STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335081	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/16/2024

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 49368 Based on observations, interviews, and record review conducted during a Recertification Survey, for one (Resident #330) of one resident reviewed, the facility did not provide services to meet professional standards of quality.Specifically, multiple doses of a medication were left unattended at the resident's bedside with no assessment completed to ensure the safety of. This is evidenced by the following: The facility policy, Patients on Self-Medication, dated 6/6/20, documented that medical and nursing staff determine if an elder is safe to self-administer medications using nursing admission assessment to identify if patient self-medicated at home. Medical staff orders self-medications based on this information. Elders on self-medication will have a secure area provided. Resident #330 had diagnosis including narrowing of the esophagus, mild cognitive impairment, and gastroesophageal reflux disease (stomach acid repeatedly flowing back into the esophagus). The Minimum Data Set Resident Assessment, dated 3/6/24, revealed Resident #330 was moderately impaired cognitively. Review of Resident #330's current Comprehensive Care Plan revealed no information related to the residents' ability to safely self-administer medications. Review of Resident #330's current Physician's orders revealed an order for calcium carbonate 500 milligram chewable tablet one time daily. The orders did not include the resident was able to self-administer medications. Review of Resident #330's April 2024 Medication Administration Record revealed that calcium carbonate 500 milligram chewable tablet was signed off as administered 4/1/24 through 4/11/24. During an observation and interview on 4/9/24 at 3:29 PM, Resident #330 was sitting in recliner in room with a medication cup containing a tablet (identified as calcium carbonate). Resident #330 stated that the medication in the medication cup was Tums and stated the nurse leaves it for them daily. Resident #330 then poured the tablet into another medication cup in their bed side tray table drawer where seven other similar tablets were observed. During an observation on 4/11/24 at 9:38 AM, Resident #330 opened their bed side tray table and displayed another medication cup containing approximately 26 similar tablets. Resident #330 stated at this time that they did not need them anymore. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/11/24 at 4:02 PM Licensed Practical Nurse #1stated there were currently no residents that were able to self-administer medications on the unit. Licensed Practical Nurse #1stated part of the process for administering medications was to ensure the resident swallowed their medications. During an interview on 4/11/24 at 4:15 PM Registered Nurse Manager #1 stated Resident #330 was not able to self-administer medications. Registered Nurse Manager #1 opened Resident #330's bed side table drawers and took out 2 medication cups filled with chewable tablets and stated they should not be in the drawer. In a nursing progress note dated 4/11/24 at 5:12 PM, Registered Nurse Manager #1 documented that 35 calcium carbonate tablets were found in Resident #330's bed side tray and were removed from the room. 10 NYCRR 415.11(c)(3)(i)

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 49368 Based on observations, interviews, and record review conducted during a Recertification Survey, for one (Resident #78) of two residents reviewed, the facility did not ensure that appropriate treatment and services were provided to prevent urinary tract infections for a resident with an indwelling urinary catheter (tube inserted into the bladder to drain urine). Specifically, Resident #78 was observed on several occasions with their uncovered urinary drainage bag (bag used to collect urine through the indwelling urinary catheter) lying directly on the floor including an observation of their urinary drainage bag resting on a dining room table above the level of their bladder with several staff within view. Additionally Resident #78's Comprehensive Care Plan did not include goals and/or interventions related to any resident behaviors related to their urinary catheter and/or urinary drainage bag. This is evidenced by the following: The current facility policy, Urinary Catheter Use and External Catheter Use Guidelines dated 7/12/22, included maintenance procedure of indwelling urinary catheter: at no time should the tubing be placed above the level of the bladder to allow back flow of urine into the bladder. Secure urinary drainage bag below the level of the bladder on the side of the bed frame and keep off the floor at all times. Use a dignity cover as needed. Resident #78 had diagnosis including neurogenic bladder (bladder with diminished sensation), benign prostatic hyperplasia (enlargement of the prostate), and dementia. The Minimum Data Set Resident Assessment, dated 4/5/24, documented the resident had severely impaired cognition, had an indwelling urinary catheter and had no behaviors identified for that time period. Review of Resident #78's current Comprehensive Care Plan