STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335081	A. Building B. Wing	01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Anns Community	1500 Portland Avenue Rochester, NY 14621

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 49971 Based on interviews and record review conducted during the Abbreviated Survey (NY00345886) for one (1) (Resident #3) of (3) three residents reviewed for pressure ulcers (injury), the facility failed to ensure the resident received the necessary care, treatment and services consistent with professional standards of practice to promote the healing of a pressure ulcer, prevent infection, and prevent new ulcers from developing (unless the individual's clinical condition demonstrates they were unavoidable). Specifically, Resident #3, who was assessed to be at risk for pressure ulcer development, was identified as having an open area on their left buttocks on 06/07/2024. A wound consult was ordered, but the medical team was not notified of the open area for five (5) days and there were no medical treatments ordered. Additionally, the resident's care plan, including interventions, was not updated and implemented promptly to prevent further deterioration of the pressure ulcer. Subsequently, Nurse Practitioner #5 identified deterioration to the pressure ulcer on the left buttocks and multiple new skin injuries were identified. This resulted in actual harm to Resident #3 that is not Immediate Jeopardy and is evidenced by the following: The facility's policy Skin Care Management, dated 06/20/2024, documented that skin care management will be provided to all elders/patients. For any change in skin integrity noted by a nurse, the Altered Skin Observation Form will be completed, and nurses, managers, coordinators, supervisors, and the Assistant Director of Nursing will: review to ensure new skin issues are addressed in a timely manner; if wounds/ulcers are identified, refer to the Skin Integrity and Wound Management Book (Clinical Practice Quick Reference Guide) for care and treatment guidelines; re-review the proactive interventions as outlined on Pressure Ulcer Proactive Interventions per the Braden Scale Score to ensure all appropriate measures are considered; and generate a referral for skin rounds (wound consultant). The Facility's Clinical Practice Quick Reference Guide, revised October 2019, documented that for Stage 2 (superficial opening that often presents itself as an abrasion, blister, or shallow crater) pressure ulcer to the buttock area, use barrier cream or zinc product twice daily and PRN (as needed). For unstageable (unable to determine the depth/extent of the wound due to dead tissue) pressure ulcer, manage exudate (drainage), fill dead space, and debride (remove dead tissue). If wound is dry or with light drainage, then clean the wound with saline, apply no-sting (liquid skin protectant), and apply a bordered gauze dressing every 24 hours and PRN (as needed). (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335081	A. Building B. Wing	01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Anns Community	1500 Portland Avenue Rochester, NY 14621

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 0686 Level of Harm - Actual harm Residents Affected - Few	Resident #3 was admitted to the facility with diagnoses including a recent urinary tract infection, heart failure and chronic obstructive pulmonary (lung) disease requiring oxygen. The Minimum Data Set (an assessment tool), dated 06/05/2024, documented the resident had moderate impairment of cognitive function, was dependent on staff for transfers, and required partial to moderate assistance with bed mobility. The resident had an indwelling urinary catheter, was always incontinent of bowel, was at risk for pressure ulcer development, had no pressure ulcers or wounds at the time, and had a pressure reducing mattress and/or cushion. Resident #3's Baseline Care Plan for skin integrity, dated 05/29/2024, documented the resident was at risk for alteration in skin integrity. The goal was for the resident to be free from skin breakdown. Interventions included, but were not limited to, nursing treatments per medical orders, preventative skin care products, weekly skin checks by a nurse, daily skin inspection with AM and PM care, encourage and support movement and self-positioning as able, and for staff to promptly report skin integrity changes. A specialty mattress and cushion were added on 06/12/2024. The 05/30/2024 Braden Scale (an assessment tool used to predict a resident's risk of developing pressure ulcers) documented Resident #3 was at mild risk (score of 16) for developing pressure ulcers. Review of the Weekly Skin Observation form, dated 06/03/2024 and signed by Licensed Practical Nurse #6, revealed Resident #3 had no pressure ulcers or skin impairments. The Resident Care Summary Kardex (care plan used by the Certified Nursing Assistants for daily care), dated 06/06/2024, documented Resident #3 was non-ambulatory and required assist of one staff for transfers using a mechanical lift, moderate assist of one for bed mobility, use of a non-skid pad to prevent sliding in their recliner chair, maximum assist for bathing, keep their skin moisturized, and use a specialty cushion (in the chair). In an Altered Skin Integrity Report, dated 06/07/2024, Licensed Practical Nurse #2 documented Resident #3 had an area of broken skin 2 centimeters by 2 centimeters on the left buttocks. The Clinical Coordinator Licensed Practical Nurse #3 was notified, and a wound consult ordered. There was no documented evidence that the medical team was notified or if any new treatments were implemented. In an Interdisciplinary Progress Note, dated 06/08/2024, Registered Nurse #4 documented Resident #3 had an area of eschar (dead tissue) on their left ankle approximately 2.5 centimeters in diameter with mild redness, which was left open to air and a wound consult ordered. There was no documented evidence that the medical team was notified or if any new treatments were implemented. There was no documented evidence of any care plan updates to include interventions for the open area on the left buttocks or the pressure area on the left ankle to prevent further deterioration and/or additional pressure ulcers from developing. In a Wound Consult note dated 06/12/2024, Nurse Practitioner #5 documented the following skin issues: - Unstageable sacral (buttocks) pressure wound 9.5 centimeters x 9.2 centimeters x 0.2 centimeters. - a right heel blister deep tissue injury 4 centimeters x 7 centimeters (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335081	A. Building B. Wing	01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Anns Community	1500 Portland Avenue Rochester, NY 14621

