STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335433	A. Building B. Wing	01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
McAuley Residence	1503 Military Road Kenmore, NY 14217

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 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. 43802 Based on observation, interview, and record review conducted during a Standard survey completed 1/8/25, the facility did not store all drugs and biologicals in locked compartments for one (Unit 2 East) of two medication storage rooms. Specifically, 16 medications for 7 residents were left unattended, unsecured on a shelf in the nurse's station. This involved Resident #s 17, 22, 68, 70, 72, 94, and 267. The findings are: The policy titled Ordering and Receiving Medications from the Dispensing Pharmacy dated 11/27/24 documented a licensed nurse receives medications delivered to the facility, immediately delivers the medications to the appropriate secure storage area (medication cart and/or narcotic cabinet) or to another licensed nursing staff member to place in their specific secure storage area on the appropriate unit. During an observation on 1/3/25 at 8:30 AM, the 2 East Nurses Station without a door or means to lock the area, located in the center of the unit near the common area where residents were sitting and no facility staff within visual view revealed the following medications on a shelf: - Resident #17 - 2 unopened bottles (473 milliliters in each) of Chlorhexidine 0.12% mouth rinse. - Resident #22 - 6 unopened bottles (473 milliliters each) of Lactulose (laxative) and 1 unopened bottle (473 milliliters) of Sorbitol 70% (laxative). - Resident #68 - 2 unopened boxes of Ipratropium Bromide 0.5 milligram and Albuterol Sulfate (medications used to open the airways) 3 milligram inhalation (30 vials in each). - Resident #70 - 1 unopened 30-ounce bottle of Citrucel Powder (laxative). - Resident #72 - 2 unopened bottles (355 milliliters in each) of Lanta liquid (antacid). - Resident #94 - 1 unopened box of Refresh tears (eye drops) (2 bottles, 15 milliliters in each). (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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Resident #267 - 1 opened bottle Betadine 10% (antiseptic used to clean minor cuts) solution (approximately 400 milliliters remaining). During an interview on 1/3/25 at 9:16 AM, Licensed Practical Nurse #2 observed the medications sitting on the shelf in the nurse's station and stated they should not be stored there because the nurse's station doesn't have a door and residents could freely enter the area, and there was not always an employee at the nurse's station to monitor the area. They stated they didn't know how long the medications had been on the shelf and they should be either in the medication cart, stored in a cabinet or given to the nursing supervisor if they were discontinued to be returned to the pharmacy. They stated they were not sure why or when they were put there and should be locked in a secure area. During an interview on 1/3/25 at 9:17 AM, Unit Manager Licensed Practical Nurse #4 stated they didn't know overflow medications could not be stored on the self in the nurse's station. They stated there were no doors at the nurse's station and there was not always staff at the nurse's station to prevent residents from wandering into the area to prevent them from having access to the medications. Unit Manager Licensed Practical Nurse #4 identified each medication and stated all the identified medications were recently delivered from the pharmacy, except Resident #267's betadine was discontinued and Resident #94's refresh tears were brought in by the resident and they should have been given to the Nursing Supervisor to be returned. They stated the facility's process for receiving medications from the pharmacy was the Nursing Supervisor received the medications from the pharmacy and they delivered the medication to the appropriate unit and gave the medication to the staff nurse. The staff nurse usually placed the medication into the appropriate medication cart unless there was no room in the drawer, then the medication was placed on the shelf in the nurse's station until there was room in the medication cart. They stated they didn't know how long the identified medications had been stored on the shelf. During an interview on 1/3/25 at 3:29 PM, Licensed Practical Nurse #3 stated they noticed several medication bottles on the shelf a few days ago but did not look at the medication bottle labels therefore were unable to describe the medications. They didn't know why they were on the shelf. They stated the nurse's station didn't have a door and the medications were not in a secure location and should have been placed in the medication cart. They sated they did not question why the medications were on the shelf and did not inform the Nursing Supervisor. They stated they left the medication bottles on the shelf and should not have. During an interview on 1/8/25 at 7:44 AM, Licensed Practical Nurse #5 stated they had been working at this facility for approximately a year and it had been the facility's process to store the overflow medications that could not fit into the medication cart on the shelf in the nurse's station. They stated there was not any doors at the nurse's station, the shelf was an unsecured location and there was not always an employee at the nurse's station to prevent a resident from access to the medications. They stated they didn't know they could not store medications on the shelf in the nurse's station. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/8/25 at 8:02 AM, Nursing Supervisor Registered Nurse #6 stated the process for receiving medications from the pharmacy, was the Nursing Supervisor received the medications from the pharmacy delivery driver and took the medications to the appropriate unit, gave the medications to the staff nurse, and expected the staff nurse to place the medications into a secure location such as a medication cart or locked cabinet. They stated medications left on a shelf in the nurse's station was not a secure location and should not have been stored on the shelf as wandering residents would have access. During an interview on 1/8/25 at 9:46 AM, the Director of Nursing stated medications should always be stored in a locked secure area and not on a shelf at the nurse's station because the nurse's station was not a locked area and there was not always an employee at the nurse's station to prevent a resident access. They stated there was a medication cabinet on the unit and the nurses should either place all medications into the medication cart or place the overflow medications into the locked medication cabinet. They stated they would have expected the nurses to ensure all medications were stored in a locked secure location. During an interview on 1/8/25 at 10:50 AM, Pharmacy Consultant stated they completed medication storage audits of medication carts and medication cabinets and had not looked at the shelves at the nurse's station because it was not a secure medication storage area, and medications should not be stored there. They stated medications stored on the shelves in the nurse's station potentially allowed a resident access to the medications and would consider this to be a safety issue for residents. 