STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335742	A. Building B. Wing	07/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Niagara Rehabilitation and Nursing Center	822 Cedar Avenue Niagara Falls, NY 14301

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43785 Based on observation, interview, and record review conducted during a Complaint investigation (NY00344362 and NY00345636) conducted during a Standard survey completed on 7/15/24, the facility did not ensure that housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior for three (Second, Third, and Fourth Floors) of three resident units and one of one main dining room. Specifically, multiple windows had dried leaves, dead insects, spider webs white and grey colored debris on the inside and outside on windowpanes and brown/black debris on the window sash in between the panes of glass; privacy curtains with reddish brown stains; tan stains and cracks on the ceilings; water dripping from the ceiling into a resident's room on the Third Floor; bathroom lights were dim and not in proper working order; resident room walls were in disrepair; and window shades had brownish reddish stains. The findings are: The policy and procedure titled Cleaning and Disinfecting of Environmental Surfaces dated 6/09 documented that housekeeping surfaces such as floors will be cleaned on a regular basis, when spills occur, or when visibly soiled. The policy documented that walls, blinds, and curtains in resident areas would be cleaned when surfaces were visibly soiled or contaminated. An undated facility document titled Housekeeping Cleaning Check List documented that staff were to wipe tables and windows in the dining room. An undated facility document titled Housekeeping Deep Cleaning Check List documented that resident windows were to be cleaned with Blue (a window cleaner) and the window seal to be cleaned with [NAME] (a multi surface disinfectant cleaner). The facility job description for a Housekeeper dated 4/23/12 documented that the responsibilities of a Housekeeper include cleaning a resident's room, other interior and exterior facility areas, and assisting in maintaining a clean and attractive environment for residents. The facility job description for Maintenance Assistant dated 4/23/12 documented that the responsibilities of a Maintenance Assistant include assisting in maintaining the physical plant, grounds, equipment, and assists in coordination of repairs. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on the Third Floor on 7/8/24 at 12:56 PM, revealed in Resident room [ROOM NUMBER] the light over the sink did not function properly. The light was dim, and the sink area was not fully illuminated. Observation on 7/11/24 at 8:03 AM revealed the light over the sink area was not fully illuminated. During this observation, an interview with the Maintenance Assistant stated that the light needed to be fixed and they were not aware of the issue. Observation on the Third Floor on 7/8/24 at 3:14 PM, revealed Resident room [ROOM NUMBER] walls were in disrepair with one hole measuring four inches by three inches deep with exposed yellow insulation, a three-inch-deep gouge into the wall and another hole measuring two feet by six and a half inches and three inches deep with exposed yellow insulation. The resident stated that the staff knew about the wall for a month, and it bothered them. Observation on the Fourth Floor on 7/9/24 at 11:55 AM, revealed the privacy curtain in the center of Resident room [ROOM NUMBER] had brown and reddish-brown stains throughout, and each stain was approximately one inch in diameter. At the time of the observation, the Maintenance Director stated the curtain needed to be taken down and washed. Observation on the Second Floor on 7/9/24 at 12:22 PM, revealed the textured solid ceiling of Resident room [ROOM NUMBER] had water stains that were various shades of tan in an area that measured approximately two feet long by two feet wide, above the sink. The area appeared cracked, patched, and re-cracked. The Maintenance Director stated it looked as if it was an old water leak. Observation on the Second Floor on 7/9/24 at 12:25 PM, revealed the textured solid ceiling of Resident room [ROOM NUMBER] had five water stains that were various shades of tan. The Maintenance Director stated it looked as if it was an old water leak. Observations on the Third Floor on 7/11/24 from 8:00 AM to 8:15 AM, revealed in Resident rooms [ROOM NUMBER], multiple windows had grey and white debris on the inside and outside of the windowpanes; multiple spider webs with dead insects on the webs; dried leaves, dead insects, brown and black debris. During these observations, the residents who resided in the rooms stated the windows were dirty and needed to be cleaned. The residents also stated the windows had been dirty for a long period of time and that the window shade was also dirty, and they would like it cleaned. Observation on the Third Floor on 7/11/24 at 8:20 AM, revealed in Resident room [ROOM NUMBER] the window had spider webs with dead insects. During this observation, the resident stated that the window didn't bother them anymore because they got used to it. Observation on the Third Floor on 7/11/24 at 8:30 AM, revealed Resident room [ROOM NUMBER] had a six-inch spider web from one wall to another outside the bathroom door, six areas on the ceiling with tan brownish colored stains, windowpanes with white and grey debris on the inside and outside with brown debris on the window sash, and floor tiles that were in disrepair with one floor tile off the floor and black debris on top of the tiles. During this observation, the resident stated that the windows had not been cleaned since they have stayed in that room for two years. The resident pointed to the ceilings at the tan brownish colored stains and stated it looked like they painted a smiley face there. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/11/24 at 8:52 AM with Housekeeper #1, they stated that room [ROOM NUMBER]'s floor was dirty and needed to be cleaned. Housekeeper #1 also stated that they could clean the inside of the windows, that spider webs should not be there, and they were not sure who was responsible for cleaning the window shades. Observation on the Third Floor on 7/11/24 at 9:55 AM, revealed Resident room [ROOM NUMBER] had water dripping from the ceiling onto the windowsill. During this observation, the Housekeeping Director stated that the air conditioner on the Fourth floor was leaking and leaked into room [ROOM NUMBER]. The Housekeeping Director stated that this should not be happening, and it should be fixed. During an interview on 7/11/24 at 9:55 AM with the Housekeeping Director, they stated that the floors should be cleaned on a regular basis. They stated that window cleaning contractors had come to the facility for estimates, but no one was hired. Observations of the main dining room on 7/11/24 at 12:31 PM, revealed multiple windows with grey and white debris on the inside and outside of the panes of windows; multiple spider webs with dead insects on the webs; dried leaves, dead insects, brown and black debris. Observations of the main dining room on 7/12/24 at 8:23 AM, revealed multiple windows with grey and white debris on the inside and outside of the panes of windows; multiple spider webs with dead insects on the webs; dried leaves, dead insects, brown and black debris. During this observation, Resident #17 stated that there's spider webs all over the windows in the dining room