revealed that Resident #78 had a suprapubic catheter (indwelling urinary catheter inserted directly into the bladder via the abdomen) due to urinary retention and neurogenic bladder with interventions to keep the bag below the level of the bladder whether sitting, lying, or walking and to change the urinary drainage bag daily. The Comprehensive Care Plan did not include that Resident #78 had any behaviors related to care of their urinary catheter and/or drainage bag. Review of Resident #78's Resident Care Summary (care plan used by the Certified Nursing Assistants for daily care), dated 4/15/24, revealed the resident had a suprapubic catheter but did not include instructions to staff to keep the bag below the level of the bladder or any resident behaviors related to their urinary catheter and/or drainage bag. Review of the current physician's orders included a suprapubic catheter to gravity drainage, to change the catheter every four weeks and the urinary drainage bag daily if being changed over to a leg bag and to change the leg bag daily. During an observation on 4/9/24 at 12:17 PM, Resident #78's uncovered urinary drainage bag was directly on the floor in the common area. There was no hook on the drainage bag (used to secure the bag to the bedframe or chair and off the floor). (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 4/10/24 at 8:50 AM Resident #78's uncovered urinary drainage bag was directly on the floor in their room. There was no hook on the drainage bag. During observations on 4/11/24 at 9:43 AM Resident #78's uncovered urinary drainage bag was directly on the floor in their room. There was no hook on the drainage bag. During observations on 4/11/24 at 4:08 PM Resident #78's urinary drainage bag was sitting on the dining room table above the level of their bladder. Several staff members were in visibility of the resident in the dining room at the time. During an interview on 4/16/24 at 9:36 AM Certified Nursing Assistant #1 stated they usually cover it (urinary catheter bag) and keep it below the bladder and off the floor. Certified Nursing Assistant #1 stated that if a urinary drainage bag did not have a hook, they would let a nurse know so it (urinary catheter bag) was not dragging on the floor, and we should never put a urinary drainage bag on a table or anywhere above the bladder. Additionally Certified Nursing Assistant #1 stated that Resident #78 sometimes played with their catheter bag and the tubing. During an interview on 4/16/24 at 10:11 AM Licensed Practical Nurse #4 stated staff should never leave the urinary drainage bag sitting on the floor and it should always be covered and hanging below the level of the bladder. Licensed Practical Nurse #4 stated Resident #78 had a history of playing with their urinary drainage bag, taking the cover off and have been known to pick up the drainage bag and put it on the table. During an interview on 4/16/24 at 11:10 AM Registered Nurse Manager #1 stated facility policy and procedures should be followed, and a urinary drainage bag should not be on the floor for infection control reasons. Additionally, Registered Nurse Manager #1 stated Resident #78 has at times moved their drainage bag, pulled the bag off, or emptied the bag. During an interview on 4/16/24 at 1:29 PM the Chief Nursing Officer stated that urinary drainage bags should not be found on the floor without a barrier and should be positioned above the level of the bladder. The Chief Nursing Officer stated it (care of the urinary drainage bag and any behaviors related to it) should be added to their individualized care plan. 10 NYCRR 415.12(d)(1)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49686 Based on observations, interviews, and record review conducted during a Recertification Survey, for two (Residents #62 and #238) of four residents reviewed, the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infections. Specifically, there was a lack of appropriate hand hygiene (washing hands or using alcohol-based hand sanitizer) and lack of appropriate glove use observed during wound care for both residents. This is evidenced by the following. The facility policy, Precautions-Standard and Transmission Based of Infectious Organisms, revised 3/22/24, documented that gloves are to be worn at all times when delivering resident personal care, and when there is contact with blood, body fluids or mucous membranes. Wearing gloves does not replace the need for hand hygiene. Hand hygiene must be performed whenever gloves are removed. Enhanced Barrier Precautions refer to an infection control intervention designed to reduce transmission of multi-drug resistant organisms that employs targeted gown and glove use during high contact resident activities. Enhanced Barrier Precautions are used with residents that have wounds or indwelling devices and are utilized when performing wound care (any skin opening requiring a dressing). Review of the facility policy Hand Hygiene, revised 10/21/22, included that hand washing is the single most important means of preventing the spread of infection from one person/environment to another. Hand hygiene should occur after touching secretions (liquids produced by the body) with wound drainage, skin infections, or blood. Alcohol-based hand sanitizer or hand washing should occur after removing gloves, and before and after touching a resident. 