resident's #91's progress notes dated 8/1/24 - 9/11/24 revealed resident was transferred to the hospital on 8/30/24 and returned from the hospital on 9/6/24. Review of the Resident's #91's entire medical record dated 8/1/24 - 9/11/24 There was no documented evidence the Notice of Transfer or Discharge form was completed which included the bed hold policy notification was provided to the resident or resident's representative. Resident #222 progress notes dated 4/1/24 - 9/9/24 documented the following: -4/14/24 transferred to the hospital and readmitted on [DATE]. -5/16/24 transferred to the hospital and readmitted on [DATE]. -5/23/24 transferred to the hospital and readmitted on [DATE]. (continued on next page)

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 09/16/2024
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)
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-8/13/24 transferred to the hospital and readmitted on [DATE]. Review of the resident's medical record dated 4/1/24 - 9/9/24 revealed there was no documented evidence the Notice of Transfer or Discharge form was completed which included the bed hold policy notification and provided to the resident or resident's representative. Review of progress notes dated 2/26/24 - 4/1/24 revealed resident was transferred to the hospital on 3/20/24 for an emergency visit and returned from the hospital on 3/20/24. Review of the resident's electronic medical record 3/20/24 - 9/9/24 revealed there was no documented evidence the Notice of Transfer or Discharge form was completed which included the bed hold policy notification and provided to the resident or resident's representative. During an interview on 9/13/24 at 1:01 PM, in the presence of the Director of Nursing, the current Administrator (previous Assistant Administrator), the [NAME] President of Long-Term Care (former Administrator) stated they have not identified that the Transfer Notification and Bed Hold Notification for residents sent to the hospital was not being done according to the regulations until identified during survey and should have. They stated they don't know why or when the notifications were stopped for hospitalized residents and believes this to be a system failure because it appeared to be widespread for all hospitalized residents. 10NYCRR 415.27(c)(3)(ii)(iv)(v)(4)