STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335638	A. Building B. Wing	07/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buffalo Center for Rehabilitation and Nursing	1014 Delaware Ave Buffalo, NY 14209

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36415 Based on observation, interview and record review conducted during a Complaint Investigation (Complaint #NY00270662) completed during the Standard survey on 7/20/21, the facility failed to ensure the resident's right to be free from abuse and neglect for two (Resident #10, 90) of eight residents reviewed. Specifically, Certified Nursing Assistant (CNA) #3 entered Resident #10's bathroom, while the resident was in the bathroom. Resident #10 became agitated, an altercation ensued, and CNA #3 slammed the door causing the resident to fall to floor. Resident #10 was sent to the hospital for evaluation and treatment and returned to the facility with diagnoses that included ORIF (open reduction internal fixation - surgical procedure to stabilize broken bone) of right femur (thigh bone) fracture. This resulted in actual harm for Resident #10 that is not immediate jeopardy. Additionally, Resident #90 was found on floor, next to their bed without the care planned safety interventions in place resulting in facial bruising. The findings are: The facility policy and procedure (P&P) Abuse, revision dated 2/2019, documented the facility prohibits the mistreatment, neglect, and abuse of residents/patients by anyone. The policy documented abuse is a willful infliction of injury and neglect is a failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Physical Abuse includes hitting, slapping, pinching, scratching, spitting, holding roughly, kicking etc. It also includes controlling behavior through corporal punishment. If the alleged abuse is confirmed, the employee is to be terminated. 1. Resident #10 had diagnoses which included unsteadiness on feet, repeated falls, and hypertension (HTN, high blood pressure). The Minimum Data Set (MDS - a resident assessment tool) dated 12/13/20 documented Resident #10 was cognitively intact. The comprehensive care plan (CCP) documented as initiated on 2/18/20 Resident #10 was at risk for falls r/t (related to) weakness and deconditioning. On 3/11/20 the care plan was revised to include the resident exhibited behavioral symptoms such as fabricates stories about events that have not occurred, changes stories depending on audience, and verbally inappropriate with staff, yelling, and swearing at staff. Interventions initiated on 3/13/20 included to have 2 staff members at all times with hands on care. Review of the facility investigation file revealed the following: (continued on next page)

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A document titled Initial Event Documentation dated 1/26/21 completed by the Registered Nurse (RN) #8, Regional Float DON (Director of Nursing), documented Resident #10 called writer (RN #8, nursing supervisor) at approximately 9:00 PM. While on the phone with the resident writer heard a knock on the door and CNA #3 asked the resident are you ok, can I use the water? I (RN #8) heard another knock and CNA #3 again asked Can I come in to use the water? Resident #10 started to yell at CNA #3 with explicate [sic] language and stated I'm on the phone with the supervisor the resident then hung the phone up. While this writer (RN #8) was going to residents' room writer was stopped by CNA #3 who stated that this resident (#10) struck them in the face with a closed fist. The police then called the supervisor phone stating they have a complaint of resident abuse and there is an ambulance on the way. Upon entering the residents (#10) room the resident (#10) was observed sitting on floor in bathroom with legs extended out front of them, their right leg over their left leg with increased swelling to the right knee. Resident (#10) stated [CNA #3] hit me and pushed me down. A handwritten statement by CNA #3, signed and dated 1/26/21 documented on second shift I was doing my rounds. I went to the room to change the resident by the window. I was holding conversation with that resident. I told the resident I was about to get started. I went to get my linen and walked toward the bathroom and knocked on the door and opened it and resident #10 was in the bathroom talking to RN #8 the supervisor. [Resident #10] started calling me out my name, all types of b's and saying I can't kick [the resident] out the bathroom, which I wasn't trying to do. All I asked was to use the sink. [Resident #10] then replied B***** I can walk. [Resident #10] struggled to get up and then punched me in my mouth. I slammed the door in [the residents] face and walked out. The Disciplinary Report dated 1/27/21 documented disciplinary action was issued to CNA #3 for carelessness affecting the health of a resident, infraction of facility rule/regulation, and reported allegation of abuse to resident. CNA #3 was terminated 1/27/21 related to abuse allegation that could not be ruled out based on staff members statement and resident's diagnosis of fracture. During an interview on 7/15/21 at 11:48 