STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335468	A. Building B. Wing	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beechwood Homes	2235 Millersport Highway Getzville, NY 14068

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36415 Based on observation, interview, and record review conducted during the Standard survey completed on 11/8/23, the facility did not ensure that each resident received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan for two (Resident #6 and #66) of seven residents reviewed for quality of care related to accidents and positioning. Specifically, there was lack of assessments and monitoring for Resident #6 after they spilled coffee on themselves, and Resident #66 was not provided with leg rests while they were in their wheelchair. Additionally, while sitting in their wheelchair, Resident #66's feet were hanging down and were approximately six inches from touching the floor for extended periods of time. The findings are: The policy and procedure (P&P) titled Positioning - Chair/Bed dated 8/29/2018 documented adaptations to the wheelchair are provided as needed and noted in the electronic medical record (EMR). Additionally, the P&P documented, if the resident's condition and need for wheelchair changes, the rehabilitation department is notified, and an evaluation will be completed. Appropriate changes will be made and documented on the resident Kardex (a guide used by staff to provide care)/care plan. Follow up nursing education will be completed based on resident need and condition to maintain safety and optimal functional level. The P&P titled Resident Accident and Incident Reporting dated 1/24/22 documented all resident accidents and incidents were reported to ensure that the residents receive appropriate intervention and care plan updates. The nurse documents the occurrence and necessary treatment in the nurse's notes. 1. Resident #66 was admitted with diagnoses dementia, osteoarthritis (a type of arthritis that causes pain and stiffness in joints), and anxiety. The Minimum Data Set (MDS- a resident assessment tool) dated 10/19/2023 documented Resident #66 was rarely understood, rarely understands and was severely cognitively impaired. The Comprehensive Care Plan (CCP) dated 10/11/2023 documented Resident #66 was at risk for alteration in positioning related to diagnosis of Alzheimer's dementia. Interventions included: for transport and meals only: high back wheelchair (a wheelchair with a higher back than a standard wheelchair) with anti-thrust cushion (a type of cushion with a higher front surface and lower back surface to prevent sliding) with gel overlay on top and bilateral leg rests. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Kardex (guide used by staff to provide care) dated 11/6/23 documented Resident #66 required for transport and meals only: high back wheelchair with anti-thrust cushion with gel overlay on top and bilateral leg rests. During a continuous observation on 11/6/23 from 9:13 AM until 12:14 PM, Resident #66 was sitting in their wheelchair with their feet dangling unsupported. Resident #66 was sitting in their wheelchair holding on to a table and rocking back and forth. Resident #66's wheelchair did not have leg/footrests and Resident #66's feet were unable to touch the floor. At 9:35 AM, Certified Nursing Assistant (CNA) #1 wheeled Resident #66 to the lounge area. Resident #66 sat in their wheelchair in the lounge area; their feet dangled, unsupported and did not touch the floor (approximately six inches from the floor). Resident #66 continued to rock in their wheelchair. At 12:00 PM, Resident #66 was wheeled back to the dining room. Staff did not attempt to put leg rests/foot support on Resident #66's wheelchair throughout the observation. During a continuous observation on 11/7/23 from 8:00 AM through 10:31 AM, Resident #66 was sitting in their wheelchair with their feet dangling unsupported. Resident #66 was sitting in their wheelchair in the dining room and occasionally rocking back and forth. Resident #66's feet were unable to reach the floor and were approximately six inches from the floor. At times, Resident #66 would move their feet and point their toes downwards. At 10:31 AM, CNA #1 wheeled Resident #66 to the lounge. CNA #1 and CNA #2 transferred Resident #66 to a reclining chair in the lounge area. CNA #1 elevated the leg rests of the reclining chair. Resident #66 placed their feet flat on the leg rest of the reclining chair. During an interview on 11/7/23 at 12:45 PM, CNA #2 stated they checked the Kardex at least once a week because the Kardex could change. CNA #2 stated Resident #66 was dependent on the staff for care. CNA #2 stated they were not sure if Resident #66's feet could touch the floor while they were seated in their wheelchair because Resident #66 was fidgety. CNA #2 stated they did not know when the last time Resident #66 had leg rests on their wheelchair and they could have been misplaced. During an interview on 11/7/23 at 12:52 PM, CNA #1 stated Resident #66's feet were able to touch the floor when Resident #66 was in their wheelchair. CNA #1 stated Resident #66 was not supposed to have leg rests on their wheelchair. CNA #1 stated they checked the Kardex every morning. During an observation on 11/7/23 at 1:01 PM, CNA #1 and CNA #2 transferred Resident #66 into their wheelchair. Resident #66's wheelchair had a cushion in it that had a dip towards the back and was raised approximately 2-3 in the front. When Resident #66 sat in their chair, their feet did not touch the floor and were approximately six inches from the floor. CNA #1 and CNA #2 stated Resident #66's feet did not touch the floor. During an interview on 11/7/23 at 1:03 PM, Occupational Therapist (OT) #1 stated, Oh Resident #66 has foot pedals. OT #1 stated, usually Resident #66 was only in their wheelchair for meals and would have pedals on the wheelchair at that time. OT #1 stated Resident #66 would have the potential for foot drop if they were in the wheelchair for an extended time without the pedals. OT #1 stated Resident #66 was very active so they were not sure how long it would take for foot drop to develop. OT #1 stated they were going to go get new foot pedals for Resident #66. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/7/23 at 1:06 PM, Registered Nurse (RN) #1 stated they expected the CNAs to check the Kardex every day for new recommendations and they should follow the recommendations on the Kardex. RN #1 stated it would not be comfortable for Resident #66 to sit for a long period of time without their feet touching the floor or foot pedals. During an interview on 11/8/23 at 10:40 AM, OT #2 stated residents were screened at least four times a year and with any referrals from nursing. OT #2 stated Occupational Therapy was responsible for wheelchair positioning. OT #2 stated Resident #66 had a lot of movement that they considered sensory movement. OT #2 stated an antithrust cushion was added to Resident #66's wheelchair on 10/6/23 to prevent Resident #66 from sliding and Resident #66 had better positioning with the antithrust cushion in their wheelchair. OT #2 stated there should have been foot pedals on Resident #66's wheelchair for foot support. OT #2 stated Resident #66 could potentially have discomfort without the foot pedals. During an interview on 11/8/23 at 10:47 AM, OT #1 stated they usually see Resident #66 during meals, and they have never checked under the dining room table to see if Resident #66 had their foot pedals on the wheelchair. OT #1 stated therapy made the recommendations, and it was expected that nursing follows the recommendations. OT #1 stated if it was noticed the recommendations were not followed, then they would intervene. OT #1 stated Resident #66 could not verbalize when they had pain, but in the past, they either pointed or tapped where they had pain. OT #1 stated, We would hope Resident #66 would point or something to tell us if they were hurting. OT #1 stated they would encourage the use of foot pedals when in the wheelchair for overall security, to keep the feet from dragging and to promote alignment and upright positioning. During a telephone interview on 11/8/23 at 11:22 AM, Hospice RN #2 stated they were concerned about the length of time Resident #66 sat in their wheelchair with their feet hanging down without any support. RN #2 stated they considered that a positioning problem and there was a possibility that Resident #66 had discomfort. During an interview on 11/8/23 at 12:05 PM, the Director of Nursing (DON) stated if it was care planned, it was expected the staff put leg rests on the wheelchair. DON stated the feet should be supported for comfort and to prevent dependent edema. DON stated the CNAs were responsible to look at the Kardex every day. DON stated the nurses on the unit should make sure the CNAs were looking at the Kardex and following it. 2. Resident #6 had diagnoses including depression, muscle weakness, and post-polio syndrome (a group of potentially disabling symptoms that appear decades after a polio infection). The MDS dated [DATE] documented the Resident #6 had moderate cognitive impairment. The Kardex dated 11/8/23 documented Resident #6 needed set up assistance for eating. The CCP dated 9/27/23 documented Resident #6 was at risk for alteration in feeding related to their diagnosis of post-polio syndrome. Interventions included mugs for soups and set up assistance for eating. During a lunch observation on 11/2/23 at 12:35 PM, Resident #6 was seated at a table in the unit dining area and spilled coffee on their lap. The lid on the disposable cup was not secured. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the nursing Progress Notes dated 11/2/23 revealed there was no assessment or monitoring of the resident's skin. Review of the Buffalo House report sheets dated 11/2/23-11/3/23 revealed there was no documentation that Resident #6 was assessed or monitored after the coffee spill. During an interview on 11/7/23 at 9:44 AM, CNA #3 stated they remembered Resident #6 spilled coffee on themselves last Thursday (11/2). CNA #3 stated they saw the resident patting themselves off, so they went over to the resident and noticed they had liquid on their clothing. CNA #3 stated the lid for the coffee cup wasn't on all the way and the resident must have spilled it on themselves. CNA #3 stated they reported it to the nurse, they weren't sure their name but thought it was the nurse working today (Licensed Practical Nurse (LPN) #1). During an interview on 11/7/23 at 12:09 PM, LPN #1 stated they left early that day (11/2/23) and didn't recall Resident #6 spilling their coffee on themselves and that nobody reported anything to them. During an interview on 11/7/23 at 12:07 PM, LPN #2 stated they worked on 11/2/23 and at lunch time they stayed on their side during lunch and did not know anything about a resident that spilled coffee on themselves. During an interview on 11/7/23 at 12:51 PM, Registered Nurse (RN) Unit Manager (UM) #3 stated if a resident spilled coffee on themselves there would usually be a note about the skin and to monitor the resident. During a telephone interview on 11/8/23 at 8:56 AM, LPN #1 stated they would expect the CNAs to tell them if a resident spilled coffee on themselves and they would have checked the resident, documented it, and told the supervisor. LPN #1 stated they were not in the dining area on 11/2/23. During an interview on 11/8/23 at 11:04 AM, the Director of Nursing (DON) stated they would consider this an accident and the staff should have told the nurse. There was a miscommunication between the CNAs where each thought the other told the nurse about the spill. The resident should have been assessed for redness and put on report to monitor for any delayed injury or if blister formed. The DON stated for hot drink spills they would fill out and incident report as there was potential for a burn. The DON stated when they found out about this yesterday, they had Occupational Therapy (OT) look at the resident which was routine for any spill during meal. The DON stated the nurse should have been in the dining room during meals to monitor the residents. During a telephone interview on 11/8/23 at 1:24 PM, CNA #4 stated when they were passing lunch trays (on 11/2/23), CNA #3 asked Resident #6 if they were ok, so CNA #4 went to see what happened. CNA #4 stated they didn't tell the nurse because they thought CNA #3 told the nurse. CNA #4 stated they didn't know if the nurse was on the floor when this happened and it was something that normally was reported to the nurse. 10NYCRR 415.12