10 NYCRR 415.18(e)(1)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43802 Based on observation, interview and record review conducted during the Standard survey completed on 1/8/25, the facility did not provide routine dental services to meet the needs of each resident for one (Resident #101) of one resident reviewed for dental services. Specifically, Resident #101 had complaints of tooth pain while chewing and was not evaluated by the dentist. The finding is: The policy titled Community Based Care: Dental Care effective date 11/18/21 documented that nursing staff will provide oral health care for each resident, assess resident's oral health upon admission, and obtain routine and 24-hour emergency dental care. Within 14 days of admission, the resident will have a comprehensive oral assessment completed by a dentist or dental hygienist unless refused by the resident. A dental service will perform an oral evaluation annually/as needed and make recommendations for an oral hygiene care plan as necessary for changes in oral/dental status. The physician/dentist will be informed of any changes noted in oral status (pain, swelling, redness, loose teeth, broken teeth, rash, etc.) and recorded in the plan of care and in the resident medical record. Resident #101 was admitted with diagnoses including dorsalgia (back pain), hemiplegia affecting the right dominant side (weakness on one side of the body), and hypertension (high blood pressure). The Minimum Data Set (a Resident Assessment Tool) dated 11/11/24 documented the resident was always understood, always understands, had moderate cognitive impairment, had mouth or facial pain, discomfort or difficulty with chewing, and did not receive routine or emergent dental care. The comprehensive care plan dated 11/6/24 documented Resident #101 had oral/dental health problems related to mouth or facial pain, discomfort, or difficulty with chewing. Interventions included to monitor, document, and report as needed an signs/symptoms of oral dental problems needing attention: pain (gums, toothache, palate), teeth missing loose, broken, eroded, decayed, and ulcers in mouth or lesions. On 11/18/24 the resident was alert and oriented to person, place and time and could participate in their plan of care. Interventions included to encourage the resident to make independent decisions and to participate in their plan of care as needed. Review of the nursing admission/readmission assessment dated [DATE] completed by Registered Nurse #4 documented Resident #101 had mouth or facial pain, discomfort, or difficulty with chewing. Review of the nursing Progress Notes dated 11/5/24-1/7/25 lacked documented evidence that Resident #101 was seen by the dentist or dental hygienist or that a medical provider was notified the resident had tooth pain. Review of Nurse Practitioner #1's progress note dated 11/8/24 and 11/11/24 documented Resident #101 had chronic back pain and received acetaminophen (Tylenol). There was no documentation that Nurse Practitioner #1 was notified of Resident #101's complaint of tooth pain. Review of the document titled Dental Services dated 12/5/24 documented Resident #101 consented for dental services at the facility. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Schedule of Residents to be Seen by the Dentist lists dated 11/18/24 and 12/16/24 did not include Resident #101. The Schedule of Residents to be Seen by the Dentist list dated 12/2/24 documented Resident #101 was to be seen by the dentist for the purpose of: New Admit. The Schedule of Residents to be Seen by the Dentist list dated 1/6/25 documented Resident #101 was to be seen by the dentist for the purpose of: New Admit (2nd attempt). The Dental Orders and Progress Notes dated 12/2/24 documented New Admission to sub-acute/short term rehab unit. Patient will be seen for acute issues/as needed/or when converted to long term care. Will follow up 30 days. There was a tooth chart at the top of the progress note form that was blank. Review of the Dental Orders and Progress Notes dated 1/6/25 documented new admission Covid-19 positive. There was a tooth chart at the top of the progress note form that was blank. During an observation and interview on 1/3/25 at 8:31 AM, Resident #101 stated they were supposed to be seen by the dentist at the facility, but they have not seen them. They began rubbing their left lower jaw and stated they had a problem with previous dental work that was done and there was a problem with the caps on their teeth. They stated they were having trouble describing the feeling, but then stated it was like a pain but not a pain; it was a sensitivity, and they felt like a dentist needed to look at it. During an interview on 1/7/25 at 12:02 PM, Licensed Practical Nurse #1 stated not all residents on the subacute unit were seen by the dentist. The residents were asked on admission if they would like to see the dentist; they would sign the consent form or sign that they declined to see the dentist. They stated if a resident had told them that they had mouth or tooth pain, they would look in their mouth and then report the resident's complaints to Registered Nurse #2. During an interview on 1/7/25 at 12:12 PM, Registered Nurse #2 stated when a resident was admitted to the facility, they were asked if they wanted to see the dentist and if they did then they would go on the dental list. They stated they had completed the Dental Services form for consent/declination with Resident #101 on 12/5/24 because they could not find the original consent form that was signed on 11/5/24. The Dental Services