and they needed to be cleaned. During an interview on 7/12/24 at 11:02 AM with Housekeeper #2, they stated that sometimes they cleaned the windows, and the windows were dirty. Housekeeper #2 stated that they were not sure who was responsible for cleaning the windows. During an interview on 7/12/24 at 12:40 PM with the Maintenance Director, they stated that Maintenance and Housekeeping were responsible for cleaning and maintaining the resident rooms. The Maintenance Director stated that the facility could clean the inside of the window, but the outside of the windows had to be cleaned by a window cleaning contractor due to safety reasons. The Maintenance Director stated that window cleaning contractors were contacted for estimates by the former Housekeeping Director approximately two or three years ago. The Maintenance Director stated that the air conditioners will leak due to condensation from staff opening windows while running the air conditioner. They stated that they needed to do an education with staff about keeping windows closed when running the air conditioners. The Maintenance Director stated that staff can contact them through the computer-based system to report any maintenance issues. They also stated that staff can also have them paged for any maintenance issues. During an interview on 7/12/24 at 1:16 PM with the Administrator, they stated that they expected the staff to clean the resident rooms. They also stated that they expected staff to report any maintenance issues to the maintenance department. 10 NYCRR 415.5(h)(2)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43785 Based on interview and record review conducted during a Standard Survey completed on 7/15/24, the facility did not ensure that all alleged violations including abuse, neglect, exploitation, or mistreatment were reported immediately, but not later than two hours after the allegation was made to the facility's Administrator for two (Resident #26 and Resident #107) of nine residents reviewed. Specifically, Resident #26 was found to have an injury of unknown origin and Resident #107 had a resident to staff altercation which were not reported to the administrator immediately. The findings are: The policy and procedure titled Abuse Prevention Program revised December 2016 documented the facility develops and implements policies and procedures to aid the facility in preventing abuse, neglect, or mistreatment of residents. As part of the resident abuse prevention, the administration will require staff training/orientation programs that include such topics as abuse prevention, identification and reporting of abuse, stress management, and handling verbally or physically aggressive resident behavior. Identify and assess all possible incident of abuse and investigate and report any allegations of abuse within timeframes as required by federal requirements. The policy and procedure titled Accidents and Incidents - Investigating and Reporting revised July 2017 documented all accidents and incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the Administrator. The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident. The policy and procedure titled Abuse Investigating and Reporting revised July 2017 documented all reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state, and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported. An alleged violation of abuse, neglect, exploitation, or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than two hours if the alleged violation involves abuse or resulted in serious bodily injury or 24 hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury. 1. Resident #26 had diagnoses that include vascular dementia, rheumatoid arthritis, and post-traumatic stress disorder. The minimum data set (a resident assessment tool) dated 12/23/23 documented the resident usually understood, usually understands and was severely cognitively impaired. The Comprehensive Care Plan dated 11/16/18, documented that Resident #26 was at risk for falls and had a history of falls related to dementia with interventions added on 2/13/24 to include resident is known to lower self to floor and get themself back up into bed and to keep environment safe and free of clutter. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 2603 Injury of dated 2/12/24 at 9:45 AM prepared by the Director of Nursing revealed writer was notified in morning report that Resident #26 had a bruise on their forehead. Writer assessed Resident #26's injuries and noted a bruise on the left side of their forehead, elbow, and lateral hands. A statement obtained on 2/12/24 from Certified Nursing Assistant #9 documented they worked on the 11th of February and noticed Resident #26 had a bruise on the side of the head. Certified Nurse Aide #9 reported it to Licensed Practical Nurse #6. A statement from Licensed Practical Nurse #5 on 2/12/24 documented they were informed by Certified Nursing Assistant #6 that morning (2/12/24) that there was a bump and bruise on the left side of Resident #26's head. The Certified Nursing Assistant also found more bruising around the left temple, left wrist, and elbow. A statement obtained from Licensed Practical Nurse #6 on 2/16/24 revealed Licensed Practical Nurse #6 was told by Certified Nursing Assistant #9 sometime on the elevator that Resident #26 had a bruise on the side of their head that they had not noticed the day before. When Licensed Practical Nurse #6 got back to the unit they checked over Resident #26 and then reported it to the next shift coming on and put them on the report sheet. Review of facility staffing sheet titled Niagara Rehabilitation and Nursing Center dated 2/11/24 documented Licensed Practical Nurse #6 worked 7 AM to 8 PM, Certified Nursing Assistant #9 worked 7 AM to 3 PM, and Licensed Practical Nurse #5 worked 11 PM to 7 AM. Facility staffing sheet dated 2/12/24 documented Certified Nursing Assistant #9 worked 7 AM to 3 PM. Licensed Practical Nurse #6 was not on the scheduled for 2/12/24. During a telephone interview on 7/11/24 at 10:19 AM Licensed Practical Nurse #6 stated they were told about the bruise on Resident #26's head in the elevator by Certified Nursing Assistant #9. They stated they reported it to Licensed Practical Nurse #5 the next morning. During an interview on 7/11/24 at 10:39 AM Licensed Practical Nurse #5 stated they were informed about the bruise the next morning (2/12/24) by Certified Nursing Assistant #9 and then reported it to the Director of Nursing. An accident and investigation were then completed. During an interview on 7/11/24 at 10:59 AM Certified Nursing Assistant #9 stated they could not recall who they reported the bruise to but knows they reported it right away. Certified Nursing Assistant #9 stated it is important to report anything right away so that they can find out what happened. During an interview on 7/11/24 at 11:48 AM the Director of Nursing stated the incident involving Resident #26 was reported to them on the morning of 2/12/24 by Licensed Practical Nurse #5. They did not know who reported it to Licensed Practical Nurse #5. The Director of Nursing stated they believed Licensed Practical Nurse #5 was made aware of the finding when they came in to work on 2/12/24. The Director of Nursing stated Licensed Practical Nurse #6 should have reported the finding to the supervisor on duty on 2/11/24 right after they were made aware of it. It is important to report findings right away so that they can be proactive and prevent circumstances from happening. The Director of Nursing stated their expectations would be that an assessment would have been done right away, and it should have been reported right away. During an interview on 7/12/24 at 11:48 AM the Administrator stated that they expect any findings to be reported right away to the Director of Nursing or someone in Administration so that an investigation can be started right away. The Administrator stated that if there was an allegation or accusation of abuse made, they would expect a thorough investigation to be completed right away to ensure compliance. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #107 had diagnoses which included chronic obstructive pulmonary disease, anxiety disorder, and major depressive disorder. The Minimum Data Set, dated dated dated [DATE] documented that the resident understood, understands, and was cognitively intact. The Comprehensive Care Plan dated 8/15/23 documented that Resident #107 had a focus added on 11/14/23 to say the residents' strengths were that they had no cognitive deficits with an intervention to provide a safe and structured environment and enhance or support short term memory using calendars and verbal cues. During an interview on 7/9/24 at 8:34 AM Resident #107 stated there was an incident that occurred recently that they reported. Certified Nursing Assistant #16, while working on the overnight shift, refused to give them another soda and during the argument about the soda Certified Nursing Assistant #16 grabbed Resident #107's wrist. Resident #107 stated they grabbed Certified Nursing Assistant #16's wrist back and then they let go. Resident #107 stated there was no mark left on their wrist This incident was also witnessed by Resident #107s' roommate, Resident #114. Resident #114 was in the room during this interview and confirmed that Certified Nursing Assistant #16 grabbed Resident #107's wrist during this argument. Resident #114 stated they wanted to jump out of the bed and beat the Certified Nursing Assistant's explicit word stated. Resident #107 stated they reported the incident to Licensed Practical Nurse #5 the next morning. During an interview on 7/11/24 at 8:59 AM Licensed Practical Nurse #5 stated they were informed about the incident involving Resident #107 and the soda about a month ago. They were told Certified Nursing Assistant #16 would not give Resident #107 a soda because they pee a lot. Resident #107 did report to them that Certified Nursing Assistant #16 grabbed their wrist during this incident. Licensed Practical Nurse #5 stated they forgot to report that part when they reported the incident to the Director of Nursing. Licensed Practical Nurse #5 stated they did an assessment of Resident #107 directly after the incident was reported to them and saw no redness or bruising and the resident did not complain of any pain at the time. Licensed Practical Nurse #5 stated Certified Nursing Assistant #16 did not deny the incident occurred but said it happened differently than how Resident #107 reported it. Certified Nursing Assistant #16 wrote a statement regarding the incident and was told they could not take care of Resident #107. During a telephone interview on 7/11/24 at 9:22 AM Certified Nursing Assistant #16 stated they remembered the incident. They were caring for Resident #107 on the overnight shift and the resident had requested another soda after having two bottles that night already. Certified Nursing Assistant #16 stated they told Resident #107 they could not have another bottle because they were going to be getting their breakfast soon. Certified Nursing Assistant #16 stated they did not grab Resident #107's wrist, only refused to give them more soda. They stated they were given a write up to sign and was not allowed to take care of Resident #107 for a couple days. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/11/24 at 11:40 AM The Director of Nursing stated they were made aware of the incident that occurred on 6/20/24 by Licensed Practical Nurse #5 that morning. The Director of Nursing stated they were told the incident involved Certified Nursing Assistant #16 refusing to give Resident #107 a soda. The Director of Nursing stated Licensed Practical Nurse #5 did not report to them that there was a physical component involved in the incident so there was no investigation started. Certified Nursing Assistant #16 was given a write up for being discourteous and unprofessional. The Director of Nursing stated they would expect to be made aware immediately of any altercation or possible altercation/accusation, or as soon as staff is made aware. The Director of Nursing stated it is important to report these types of things to administration so that corrective actions can be made to prevent reoccurrence and to get notification out to the proper entities. The Director of Nursing stated any type of physical altercation or accusation of physical altercation should be submitted within 2 hours to the state after it's reported to staff. During an interview on 7/12/24 at 11:48 AM the Administrator stated that if there was an allegation or accusation of abuse made, they would expect a thorough investigation to be completed and the employee be suspended pending investigation to ensure compliance. The Administrator stated this incident should have been reported to the Director of Nursing and then the Administrator so that an investigation could have occurred. On 7/11/24 all accident and incidents involving Resident #107 were requested from the Director of Quality Assurance. The Director of Quality Assurance was unable to produce an accident or incident form and/or investigation for this incident that occurred on 6/20/24. 10 NYCRR 415.4(b)(4)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 43785 Based on interview and record review conducted during the Standard survey completed on 7/15/24, the facility did not ensure that services provided by the facility as outlined in the comprehensive care plan, met professional standards of quality for one of (Resident #23) of six residents reviewed. Specifically, medications were known to be transcribed erroneously which resulted in duplicate orders. The medication orders were not clarified or reported to a medical provider. In addition, the nursing staff signed both of the medications as being administered on multiple occasions. The finding is: The policy and procedure titled Medication and Treatment Orders with revised date July 2016, documented that orders for medications and treatments would be consistent with principles of safe and effective order writing. Resident #23 had diagnoses that included end stage renal disease, dependence of renal dialysis and hypertension. The Minimum Data Set (a resident assessment tool) dated 6/13/24 documented the resident was understood, understands, and was cognitively intact. Review of the Comprehensive Care Plan with date initiated 6/12/24, documented that Resident #23 had hypertension. Interventions include to give antihypertensive medications as ordered and obtain blood pressure readings. Review of the Order Summary report dated 7/15/24 documented that Resident #23 had an order for: Isosorbide mononitrate extended release 30 milligrams in the morning for hypertension with order date of 5/30/24. -Additionally, there was a second order for Isosorbide mononitrate extended release 30 milligrams in the morning for hypertension with order date of 5/30/24. labetalol HCL 200 milligrams every 12 hours for hypertension -Additionally, there was second order for labetalol HCL 200 milligrams every morning and at