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 0686 Level of Harm - Actual harm Residents Affected - Few	- a left ankle stage 3 (full thickness tissue loss) pressure wound 1.5 centimeters x 1 centimeter x 0.2 centimeters. - a right bunion deep tissue injury. - a stage 2 pressure ulcer on the scrotum. - a deep tissue injury to the resident's lower back. Nurse Practitioner #5 documented that Resident #3 was started on antibiotics for infection and all pressure injuries were facility acquired. Resident #3 was discharged to the community on 06/18/2024 and did not return to the facility. During an interview on 01/02/2025 at 1:45 PM, Certified Nursing Assistant #1 stated it was their responsibility to report any new reddened area to the team leader. Certified Nursing Assistant #1 stated they had noticed a red area on Resident #3 (buttocks) and reported the area to Licensed Practical Nurse #2 who told them to put moisturizer cream on the area. During an interview on 01/02/2025 at 2:00 PM, Licensed Practical Nurse #2 stated that as Team Leader, their responsibility was to evaluate the reported reddened area and document any findings in an Altered Skin Integrity Report and to notify Clinical Coordinator Licensed Practical Nurse #3, which they did do. During an interview on 01/07/2025 at 11:30 PM, Clinical Coordinator Licensed Practical Nurse #3 stated they had received a report of a reddened area on Resident #3's sacrum and they placed a wound consult order. Clinical Coordinator Licensed Practical Nurse #3 stated wound consults were completed once a week unless you called and asked for an earlier consult. Clinical Coordinator Licensed Practical Nurse #3 stated no request for an earlier consultation was made and no notification to the provider for any treatments to the area was made. In a follow-up interview at 12:00 PM, Clinical Coordinator Licensed Practical Nurse #3 stated they were made aware of Resident #3's scabbed area on the resident's left ankle on 06/08/2024, but did not notify the medical provider or request any treatments or document it in the electronic medical record. During an interview on 01/07/2025 at 1:30 PM, Nurse Practitioner #5 stated when a wound consult is ordered, wound rounds would be made on the next scheduled day of the week and are then done weekly. If a wound consult is required sooner, staff just need to make a call and they would come and assess the resident sooner. Nurse Practitioner #5 stated there had been no request to come sooner for Resident #3 and that interventions were not followed according to the facility's Clinical Reference Quick Guide (for skin issues). During an interview on 01/07/2025 at 10:00 AM, the Chief Nursing Officer stated Clinical Coordinator Licensed Practical Nurse #3 was responsible for notifying the provider and obtaining an order for the pressure area when it was discovered on 06/07/2024, and had received additional in-house training for the senior nurse role. The Chief Nursing Officer stated they had not focused on Registered Nurse #4's (lack of intervention) during their investigation, just Clinical Coordinator Licensed Practical Nurse #3. 10 NYCRR 415.12(c)(1)