AM, Resident #10 stated on 1/26/21 in the evening, the resident was in the bathroom, talking to the supervisor on the telephone. Resident #10 stated that they had a roommate at the time and staff frequently interrupted the resident when Resident #10 was in the bathroom. CNA #3 knocked on the door and entered the bathroom to obtain water to provide care for the roommate. Resident #10 stated that they told CNA #3 to wait until they were finished in the bathroom. Resident #10 stated CNA #3 became upset, slamming the door, which hit the resident in the face caused them to fall on the floor and break their glasses. During an interview on 7/16/21 at 11:20 AM, the DON stated a CNA intentionally slamming a door on a resident would be considered an abusive situation. Additionally, it would be considered harm if the resident subsequently fell from the door being slammed and sustained a fracture. During an interview on 7/19/21 at 9:18 AM, the Physician Assistant (PA) stated CNA #3 should have waited until Resident #10 exited the bathroom to obtain water. The PA would consider slamming the door abuse and it would be considered harm if the resident subsequently fell from the door being slammed and sustained a fracture. During an interview on 7/19/21 at 12:24 PM, the facility Administrator stated it was unacceptable, unprofessional, and abusive for a staff member to slam a door on a resident. Additionally, if an alert and oriented resident stated the slammed door hit them, and they fell sustaining a fracture it would be considered harm to the resident. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	2. Resident #90 had diagnoses which included repeated falls, dementia with Lewy bodies (progressive) and muscle weakness. The MDS dated [DATE] documented Resident #90 was cognitively intact. The CCP initiated 3/17/2020 documented Resident #90 was at for risk for falls. Interventions included the use of floor mats initiated on 9/2/2020 and to ensure resident's bed was against the left side of wall was initiated on 9/6/2020. Review of the Bedside Kardex (guide used by staff to provide care) dated 7/19/21 documented safety instructions which included Resident #90 utilized floor mats and the bed should be against the left side of the wall. Review of the facility investigation file revealed the following: Incident Report, completed by RN Supervisor #7, dated 5/18/21 documented Resident #90 had a fall and was found sitting on the floor in their room at 2:45 AM and had an eccymotic (bruise) area noted to their left eye and forehead. Assigned care giver was CNA #7. A document titled Initial Event Documentation completed by RN #7 on 5/18/2021 at 2:45 AM, documented Resident #90's safety (floor) mat was not down and was located on top of the residents' closet. Disciplinary Report completed by the Assistant Director of Nurses (ADON) dated 5/24/21 documented an infraction of a safety rule. On 5/18/21 at 2:00 AM CNA #7 was the care giver for resident #90. The resident had a fall, the floor (safety) mat was not in place on the floor next to the resident's bed, and the resident sustained a bruise to their face. CNA #7 was suspended. During a telephone interview on 7/19/21 at 8:53 PM, CNA #7 stated on 5/18/21 they worked the 11-7 am shift. Resident #90 was in bed. At 2:45 AM Resident #7 was found on the floor next to their bed and had a purple knot on the left side of their head. CNA #7 stated the bed was in the middle of room and didn't know Resident #90 needed floor mats for safety. CNA #7 stated that that they should have read the care plan, and there were no mats in the resident's room. During an interview on 7/20/21 at 7:12 AM, RN #7 stated Resident #90 was supposed to have a mat down on 5/18/21 and the mat was on top of Resident #90's closet. During an observation on 7/14/21 at 2:42 PM, Resident #90 was in bed sleeping. The bed was in the center of the room (not against the wall) and there were no floor mats in place next to the bed as per the resident's care plan. During an interview and observation on 7/14/21 at 4:35 PM, Licensed Practical Nurse (LPN) Unit Manager #9 stated Resident #90 had a history of falls and remained at risk. The resident should have floor mats in place while in bed and bed should be up against wall for safety. At this time, Resident #90 was not present in the room; however, the bed was in the middle of the room and LPN #9 was unable to locate the floor mats. During an observation on 7/16/21 at 7:30 AM Resident #90 was in bed sleeping. The bed was in the center of the room (not against the wall) and there were no floor mats in place next to the bed as per the resident's care plan. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 7/20/21 at 10:37 AM, CNA #8 worked on the Resident #90's unit and stated if a resident needed floor (safety) mats it would be on the Kardex, and if floor mats could not be located, the nurse would be notified. Floor mats were very important for residents who fall to prevent injury. If the care plan wasn't followed it would be neglect. During an interview on 7/20/21 at 10:42 AM, CNA #9 stated they were familiar with Resident #90, and added that Resident #90 was definitely a fall risk. The bed should be against the wall and floor mats in place if it is on the Kardex. It was considered abuse if a resident's care plan wasn't not followed. During an interview on 7/20/21 at 10:48 AM, LPN Unit Manager #9 stated if an incident involved not following the residents' plan of care it would be neglect because it was a break in the residents' plan of care. During an interview on 7/20/21 at 11:00 AM, the ADON stated the caregiver would be responsible to ensure a resident's care plan is followed. Resident #90 had a history of falls, when safety measures (floor mats and bed positioning) weren't put into place, it was a break in the plan of care and would be neglect. During an interview on 7/20/21 at 11:10 AM, the DON stated all staff were responsible for ensuring that safety measures are in place. Resident #90's care plan wasn't followed, and an injury occurred. Injury with fall per NYS (New York State) guidelines is neglect. During an interview on 7/20/21 at 11:17 AM, the Administrator stated there was a breach of Resident #90's care plan and it would be considered neglect because we forgot to put down the floor mat. 415.4(b)(1)(i)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 36415 Based on observation, record review, and interview conducted during a Complaint investigation (Complaint #NY00262985) during the Standard survey completed on 7/20/21, the facility did not provide food and drink that was palatable, attractive, and at a safe and appetizing temperature. Specifically, one (fourth floor unit) of three resident units reviewed for food temperatures during meals had issues involving food items that were not served at safe and appetizing temperatures. Residents # 32, #92, #98 and #141 were involved. The finding is: The facility's undated Policy and Procedure (P&P) titled Food Safety documented to hold hot foods hot and cold foods cold. For holding hot foods: serve immediately or hold at or above 135 F (degrees Fahrenheit) and cold foods should be served between 32-41 F . Review of facility's Resident Council-Resident Notification Summary dated 6/24/21 revealed the residents stated the food was not warm enough while being passed. The dietary department response was that the quality of food was addressed with the Food Service Director (FSD) and food temps would be taken before the food goes up to the resident units to ensure proper temperatures were reached. During an interview on 7/13/21 at 10:15 AM, Resident #141 stated the food was served cold almost daily. During an interview on 7/13/21 at 12:10 PM, Resident #98 stated the food was always cold and tasted gross. The resident stated they ate sandwiches for just about every meal. During an interview on 7/13/21 at 2:54 PM, Resident #92 stated the food was terrible and all tasted the same. The resident stated the food was dry, tough, bland, and the resident frequently ordered take out. During an observation on 7/15/21 at 11:24 AM at the start of the kitchen tray line for lunch, all hot foods were temped by the FSD over at 170 F . Continual observation of the tray line revealed at 1:02 PM the facility ran out of warming lids to cover the plates and for the last meal cart for the fourth floor resident unit, staff began wrapping lunch plates with plastic wrap, which included the test tray. All resident lunch trays were plated and sent to the fourth floor at 1:47 PM. During the tray line observation, the food was not temped prior to going to the resident units. During an observation on 7/15/21 at 2:02 PM, all lunch trays from the fourth floor last meal cart were passed to the residents. The test tray temperatures were then taken by the FSD using a facility thermometer. The temperatures obtained were as follows: - mashed potatoes measured 120 F and tasted lukewarm and bland - green beans measured 102 F and tasted lukewarm, were mushy and bland - sliced turkey with gravy measured 100 F and tasted cold and bland (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- milk measured 62 F and tasted lukewarm - fruit cup measured 68 F and tasted lukewarm - juice cup measured 62 F and tasted lukewarm During an interview on 7/15/21 at 2:05 PM, the FSD stated the hot foods should be at least 135 F and cold foods should be below 40 F. The food could be cold because the facility did not have enough warming covers to cover all resident plates, the facility has not had enough warming covers for at least two months. A request for new warming covers was sent to corporate, but the facility has not received them. The FSD stated they did not know why the cold items were not temped at colder temperatures. During an interview on 7/15/21 at 2:56 PM, Resident #32 stated the turkey was cold with no taste, the mashed potatoes were ok, and the food was never served hot. During an interview on 7/19/21 at 11:30 AM, the Registered Dietitian (RD) stated he has been with the facility for approximately one month and he attended the resident council meeting in June and the residents complained about the food being cold. The RD stated hot foods should be above 135 F and cold foods below 40 F when served. 415.14(d)(1)(2)