1. Resident #238 had diagnoses of diabetes, gangrene (death of body tissue due to lack of blood flow or serious bacterial infection) of the left second toe, and multiple pressure ulcers/injuries. The Minimum Data Set Resident Assessment, dated 2/26/24, documented that Resident # 238 was severely impaired cognitively and had several pressure ulcers/injuries which required care. In a medical wound status report dated 4/10/24, Nurse Practitioner #1 documented that Resident #238 had the following pressure ulcers/injuries: -A deep tissue injury (a localized area of purple or maroon discoloration of intact skin or blood-filled blister indicating underlying soft tissue injury) of the left outer foot (wound #1). -An unstageable pressure ulcer/injury covered with slough or eschar (dead tissue that prevents assessment of the true depth of an ulcer) to the left second toe (wound #2). -An unstageable pressure ulcer to the left third toe (wound #3). -A stage 2 (partial thickness loss of skin that appears as a shallow crater) to the left buttock (wound #4). -A stage 2 pressure ulcer to the natal cleft (the groove between the buttocks) (wound #5). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of current Physician orders dated 4/10/24 included treatments for all the above pressure ulcers/injuries listed above. Observation of wound care on 4/12/24 at 10:16 AM for Resident #238 included the following: -Licensed Practical Nurse #2 put on a disposable gown and gloves. Licensed Practical Nurse #2 did not complete any hand hygiene prior to applying the gloves. -Licensed Practical Nurse #2 removed the soiled dressing from wound #1. Licensed Practical Nurse #2 did not change gloves or perform hand hygiene after touching the soiled dressing prior to applying the prescribed treatment and a clean dressing. -Wearing the same gloves, Licensed Practical Nurse #2 then removed the soiled dressing from wound #2 (gangrenous toe wound) and applied the prescribed treatment and a clean dressing without performing hand hygiene or changing their gloves. -Wearing the same gloves and without performing hand hygiene, Licensed Practical Nurse #2 applied clean gauze between wound #2 and wound #3. -Licensed Practical Nurse #2 removed their soiled gloves and without performing hand hygiene, applied clean gloves and removed the soiled dressing from wound #4 and wound #5. Treatments and new dressings were again provided to both wounds without completing hand hygiene or changing gloves. -Wearing soiled gloves, Licensed Practical Nurse #2 assisted Resident #238 with repositioning then removed their gloves, and placed a tube of cream in their shirt pocket without performing hand hygiene. During an interview on 4/12/24 at 11:10 AM, Licensed Practical Nurse #2 stated that they should have performed hand hygiene and re-glove between wounds, but they were in a hurry. During an interview on 4/12/24 at 12:55 PM, Registered Nurse Manager #2 stated that hand hygiene and changing of gloves should be performed after removing the old dressing before applying a new dressing and between care of different wound sites. 2. Resident #62 had diagnoses including a recent periprosthetic fracture (broken bone that occurs around the prothesis following knee or hip surgery) and a stage 3 pressure ulcer/injury (full thickness wound involving damage to or necrosis of tissue). The Minimum Data Set Resident assessment dated [DATE], documented the resident was moderately impaired cognitively and had a stage 3 pressure ulcer/injury. Current Physician orders included treatments to the stage 3 natal cleft area daily and as needed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation & interview on 4/12/24 at 9:41 AM, Licensed Practical Nurse #3 put on a pair of gloves and removed the soiled dressing from Resident #62's pressure ulcer/injury. Without changing gloves or completing hand hygiene, Licensed Practical Nurse #3 applied the prescribed treatment and a clean dressing. Using the same pair of gloves used to change the resident's dressing, Licensed Practical Nurse #3 then touched the Apex machine (a device to assist a resident with transferring), Resident #62's clothing, their own face mask and multiple environmental surfaces. Licensed Practical Nurse #3 stated at that time that they did not change their gloves after removing the soiled dressing but should have. In an interview on 4/12/24 at 2:22 PM. the Infection Control Nurse stated hand hygiene should be performed prior to resident care and after taking off their gloves. The Infection Control Nurse said gloves should be changed and hand hygiene performed after removing the old dressings between each wound area on the body and nurses should not touch anything else (in the room) with the same pair of gloves after a dressing change. During an interview on 4/16/24 at 10:31 AM, the Chief Nursing Officer stated they would expect the nurses to remove gloves, perform hand hygiene and apply new gloves before proceeding to another wound and should also administer care from the cleanest wound first then proceed to the dirtiest wounds to prevent contamination. 10 NYCRR 415.19(b)(4)