bedtime for hypertension with order date of 5/30/24. The medication administration records from 5/30/24-7/11/24 documented that Resident #23 had the following orders: -Isosorbide mononitrate extended release 30 milligrams daily at 7:00 AM -Isosorbide mononitrate extended release 30 milligrams daily at 9:00 AM -labetalol 200 milligrams every 12 hours at 9:00 AM and 9:00 PM -labetalol 200 milligrams in the morning and at bedtime at 7:00 AM and 7:00 PM (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nursing staff erroneously signed off both medications as being administered for a total of 99 doses. Review of Interdisciplinary Notes from 5/29/24 through 7/15/24 revealed there was no documented evidence the medical provider was notified of duplicate orders and need for clarification for isosorbide mononitrate and labetalol HCL. During an interviews on 7/11/24 between 3:20 PM and 3:42 PM, Licensed Practical Nurse #8, Licensed Practical Nurse #9 Resident Care Coordinator, and Licensed Practical Nurse #1 all stated they knew Resident #23 had two orders (duplicative) for the isosorbide and labetalol. They stated they did not notify anyone to clarify the medication orders but should have. They also stated they may have signed for the administration of the second doses, but they did not actually administer the second doses. Additional in person and telephone interviews: 7/12/24 at 1:29 PM, Licensed Practical Nurse #10 stated they did not notify the medical provider or supervisor for clarification of Resident #23 duplicate orders but should have. They stated that there was a potential of nursing staff to administer two doses of isosorbide and labetalol but everyone should know it was a duplicate order. 7/15/24 at 3:03 PM, Licensed Practical Nurse #6 stated double orders on the medication administration record had happened before because there must be a glitch in the system. They stated they did not notify the supervisor or medical provider for order clarification but should have. Licensed Practical Nurse #6 stated there could be a potential for other nurses to administer double doses but hoped they would know it was just glitch in the system. 7/15/24 at 10:01 AM, Licensed Practical Nurse #12 Nursing Supervisor stated they did not notify the medical provider for clarification of the duplicative medication orders but should have. Licensed Practical Nurse #12 stated no residents should have orders like that and the order should contain blood pressure parameters. 7/15/24 at 10:49 AM, Licensed Practical Nurse #2 stated they did not administer two doses of isosorbide and labetalol. They stated that residents have duplicate orders at times, and when that happens, they only administer one dose. Licensed Practical Nurse #2 stated they did not notify the medical provider for clarification. They stated that duplicate orders could cause confusion for other nursing staff and if they were to administer two doses it could result in Resident #23's blood pressure going too low. During a telephone interview on 7/15/24 at 10:18 AM, Consultant Pharmacist #2 stated on 5/31/24 and 6/18/24 the Consultant Pharmacist #1 sent the Director of Nursing Nursing Referral Findings notification via email about Resident #23 duplicate orders for isosorbide and labetalol. Consultant Pharmacist #2 stated it was a clerical error in transcription of the orders. During a telephone interview on 7/15/24 at 11:38 AM, Medical Provider #1 stated they were never notified of the transcription error/duplicative orders for Resident #23 and should have been as soon as the nursing staff were aware of the error. Medical Provider #1 stated there was a potential for Resident #23 to receive double doses of the medications. They further stated there should have been a double check so these types of errors would not occur. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/15/24 at 12:01 PM, the Director of Nursing stated they could not locate the Nursing Referral Findings that Consultant Pharmacist #1 sent on 5/31/24 and 6/18/24 to discontinue Resident #23's duplicate orders for isosorbide and labetalol. The Director of Nursing stated that they had entered the initial order for Resident #23's labetalol and isosorbide on admission. Later that day, Licensed Practical Nurse #12 re-entered another order for labetalol and isosorbide. The staff nurses should have notified them or the nursing supervisor as soon as the double order was noted. The Director of Nursing stated that the nurses could have administered a double dose where the adverse effects to Resident #23 would not be good. During an interview on 7/15/24 at 12:14 PM, the Director of Quality stated Resident #23's labetalol and isosorbide orders were transcribed twice upon admission. They stated their expectation was that the medical provider would be notified for order verification. The Director of Quality stated that there was a potential for Resident #23 to be overdosed causing negative health outcomes and low blood pressures. 10 NYCRR 415.11(c)(3)(i)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Niagara Rehabilitation and Nursing Center	822 Cedar Avenue Niagara Falls, NY 14301

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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. 43785 Based on observation, interview, and record review conducted during a Standard survey completed on 7/15/24, the facility did not ensure that a resident who was unable to carry out activities of daily living received the necessary services to maintain good grooming and personal hygiene for one (Resident #9) of six residents reviewed. Specifically, Resident #9 who was dependent on staff for hygiene was not assisted with removing unwanted facial hair. The finding is: The policy and procedure titled Activities of Daily Living (ADL) dated March 2018 documented appropriate care and services will be provided for residents who are unable to carry out activities of daily living independently, with the consent of the resident and in accordance with the plan of care. Resident #9 had diagnoses that included metabolic encephalopathy (disease of the brain), diabetes, and schizoaffective disorder (a mental health condition that changes a person's thoughts, mood, and behavior). The Minimum Data Set (MDS - a resident assessment tool) dated 6/26/24 documented Resident #9 was understood, understands, and had moderate cognitive impairment. The Minimum Data Set documented Resident #9 required set-up/clean up assistance for personal hygiene and had no behaviors to include refusals of care. The comprehensive care plan with a revision date of 6/23/22, documented Resident #9 had an Activity of Daily Living self-care performance deficit. Interventions included limited assistance of one staff member for personal hygiene. The Visual/Bedside Kardex Report (a guide for staff to provide care) dated 7/15/24 documented Resident #9 required limited assist of one staff member for personal hygiene. The Treatment Administration Record dated July 2024, documented that weekly skin monitoring one time a day every Monday was completed on 7/1/24 and 7/8/24. Review of Nursing Progress Notes dated 7/1/24 through 7/15/24 revealed there was no documented evidence that Resident #9 refused to be shaved. During an observation and interview on 7/9/24 at 9:06 AM, Resident #9 had multiple dark grey and white facial hairs (0.25 - 0.5 inches) on their upper lip and multiple long white hairs 0.5 - 1 inch present on chin and neck. Resident #9 stated they did not like the facial hair and had asked staff for razors in the past. During intermittent observations made on 7/10/24 at 10:31 AM, 7/11/24 at 11:43 AM, and 7/12/24 at 9:51 AM Resident #9 continued to have long facial hairs to their upper lip, chin, and neck. During an observation and interview on 7/12/24 at 9:51 AM, Resident #9 stated they had a bed bath and was not offered or provided with assist to remove their unwanted facial hair. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During further observation on 7/12/24 at 9:59 AM, Resident #9 had their call light on, and a staff member answered the call light. Resident #9 was observed asking the staff member for a razor and stated they wanted to shave. During an observation of morning care on 7/15/24 at 8:54 AM, Resident #9 stated to Certified Nurse Aide #7 and Certified Nurse Aide #18 that they used to shave every two days, the hair on their upper lip would grow fast, and that they did not like having facial hair. During the observation Resident #9 verbalized to Certified Nurse Aide #7 that they needed their facial hair removed. Certified Nurse Aide #7 gathered the soiled linen bags and left the room without offering or providing assist to remove Resident #9's facial hair. Certified Nurse Aide #7 completed Resident # 9's morning care and left their room. During an interview on 7/15/24 at 9:48 AM, Certified Nurse Aide #7 stated they had completed morning care with Resident #9. Certified Nurse Aide #7 stated Resident #9 had long facial hairs and they should have been removed during morning care. Certified Nurse Aide #7 stated residents should be shaved on shower days or when facial hair was present. They stated it was important so the residents would feel more confident. During an interview on 7/15/24 at 9:54 AM, Licensed Practical Nurse #4 stated residents should be shaved/have facial hair removed on shower days and when needed. They stated Resident #9 had facial hair present to upper lip, chin, and neck with some length and it should have been removed. During an interview on 7/15/24 at 9:57 AM, Licensed Practical Nurse Care Coordinator #5, stated they expected their staff to shave residents on their shower days and when it was needed. They stated the Certified Nurse Aides were responsible to shave residents and expected the nurses to complete their shower checks. Licensed Practical Nurse Care Coordinator #5 stated it would be important to the resident's self-esteem and for them to feel good about themselves. During an interview on 7/15/24 at 10:41 AM, the Director of Nursing stated they expected staff to shave both male and female residents regularly and at minimum once a week on shower days. They stated the Certified Nurse Aide assigned to the resident would be responsible. The Director of Nursing stated it was a dignity issue for a resident to not be clean shaven if that was their preference. 10 NYCRR 415.5(a)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 43785 Based on observation, interview, and record review conducted during the Standard survey completed on 7/15/24, the facility did not ensure residents with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, and prevent new ulcers from developing for one (Resident #68) of two residents reviewed. Specifically, Resident #68 was not provided with an air mattress (a mattress that provides air flow to relieve pressure) as ordered by the physician. Additionally, nursing staff were inaccurately documenting that the air mattress was provided. The finding is: The policy and procedure titled Pressure Ulcers/Skin Breakdown dated March 2014, documented the nursing staff and attending physician will assess and document an individual's significant risk factors for developing pressure sores, for example, immobility, weight loss, and a history of pressure ulcers. The physician will authorize pertinent orders related to wound treatments and will help identify medical interventions related to wound management. Resident #68 had diagnoses that included arthritis (pain and inflammation of the joints), chronic obstructive pulmonary disease (lung disease), and left fibula (bone in the lower leg) fracture. The Minimum Data Set (a resident assessment tool) dated 4/19/24, documented Resident #68 was cognitively intact, was understood and understands. The Minimum Data Set documented, Resident #68 required substantial/maximal assistance (helper does more than half the effort) for bed mobility. Additionally, it was documented that Resident #68 was at risk of developing pressure ulcers, had one Stage 2 (partial thickness skin loss) pressure ulcer, one Stage 4 (full thickness tissue loss with exposed bone, tendon, or muscle) pressure ulcer, and moisture associated skin damage. The comprehensive care plan (identified as current) dated 10/30/23 with a revision date of 1/5/24 documented Resident #68 had limited physical mobility, was non ambulatory and required extensive assist of two staff members for bed mobility. The resident had an actual pressure ulcer on the left foot. Interventions included heel booties, weekly skin assessment, and protect skin from moisture. The comprehensive care plan was not care revised to include pressure ulcer development, history, and/ or resolution except to the heel and did not include the use of an air mattress. Review of the current Visual/Bedside Kardex Report (a guide for staff to provide care) documented Resident #68 required extensive assist of two staff members for bed mobility, incontinent care was to be provided every 2-3 hours, barrier cream to be applied with incontinent care, and staff was to report any areas of breakdown to nurse. The Kardex did not include the use of an air mattress. Review of the Electronic Medical Record order created on 4/12/24 by the Assistant Director of Nursing documented an air mattress was ordered for skin integrity and was to be in place at all times to promote skin integrity. Review of the Order Summary Report dated 7/12/24, revealed the air mattress ordered 4/12/24 was still in place. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the most recent Braden Scale (a tool for predicting pressure ulcer risk) dated 4/16/24, documented Resident #68 had slightly limited sensory perception (ability to respond to pressure-related discomfort), skin was very moist, activity level was chairfast, had very limited mobility, and that there was a potential problem with friction and shear. The nursing progress note dated 6/17/24, completed by the Assistant Director of Nursing documented Resident #68's wounds were healed, remained incontinent, and was at high risk to continuously break down. Additionally, the Assistant Director of Nursing documented Resident #68 was put on a turn and positioning schedule along with monitoring for incontinence every 2-3 hours. Review of the Skin and Wound Evaluation dated 6/17/24, revealed Resident #68 had an in-house Stage 2 (partial-thickness skin loss) pressure ulcer that was documented as resolved. Further review of the Physician wound consultant notes documented Resident #68 was seen on 6/6/24, 6/11/24, and 6/17/24 for skin related concerns which included pressure ulcers and moisture associated skin damage. During intermittent observations made on 7/8/24 at 3:19 PM, and 7/12/24 at 11:23 AM, Resident #68 was in bed and did not have an air mattress in place as ordered to promote skin integrity. Further observations made on 7/10/24 at 10:27 AM and 7/11/24 at 11:35 AM, Resident #68 was out of bed in wheelchair and no air mattress was present on bed. Review of the Treatment Administration Record