STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335314	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wells Nursing Home Inc	201 W Madison Avenue Johnstown, NY 12095

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 21414 Based on record review and interviews during the recertification survey, the facility did not ensure that residents and/or their designated representative were fully informed of their right to an expedited review of a service termination for 2 of 3 residents reviewed. Specifically, the facility did not ensure 2 (Residents #141 and #142) who received Medicare Part A services, received timely notification (2-day notification) of the termination of services with the required form Notice of Medicare Non-Coverage, Form CMS 10123-NOMNC. This is evidenced by: There was no documented evidence that residents #141 and #142 received 2-day notification prior to the termination of rehabilitative services. During an interview on 9/06/2024 at 11:34 AM, Fiscal Clerk #1 stated that they could not account as to why residents #141 and #142 did not receive a 2-day notification prior to the termination of Medicare services. During an interview on 9/06/2024 at 11:37 AM, Administrator #1 stated that the Fiscal Clerk would be re-educated on the 2-day notification. 10 New York Codes, Rules and Regulations 415.3 (g)

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

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 48744 Based on record review and interviews during the recertification and abbreviated survey (Case #NY00338006), the facility did not ensure the resident's right to be free from neglect for 1 (Resident #48) of 18 residents reviewed for abuse and neglect. Specifically, on 4/03/2024, Certified Nurse Aide #2 did not use two-person assist for bed mobility as required in Resident #48's Comprehensive Care Plan while providing care to the resident. Resident #48 rolled out of bed onto the floor. Resident #48 sustained a pelvis fracture (a break of the bony structure of the pelvis). This resulted in actual harm that was not immediate jeopardy. This is evidenced by: Resident #48 was admitted with diagnoses of pulmonary edema (fluid collection in the chest cavity causing breathing difficulty), legal blindness, and chronic kidney disease (dysfunction of kidneys that never gets better). The Minimum Data Set (an assessment tool) dated 8/10/2024 documented the resident had severe cognitive impairment, could be understood, and sometimes understand others. A facility policy titled Point of Care dated 8/2014 documented the activities of daily living codes used to indicate resident abilities and the required staff responsibilities for each code, including the number of people required to give personal care to residents. A facility policy titled Comprehensive Person-Centered Care Plans dated 10/2000 documented the information derived from the comprehensive assessment enabled the staff to plan care that allowed the resident to reach their highest practicable level of functioning and included, but was not limited to: physical and mental function status, ability to perform activities of daily living including bathing, dressing, grooming, transferring, ambulation, toilet use, eating, and other communication systems. It also documented determining the resident's needs for staff assistance and assistive devices or equipment to maintain or improve functional abilities. Resident #48's Comprehensive Care Plan for Activities of Daily Living initiated on 1/31/2022, and last revised on 7/11/2024, documented Resident #48 required assistance with Activities of Daily Living related to dementia, legal blindness, and decreased mobility. Interventions documented included AM/PM care per policy and refer to Point of Care task record and Kardex (resident care card followed by Certified Nurse Aides) for specific care information. Resident#48 required assistance with meals, documented as a total care; bathing: shower two person assist, provide sponge bath when a full shower cannot be tolerated, and monitor resident's skin with AM/PM care. Resident #48's Comprehensive Care Plan for falls, initiated on 1/31/2022 and last revised on 7/11/2024, documented the resident was at risk for falls secondary to confusion and generalized weakness. The resident fell from bed during personal care on 4/03/2024, which was also documented under Focus of Falls. The goal was to be free from falls daily. Interventions documented include; refer to Plan of Care task record and Kardex (resident care card followed by Certified Nurse Aides) for specific care information, transfer mechanical lift with two-person assist, and physical therapy and/or treatment accordingly. Resident #48 was documented as non-ambulatory and required assistance to transfer to and from bed and the chair. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Resident #48's Certified Nurse Aide accountability and Care Guide dated 3/2024 documented the resident was dependent for two-person assist mechanical lift transfer in and out of bed, two-person assist for showering and bathing, two-person dependent for turning and position to roll both to the left and right, dependent for locomotion on the unit, and dependent for activities of daily living. Nursing notes dated 4/03/2024 at 1:04 PM, documented the resident fell from the bed and was noted to have full range of motion and no viable injuries. The resident's attending physician and the resident's husband were notified of the fall. Nursing note dated 4/03/2024 at 5:39 PM written by Registered Nurse #1 documented the resident had vomited. This was again documented at 6:25 PM. Nursing notes dated 4/03/2024 at 6:35 PM, the Nurse Practitioner #1 was made aware of the resident's continued vomiting and ordered the resident be sent to the hospital for a Computed Tomography scan. Resident #48 Hospitalist History and Physical dated 4/04/2024 at 12:14 AM documented Resident #48 was referred to the emergency room for evaluation of projectile vomiting over the last few hours. Patient rolled out of bed and fell . Chest, abdomen, and pelvis computed tomography (CT) showed evidence of acute nondisplaced right inferior pubic ramus fracture (a break in a group of bones that make up part of the pelvis) and likely nondisplaced right superior ramus fracture (a break in one of the bones that make up the pelvic ring) and nondisplaced fracture of the right sacral ala (a break in the sacral bone). No surgical intervention was required for treatment. The facility investigation dated 4/08/2024, documented on 4/03/2024 Certified Nurse Aide #1 and Certified Nurse Aide #2 put Resident #48 back in bed. Certified Nurse #1 left the room and Certified Nurse #2 continued to give care. Certified Nurse #2 rolled Resident #48 onto their side by themselves, and the resident rolled off the bed and onto the floor. Initially upon assessment of Resident #48, it was documented Resident #48 did not have complaints of pain. It further documented later the same day, the resident complained of pain and was vomiting. The medical team at the facility determined the resident should be sent to the hospital. The investigation determined Certified Nurse Aide #2 failed to follow the plan of care, received a verbal and written warning following the incident, had not had any previous disciplinary reports, and was counseled. The investigation also documented the plan of correction which included mandatory in-service scheduled 4/17/2024 for following the plan of care and a random quality assessment conducted on five residents per week for 3 months then monthly specifically related to turning and repositioning of residents who required assistance with Activities of Daily Living. On 9/10/2024, Resident #48 declined to be interviewed. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 9/11/2024 at 9:38 AM, Certified Nurse Aide #1 stated Director of Nursing #1 spoke to them the next day they worked after the fall on 4/03/2024. Certified Nurse Aide #1 stated it was reinforced that Certified Nurse Aides should check the Point Click Care system to double check tasks like transfer status. Certified Nurse Aide #1 stated they now made sure they checked resident's care requirements before they do anything with residents they do not know. They stated if they observe any staff assisting resident who require two-persons by themselves, they would stop the employee and educate them on where they should look for information about the resident. They stated if a new resident was on the unit and they did not know if the resident was a one or two person assist, they would not make assumptions about the resident's care. They would ask their coworkers and check on the computer for orders and direction. During an interview on 9/11/2024 at 10:16 AM Certified Nurse Aide #2 stated after Resident #48's fall, there was house wide education done regarding resident care. The education provided was an information packet with a post-test and there had also been at least 1 but possibly 2 staff meetings devoted to reinforcing how to care for residents responsibly. The education provided, reinforced to look in Point Click Care every day and ask questions if the Certified Nurse Aide did not know what to do. Certified Nurse Aide #2 stated if a new resident came to the unit, there would be a discussion on their care needs. They stated if they saw a new employee handling a two person assist resident by themselves, they would intervene, help them finish the task, and then show them where to find the information they were lacking. Additionally, Certified Nurse Aide #2 stated they would also tell the charge nurse what had happened regardless of if there was an incident or not. They stated under no circumstances would they try to give a two-person care by themselves. During an interview on 9/11/2024 at 10:20 AM, Licensed Practical Nurse #2 stated after resident's fall, education was given house wide. Required in-service education reminders were sent to staff on Point Click Care. Licensed Practical Nurse #2 stated the fall on 4/03/2024 was considered a major event for the facility. Everyone was educated on how to avoid it. Licensed Practical Nurse #2 stated they were not on the 2nd floor when the fall happened but heard about it within hours of it occurring. Licensed Practical Nurse #2 stated they understood if they did not know what a resident's needs were, they would ask and get help before trying to do anything with residents. During an interview on 9/11/2024 at 10:24 AM, Registered Nurse #1 stated everybody received education after Resident #48's fall. Registered Nurse #1 stated they assessed the resident at the time of the fall on 4/03/2024. The resident did not appear to be injured until later in the day when the resident complained of pain. New staff were educated on reading care plans and Kardex (resident care card followed by Certified Nurse Aide) before giving care. The therapy department met with new staff to teach them how to handle residents based on the level of need they required. Registered Nurse #1 stated all the departments have been involved with reinforcing safety with all the staff. Additionally, Registered Nurse #1 stated Certified Nurse Aide #2 was one of their best Certified Nurse Aides, the fall was an accident. They also stated they felt confident stating the facility did everything it could to make sure the staff had been educated to the best of their abilities to ensure events like this one would not happen again. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 9/12/2024 at 9:15 AM, Director of Nursing #1 stated staff discussed incidents in morning report every morning. Falls were discussed during the Inter Disciplinary Team meetings. Director of Nursing #1 stated they and other nursing staff talked to providers to implement changes for residents that fell . If there were no physical things that could be done to prevent falls, they would look at medical reasons for why residents fell . There was a team approach to keeping the residents safe. When asked if the medical staff were involved in the Quality Assurance of this incident and others, Director of Nursing #1 stated either the medical doctor or the nurse practitioner were involved with all the Quality Assurance meetings.? Based on the following corrective actions taken, there was sufficient evidence the facility corrected the noncompliance and was in substantial compliance for this specific regulatory requirement at the time of this survey: Certified Nurse Aide #2 was suspended for 4 weeks and counseled on turning, positioning, and handling residents requiring assistance with Activities of Daily Living. Completed facility wide education on 4/17/2024 on the following policies: Abuse/Crime Prohibition, Transfers, and Point of Care. A facility assessment of transfer status of all residents, ensuring accuracy of resident records was done on 4/04/2024. Quality and Assessment audit on 10 residents per month for 3 months including all three shifts was completed to make sure the plan of care was being followed dated 4/04/2024 through 9/05/2024. Additionally, a Quality Assurance audit was conducted weekly with 4 staff including all 3 shifts on abuse, neglect, and mistreatment for three months. After 3 months the audit was conducted monthly with 5 staff members for 3 months. Documentation provided dated 4/25/2024 through 8/02/2024. 10 New York Codes, Rules, and Regulations 415.4(b)(1)(i)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48744 Based on observation, record review, and interviews conducted during the recertification survey, the facility did not ensure drugs and biologicals were labeled and stored in accordance with professional standards of practice. Specifically, opened medications had no open and/or expiration dates for 1 (2nd floor medication cart) of 2 medication carts reviewed. This is evidenced by: The facility's Medication Storage and Expiration of Medications policy revised on ,d+[DATE] documented, once any medication or biological product was opened, follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Record the date opened on the medication container when the medication had a shortened expiration date once opened. Record calculated expiration date based on date opened on the medication container. The facility's Medication Administration Procedures policy dated ,d+[DATE] documented to not give a medication if the label was unclear or illegible. During an observation on [DATE] at 12:10 PM, 2nd floor, Cart #1 contained 1 Troujeo Max Solostar insulin pen with no expiration date, 1 Basaglar Kwik Pen insulin pen, and 1 Aspart insulin pen both without open dates or expiration dates. At the time of observation, Licensed Practical Nurse #1 stated the insulin pens must have been new because the cart was checked the previous day. During an interview on [DATE] at 12:10 PM, Licensed Practical Nurse #1 stated that new insulin pens should have had a sticker on them with the date opened and the expiration date written on them. Licensed Practical Nurse #1 stated they would not use an unlabeled pen and go ask the unit manager what to do as they had just started working at the facility. Licensed Practical Nurse #1 stated that they knew not to use the unlabeled pen, but they were unclear how to procure a new one. During an interview on [DATE] at 9:08 AM, Registered Nurse #1 stated the policy regarding labeling and storage of insulin pens was that when pens are opened, they should be labeled with the date opened and the expiration date. Registered Nurse #1 stated that if a staff member were to remove an insulin pen and saw that it was not labeled, the expectation was they would not use the unlabeled pen and procure a new one and label it appropriately. During an interview on [DATE] at 9:15 AM, Director of Nursing #1 stated they spoke to nurses about labeling medications often. They stated if two Registered Nurses were on every evening, one nurse would be tasked to go through all the medication carts weekly and check for expired or mislabeled medications. Director of Nursing #1 stated that this was last done on [DATE]. Additionally, the Director of Nursing #1 stated nurses discuss expiration dates and labeling medications. 10 New York Codes, Rules, and Regulations 415.18(d)