consent/declination form was not in the chart, and neither were the Dental Progress Notes. They stated after the consent form was signed, the Health Information Management Clerk #1 was notified and placed the resident on the list to be seen by the dentist. During an interview on 1/7/25 at 12:16 PM, Registered Nurse #3 stated they recalled when Resident #101 was admitted they were complaining about the crowns on their teeth hurting and they wanted to see the dentist. They stated they were unsure how often the dentist came into the facility, but they should have seen Resident #101 the month after they were admitted . (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 1/8/25 at 8:19 AM, the Quality Assurance Regional Manager, from the facility's dental contractor, stated the dentist who went to the facility was unavailable, but they would be able to answer questions regarding the process for residents to be seen by the dentist and some resident specific questions. They stated the dental team went to the facility twice a month to see residents, but if there was a more urgent dental problem, they were able to send a dentist sooner if needed. The Health Information Management Clerk #1 was responsible to give a list of any acute dental issues, the new admissions, and discharged residents. The Quality Assurance Regional Manager stated the facility had informed the contracted dental provider not to see any residents who were on the first floor unless there was an acute dental concern because they were subacute residents. Because of that, when there was a new admission on the subacute unit it would be documented on the Dental Orders and Progress Notes: New Admission to sub-acute/short term rehab unit. Patient will be seen for acute issues/as needed/or when converted to long term care. They stated the dental team wrote this as a reminder for themselves to follow up and see the resident within the next 30-60 days. It did not indicate that the resident was seen by the dentist. They expected the facility to let them know when a resident became long term care or had an acute complaint. Acute complaints included any pain or lost dentures; pain was something that would trump everything and the dentist would make sure to see the resident if they had any complaints of tooth or mouth pain. During a telephone interview on 1/8/25 at 8:53 AM, the Quality Assurance Regional Manager, from the facility's dental contractor, stated the dentist was not aware that Resident #101 had any pain or discomfort and if they were aware, it would have been documented on the Dental Orders and Progress Notes and it would have been documented on the Schedule of Residents to be Seen by the Dentist List at the facility. They stated the dentist was at the facility on 1/6/25 and saw there was a sign on Resident #101's door indicating they had a diagnosis of Covid-19, but the nursing staff at the facility did not tell the dentist that Resident #101 had complained of tooth or mouth pain. They stated if the dentist had known about the pain, they would have examined Resident #101 sooner. During an interview on 1/8/25 at 9:08 AM, Health Information Management Clerk #1 stated they provided the dentist with a list of any residents who were new admissions, discharges, and any residents who needed extra attention. They stated that when a resident had a specific complaint, the nursing staff would send a referral form that lists out the room number, resident name, reason for visit and last exam. After they received the referral, they gave that form to the dentist and they kept it. The referral form was how the dentist was aware of any resident who needed to be seen for any complaints. They didn't keep track of the referral forms or keep a copy of them. During an interview on 1/8/25 at 9:24 AM, Registered Nurse #3 stated when they were completing the Dental Services consent/declination with Resident #101 on their admission day, they told them that their tooth felt tender when they bit down and that it had something to do with their crowns on their teeth. They stated that they put in a referral for speech language pathology and because they signed the consent to be seen by the dentist, the dentist should have seen them. They stated they did not fill out a referral for the dentist only the Dental Services consent/declination form. During an interview on 1/8/25 at 9:33 AM, Registered Nurse #4 stated they completed Resident #101's Admission Assessment and Resident #101 was complaining of pain when they would chew and pain in their teeth. They stated because they were newer to the facility, they reported that information to a more senior nurse and that it might have been Registered Nurse #3. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/8/25 at 9:40 AM, Nurse Practitioner #1 stated they did not recall being informed by either the nursing staff or Resident #101 of any tooth pain or pain while chewing. They expected the staff to notify them or the dentist because as a medical provider they would have completed an assessment and may have been able to treat the problem. It was expected that the dentist should have been notified because they were a specialist in that area, and it could have been a problem that they would have been able to treat. During an interview on 1/8/25 at 10:29 AM, the Director of Nursing stated they expected the residents on the subacute units to be seen by the dentist based on the dentist's availability and if the resident consented to be seen. They stated they were unaware that subacute residents were not seen routinely by the dentist. They stated if Resident #101 was complaining of tooth pain on admission, it was expected that the Nurse Practitioner be notified in the event they were able to treat the problem and if the dentist was needed, it was expected Resident #101 be placed on the dental list with the reason they needed to be seen. Communication to the Nurse Practitioner and dentist were expected because it was for the comfort and care of Resident #101. During an interview on 1/8/25 at 10:52 AM, the Administrator stated they expected the dentist to see the residents on the subacute unit routinely and for the nursing staff to reach out to the Health Information Management Clerks to communicate any dental complaints by residents to the dentist. They stated Resident #101 should have been seen by the dentist because it was their request, and the facility should have followed through. 10 NYCRR 415.17(c)