from 7/1/24 through 7/12/24 revealed the nursing staff had initialed (documented) the air mattress was in place every shift. There was no documented evidence in the Treatment Administration Record Resident #68 refused the air mattress. During an observation and interview on 7/12/24 at 12:10 PM, Licensed Practical Nurse #4 stated Resident #68 had chronic pressure ulcers to the right and left buttocks that would frequently open and close. They stated preventative measures used for Resident #68 were barrier creams, powders, wheelchair cushion, and heel booties. Licensed Practical Nurse #4 entered Resident #68's room and stated resident did not have an air mattress in place. Licensed Practical Nurse #4 stated Resident #68 should have had an air mattress due to high risk for skin breakdown as they would refuse incontinent care and turn and positioning. During an interview on 7/15/24 at 10:34 AM, the Assistant Director of Nursing stated they were responsible for completing weekly wound rounds. They stated Resident #68's pressure ulcers were healed and that there was a daily treatment in place to maintain skin integrity. The Assistant Director of Nursing stated Resident #68 remained high risk for skin breakdown, had limited mobility and was incontinent. They stated residents that were high risk for skin breakdown should have an air mattress in place and would be documented on the care plan. They stated Resident #68 did not have an air mattress. During an interview on 7/15/24 at 10:41 AM, the Director of Nursing stated they would expect any resident that was at high risk for skin breakdown would have an air mattress and would expect the care plan to be updated by the nurse manager. The Director of Nursing viewed Resident #68's treatment administration record and stated that the order for the air mattress was being signed off every shift as present. They stated they would have expected the nurses to notify their nurse manager, Director of Nursing, Assistant Director of Nursing, or maintenance that Resident #68 did not have an air mattress in place per the physician order. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10NYCRR 415.12 (c) (1)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43785 Based on observation, interview, and record review conducted during a Standard survey completed on 7/15/24, the facility did not ensure that residents who receive a psychotropic medication have gradual dose reductions, unless clinically contraindicated, in an effort to discontinue these drugs for one (Resident #63) of five residents reviewed for psychotropic medication use. Specifically, Resident #63 had no attempted gradual dose reductions since Prozac (antidepressant medication) was ordered on 3/3/23 and there was a lack of adequate supporting evidence for its continued use. The finding is: The policy and procedure titled Tapering Medications and Gradual Drug Dose Reduction, revised date 7/22 documented residents who use psychotropic medications shall receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. The staff and practitioner will consider tapering of medications as one approach to finding an optimal dose or determining whether continued use of a medication is benefiting the resident. The policy documented that the staff and the practitioner will consider tapering medications under circumstances when the residents' clinical condition has improved or stabilized; the underlying causes of the original target symptoms has resolved, or non-pharmacological interventions have been effective. For any individual who is receiving a psychotropic medication the staff and practitioner shall attempt a gradual dose reduction for psychotropic medications in two separate quarters within the first year of admission or new order, with at least one month between attempts unless contraindicated. After the 1st year, the facility shall attempt a gradual dose reduction at least annually, unless clinically contraindicated. The policy documented that the tapering may be considered clinically contraindicated if the physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability. Resident #63 had diagnoses including cerebral infarction (stroke), diabetes mellitus type 2 and major depressive disorder. The Minimum Data Set (a resident assessment tool) dated 5/31/24, documented Resident #63 was cognitively intact, understands and was understood. The assessment documented that resident had mild depression, no behaviors were exhibited and received an antidepressant medication. The comprehensive care plan initiated on 6/5/18 documented that Resident #63's communication was a strength, and they were able to make needs known. The care plan documented the resident used antidepressant medication due to major depressive disorder. Interventions included to administer antidepressant medications as ordered and evaluate and monitor for gradual dose reductions per pharmacy and medical doctor's reviews. The Order Summary Report dated 7/15/24 documented that Resident #63 had an active order for Prozac 20 mg daily for depression with start date of 3/4/23. The Order Summary Report revealed no attempted gradual dose reduction of Prozac since the start date of 3/4/23. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the physician Progress Notes from 7/2/23 to 7/12/24 contained no documented evidence of a clinical rationale for the gradual dose reduction of Resident #63's Prozac being clinically contraindicated. There was no documented evidence that Resident #63 was having depression symptoms, and it was documented that the resident had appropriate mood and affect. Review of Resident #63's interdisciplinary Progress Notes dated 2/1/24-7/15/24 contained no documented evidence that Resident #63 was displaying any behaviors or depressive signs or symptoms. During intermittent observations on 7/8/24 to 7/12/24 from 10:35 AM to 3:03 PM, Resident #63 displayed no negative behaviors, was pleasant, calm, and appeared well groomed. During an interview and observation on 7/12/24 at 12:00 PM, Resident #63 was sitting in the main dining room. The resident was pleasant and well-kempt. Resident #63 stated that they were doing good and were not having any depressive symptoms. Resident #63 stated that the medical provider had not reduced the dosage of their Prozac in over a year and would be agreeable to have a dose reduction if asked. During an interview on 7/12/24 at 2:52 PM, Licensed Practical Nurse #4 stated that Resident #63 has had no recent signs of depression. They stated Resident #63 enjoyed reading the paper and spent their days socializing with other facility residents on the first floor in the main dining room. During a telephone interview on 7/12/24 at 3:52 PM, Medical Provider #1 stated that Resident #63 was seen for a provider visit last week and was stable and did not have any signs of depression. Medical Provider #1 stated they do not recall when the last time Resident #63 had a gradual dose reduction of their Prozac but one should have been attempted within the last year. Medical Provider #1 stated that they attempt a gradual dose reduction of psychotropic medications so that the resident would be on the lowest effective dose possible and are unsure why they did not attempt a reduction or discontinuation of Resident #63 Prozac. During a telephone interview on 7/15/24 at 9:37 AM, Consultant Pharmacist #2 stated that the consultant pharmacist would request the medical providers attempt a gradual dose reduction of psychotropic medications per federal regulations unless the resident has a medical diagnosis of major depressive disorder. Consultant Pharmacist #2 stated that Consultant Pharmacist #1 did not send the medical provider a request a gradual dose reduction for Resident #63 Prozac probably because Resident #63 had a diagnosis of major depressive disorder. During an interview on 7/15/24 at 10:59 AM, Licensed Practical Nurse #5 (Resident Care Coordinator for the 3rd floor) stated that Resident #63 did not demonstrate any signs and symptoms of depression and did not have any behaviors. Licensed Practical Nurse #5 stated they had not participated in any interdisciplinary meeting for Resident #63 to discuss a gradual dose reduction of their Prozac that was ordered on 3/4/23. They stated the reason a resident should have a gradual dose reduction was so that they were on the least amount of medication possible because the body gets used to the medication and the medication doesn't work anymore. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/15/24 at 11:04 AM, Social Worker #1 stated that Resident #63 did not present with any negative behaviors and a times would [NAME] the losses they have had in the past couple years. Social Worker #1 stated that the interdisciplinary team would meet quarterly to discuss resident's behaviors, the dosages of psychotropic medications and if a gradual dose reduction was needed. They stated the last time Resident #63 was reviewed at an interdisciplinary meeting was maybe at the beginning of 2024. Social Worker #1 stated that if a resident was at their baseline or their behaviors had improved then the team would start a gradual dose reduction of their psychotropic medications. Social Worker #1 stated that Resident #63 was at their baseline, and they should have had a dose reduction attempted of their Prozac within the last year. During a telephone interview on 7/15/24 at 11:24 AM, Nurse Practitioner #1 stated that they took over Resident #63 care about four months ago and is unsure why the resident has not had a gradual dose reduction in their Prozac. The Nurse Practitioner #1 stated they reviewed the medical provider's documentation for Resident #63 and that the resident did not have a gradual dose reduction attempt of Prozac in the past year and the documentation did not include a contraindication for a gradual dose reduction. During an interview on 7/15/24 at 11:48 AM, the Director of Nursing stated that the facility reviewed resident psychotropic medication in an interdisciplinary meeting every quarter with the consultant pharmacist, social worker, administrator, and therapy. The Director of Nursing stated they started working at the facility in December 2023 and Resident #63 was not reviewed during a psychotropic interdisciplinary meeting since then and the resident had no behaviors or signs/symptoms of depression. The Director of Nursing stated that a gradual dose reduction of a resident's psychotropic medication should be attempted quarterly to meet federal regulations. During an interview on 7/15/24 at 12:05 PM, the Director of Quality stated that the facility should be performing monthly gradual dose reduction meetings that would be documented in the electronic medical record. The Director of Quality stated that Resident #63 was ordered Prozac in March of 2023 and there were no psychoactive medication review notes documented in the past year in their electronic medical record. They stated that the resident's Prozac dose should had been reviewed with the pharmacist and interdisciplinary team for a possible gradual dose reduction. The Director of Quality stated the federal guidance for a reduction of a psychotropic medication would be an attempted reduction twice within the first year of admission or a new order and then annually or a medical provider should document the reason a reduction was contraindicated. 10 NYCRR 415.12(l)(2)(ii)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43785 Based on observation, interview, and record review conducted during a Standard survey completed on [DATE], the facility did not store, prepare, distribute, and serve food in accordance with professional standards for food service safety. Specifically, two (Unit 2 and Unit 4) of three unit nourishment refrigerators, one of one main kitchen observed had issues. The nourishment room refrigerators contained undated, unlabeled, and out of date food and drink items. The kitchen walk-in, beverage reach-in and tray line coolers contained undated and unlabeled items. The beverage reach-in cooler contained potentially hazardous beverages that exceeded the safe holding temperature for cold beverages. The findings are: The policy and procedure titled Food Preparation and Service revised [DATE] documented the danger zone for food temperatures is between 41 degrees Fahrenheit and 135 degrees Fahrenheit and that this temperature range promotes the rapid growth of pathogenic microorganisms that cause foodborne illness. Potentially hazardous foods include seafood, milk, yogurt, and cottage cheese. The policy and procedures titled Food Receiving and storage revised [DATE] documented all foods stored in the refrigerator or freezer will be covered, labeled, and dated (use by date) and refrigerated foods must be stored below 41 degrees Fahrenheit and food items and snacks kept in the nursing units must be kept below 41 degrees Fahrenheit and labeled with a use by date. All foods belonging to residents must be labeled with the resident's name, the item and the use by date. The policy and procedure titled Foods brought by Family/Visitors revised [DATE] documented food that is left with the resident to consume later will be labeled and stored in a manner that is clearly distinguishable from facility-prepared food and perishable foods must be stored in re-sealable containers with tightly fitting lids in a refrigerator. Containers will be labeled with the resident's name, the item and the use by date. The nursing and/or food service staff will discard any foods prepared for the resident that show obvious signs of potential foodborne danger (for example, past due package expiration dates). 1. An observation of the main kitchen on [DATE] at 10:02 AM revealed the beverage reach-in cooler in the alcove between the dining area and the kitchen displayed an internal temperature of 48 degrees Fahrenheit, and a thermometer placed inside the cooler displayed a temperature of 51 degrees Fahrenheit. There was a temperature log on the outside of the cooler. The cooler contained 7 unopened half gallons of whole milk, a box of single serve coffee creamers, a 22-quart white food grade square bucket with an orange liquid and a plastic 2-cup measuring cup floating in the liquid. The bucket was not covered. Review of the 2024 Fridge/Freezer/Cooler Temps log on the door of the cooler revealed that from [DATE] to [DATE] the temperature documented once daily exceeded 40 degrees Fahrenheit on 11 of the 69 days, there were 10 blank days, and the temperature documented on [DATE] was 44 degrees Fahrenheit. At the bottom of the log, it stated Refrigerator 40* or lower. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and observation on [DATE] at 10:07 AM, Dietary Director #1 stated the milk and creamers were potentially hazardous foods and was not sure how long the temperature of the cooler had been above 41 degrees Fahrenheit. Dietary Director #1 used a facility food thermometer to obtain the temperature of the milk. The temperature of the milk was 47.5 degrees Fahrenheit. Dietary Director #1 stated the cooler temperature was documented once daily first thing in the morning by the dietary supervisor upon their arrival at the facility. Dietary Director #1 stated they were not aware this cooler had operated at a temperature exceeding 40 degrees Fahrenheit. During an interview on [DATE] at 10:54 AM, Dietary Supervisor #1 stated they arrived at the facility at 4:00 AM on their workdays and had worked on [DATE]. They stated the cook arrived at 5:00 AM and either they or the cook took responsibility of documenting the temperatures of coolers and freezers first thing in the morning. They stated that they documented the temperature of the outside display at that time and if the temperature exceeded 40 degrees Fahrenheit, they were supposed to notify Dietary Director #1 but did not. Dietary Supervisor #1 stated that the orange liquid in the bucket observed in the cooler on [DATE] should not have had a measuring cup floating in it, the measuring cup should have been washed and hung up. 2. An observation of the main kitchen on [DATE] at 10:10 AM revealed the French door fridge/freezer near the tray line contained an opened package of bologna inside a zipped plastic bag that was not labeled or dated. The walk-in cooler contained a food grade clear square container that was covered with clear plastic wrap and contained a light-yellow powdery substance that was labeled Cheese ,d+[DATE]. There was an opened 46-ounce container of thicken lemon water with no lid and an opened 46-ounce container of thickened apple juice. Both containers were not dated/labeled with use by date and the instructions printed on the containers documented they may be kept up to 7 days under refrigeration after opening. During an interview at the time of this observation, Dietary Director #1 stated the cheese was expired and should not be in the cooler. They stated opened items of food should not be kept more than 3 days past the date they were opened. 3. An observation in the Unit 4 nourishment room on [DATE] at 9:25 AM revealed one fish, cut into pieces, including the head, in a zipped plastic bag, a plastic container of about 1 cup of cooked rice, a plastic grocery bag with three plastic containers of food (macaroni and cheese, French fries, and fried chicken), and opened 16.9 ounce bottled water about two-thirds full, one commercially packaged burrito within manufacturer's best by date. All off these items were not labeled with a resident's name and identification of food item and were not dated. The freezer contained at least three flattened and misshapen popsicles with their packaging stuck to the bottom and sides of the freezer that could not be moved. A sign posted on the front of the nourishment refrigerator titled Refrigerator Rules documented no staff items were to be stored in this refrigerator, resident items were to be dated and labeled with their name, and any item that was in the refrigerator not dated, not labeled with a name, or was more than three days old would be discarded. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335742	A. Building B. Wing	07/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Niagara Rehabilitation and Nursing Center	822 Cedar Avenue Niagara Falls, NY 14301

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and observation on [DATE] at 1:10 PM of the Unit 4 nourishment room, Certified Nurse Aide #15 stated resident food needs to be labeled, dated, and only kept up to three days in the nourishment refrigerator. If food items had no names and dates on them, staff would not know whose food it was, and they stated they had no idea who the fish belonged to and how long it had been in this refrigerator. During an interview and observation on [DATE] at 4:35 PM of the Unit 4 nourishment room, Dietary Director #1 stated the Refrigerator Rules were standard practice and should be followed. They stated the nourishment refrigerators were for resident food only. They assumed the fried chicken, macaroni and cheese, and French fries belonged to a resident, and they needed to ask the nurses if anyone knew who this food belonged to. If they thought it was greater than three days old or if it could not be identified with a date, it must be thrown out. Additionally, they stated the fish should have been labeled with a name and date and should be thrown out at this time. Dietary Director #1 stated they personally checked nourishment refrigerators each morning around 7:00 AM for a quick glance to guide the dietary staff for the day, and a dietary staff member checked these refrigerators at 7:00 PM each night to add nourishments. Dietary Director #1 stated, if a resident's family members brought in food for a resident, it must be labeled, but they were not certain whose responsibility it was to label it. During an interview and observation on [DATE] at 4:45 PM of the Unit 4 nourishment room, Certified Nurse Aide #10 stated staff food did not belong in the nourishment room refrigerators. Resident food should be labeled with a name, room number, and date. They further stated the food must always be labeled with a date because if the food was more than a couple of days old residents should not eat it. Certified Nurse Aide #10 stated they had not previously noticed the whole fish in the zipped plastic bag in this refrigerator, it looked raw to them, and they believed a resident should not eat raw fish for their safety. 4. An observation in the Unit 2 nourishment room on [DATE] at 10:40 AM revealed the nourishment refrigerator contained a 64-ounce bottle of coffee creamer, one quarter full with a manufacturer's best by date stamp of [DATE], several individual 2 ounce cups of a white creamy liquid and a clear brown liquid, one opened commercially packaged pudding cup, half full, two commercially packaged freezer meals (labeled with a room number), an opened 15.2 ounce bottle of brand-name orange juice, three quarters full, and one bag of .75 pounds of grapes. There were no names or dates on any of these items. At the time of this observation, Plant Operations Technician #1 stated the pudding cup needed to be thrown away and placed it in the trash. During an interview and observation on [DATE] at 4:50 PM in the Unit 2 nourishment room, Dietary Director #1 stated the commercially packaged freezer meals documented Keep Frozen on the packages, therefore they should not be in the refrigerator. They also stated they expected a name and date opened on the bottle of orange juice and the individual cups of white creamy and clear brown liquid and the coffee creamer needed to be thrown out. Additionally, they stated they expected the grapes to be labeled with a date and resident name. During an interview on [DATE] at 4:50 PM, Certified Nurse Aide #14 stated both Certified Nurse Aides and residents themselves could place food in this refrigerator and whoever placed the food in the refrigerator should label it. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 10:09 AM, the Administrator stated they were the person who wrote the Refrigerator Rules and placed them on the unit refrigerators in the nourishment kitchens. They stated they expected Certified Nurse Aides and Nurses to label food placed in these refrigerators and toss items over three days old. The Administrator stated dietary staff check the unit fridges for temperatures and it was important to label food items, date them, and discard them after three days, so no residents get sick from eating expired foods. NYCCR 415.14 (h) Subpart ,d+[DATE] Food Service Establishments ,d+[DATE].31(c), ,d+[DATE].40, ,d+[DATE].43(e)