STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335105	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jewish Home of Rochester	2021 Winton Road South Rochester, NY 14618

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on interviews and record review conducted during a Recertification Survey completed on 09/25/2025, for two (2) (Resident #127 and #280) of two (2) residents reviewed, the facility did not ensure all alleged violations involving abuse, neglect, or mistreatment are reported immediately, but not later than two (2) hours after the allegation is made, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to the State Survey Agency in accordance with State law through established procedures. Specifically, Resident #127 was physically aggressive toward other residents during several resident-to-resident altercations occurring from 05/17/2025 to 09/13/2025, and the incidents of physical abuse were not reported to the State Survey Agency. Resident #280, fell off a sidewalk curb, sustained a major injury (head strike resulting in a laceration and bleeding requiring hospitalization and sutures), and the facility did not report the incident to the State Survey Agency. The findings are:The facility policy Abuse Investigation dated 08/16/2025 included, but was not limited to, the New York State Health Department is notified when there is reasonable cause to believe abuse, neglect, or mistreatment has occurred. Reporting Requirements included: identify if abuse and other incidents have occurred, report abuse immediately to the administrator or designee and appropriate agency (i.e. New York State Department of Health) with immediately defined as within 24 hours after discovery of the incident. If serious bodily injury has occurred, report within two (2) hours of forming the suspicion of abuse and all other incidents must be reported within 24 hours. 1. Resident #127 had diagnoses including severe dementia with other behavioral disturbance, cognitive communication deficit (an impaired ability to communicate effectively), and aphasia (a language disorder that affects a person's ability to communicate). The Minimum Data Set (a resident assessment tool) dated 08/06/2025 documented the resident had severely impaired cognition, exhibited physical behaviors directed toward others, and their behaviors worsened since the previous assessment. Review of the Comprehensive Care Plan last revised on 09/09/2025 revealed Resident #127 had behaviors including involvement in 16 resident-to-resident incidents occurring from 05/17/2025 to 09/13/2025. For 12 of the 16 documented incidents, Resident #127 struck/slapped/hit residents in the face, head, or other body part, and pushed a resident causing them to fall. Interventions included, but were not limited to, document behaviors every shift, separate involved residents, redirect Resident #127 away from others with the assistance of two (2) staff, provide increased supervision, and to notify medical providers. Review of facility Incident/Accident Reports and investigations from 05/13/2025 to 09/24/2025 included Resident #127 was involved in 16 resident-to-resident incidents, 15 of which documented the physical aggression of Resident #127 directed toward another resident. One (1) incident, dated 07/13/2025, included Resident #127 pushed another resident, causing that resident to fall and sustain a skin tear to their right elbow. There was no documented evidence the facility had reported any of the resident-to-resident incidents to the New York State Department of Health.During an interview on 09/22/2025 at 8:59 AM, the Director of Neurobehavioral stated Resident #127 was behaviorally complicated due to being intrusive and unpredictable. Resident #127 would get into other (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident's space and swat at them, but it was never with a closed fist. The Director of Neurobehavioral stated resident-to-resident altercations were investigated promptly, and the incidents were reported to the Administrator, families, and the interdisciplinary team.During an interview on 09/23/2025 at 10:33 AM, Certified Nurse Assistant #6 stated Resident #127 had a history of violence and did not like other residents in their space. They stated Resident #127 was unpredictable, did not like noise, and would get in the faces of other residents. If residents were to yell out, the yelling would agitate the Resident #127, resulting in them hitting or grabbing the other resident. Certified Nurse Assistant #6 stated Resident #127 had been involved in a significant number of resident-to-resident altercations, and it was hard to keep everyone safe.During an interview on 09/23/2025 at 10:53 AM, Behavioral Specialist #1 stated there were times when Resident #127 had hurt other residents during their episodes of physical aggression. During an interview on 09/23/2025 at 12:59 PM with the [NAME] President of Resident Services (Director of Nursing), Administrator, and Assistant Director of Nursing, the [NAME] President of Resident Services stated none of the resident-to-resident altercations had been reported to the New York State Department of Health because no one was injured, and the altercations were not sexual in nature. The Administrator stated the physical altercations were not reported to the New York State Department of Health because no care plan violations were involved.During an interview on 09/24/2025 at 9:38 AM, Licensed Practical Nurse #10 stated resident-to-resident altercations should be reported to the New York State Department of Health if there was an injury associated or if a resident had several incidents. 2. Resident #280 had diagnoses including dementia, difficulty walking, and weakness. The Minimum Data Set, dated [DATE] included the resident was cognitively intact.During an observation and interview on 09/17/2025 at 11:43 AM, Resident #280's left side of their face was bruised with a large bandage on their forehead. The resident stated they were outside, went to step off the curb, fell on their head, and went to the hospital for a couple of days. In a progress note dated 09/10/2025, Registered Nurse Supervisor #1 documented they were notified Resident #280 fell in the parking lot and a lot of blood was noted. The resident stated they felt dizzy, oxygen was applied, 911 was called, and the resident was transported to the hospital.Review of an undated Investigative Report revealed on 09/10/2025, Resident #280 was wheeled from Cottage 3 (residential unit) to an outside event and placed on the sidewalk by Recreation Therapy Assistant #1. Recreation Therapy Assistant #1 locked the right side of the resident's wheelchair and returned to the Cottage to retrieve paperwork they had dropped during the transport. As Recreation Therapy Assistant #1 turned to walk back to Cottage 3, Resident #280's wheelchair began to slowly roll off the curb. Recreation Therapy Assistant #1 and Security Guard #1 ran to the resident's side. Resident #280 had a laceration above their left eye with bruising, multiple staff responded to assist, emergency medical services (911) were called, and the resident was sent to the hospital. The investigation included Resident #280 usually self-propelled the wheelchair around their Cottage, leg rests were placed on the wheelchair to attend an event, and the left side of the wheelchair was not locked by Recreation Therapy Assistant #1 which may have contributed to the fall. Following review of the incident, Recreation Therapy Assistant #1 was counseled, and the recreation therapy team was educated on wheelchair safety. During an interview on 09/25/2025 at 8:42 AM, the Director of Nursing stated they did not report Resident #280's fall on 09/10/2025 to the State Survey Agency as they only report falls with major injuries to the health department if a care plan violation had been identified. 10 NYCRR 415.4 (b)(2)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review conducted during a Recertification Survey completed on 09/25/2025, 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 diseases and infections for three (3) (Residents #10, #37, and #143) of eight (8) residents and one (1) (Unit 4 North East) of 15 residential units reviewed. Specifically, for Residents #10, #37, and #143 the facility did not appropriately implement the use of Enhanced Barrier Precautions (EBP, an infection control strategy that uses gloves and gowns during high contact resident care to reduce the spread of infection) and there were several observations where staff did not use personal protective equipment (PPE, equipment, such as gown and gloves, worn to protect individuals and reduce the risk of exposure to and spread of infections) as required for high-contact care. During observations of wound care for Resident #10 and of a staff and resident interaction on Floor 4 North East, staff did not perform hand hygiene during wound care and/or appropriately remove gloves and perform hand hygiene in between residents.The findings are:The facility policy Enhanced Barrier Precautions dated 06/24/2024 included, but was not limited to, enhanced barrier precautions expand the use of personal protective equipment beyond situations in which exposure to blood and body fluids is anticipated and refer to the use of gloves and gowns during high contact resident care activities that promote opportunities for transfer of multi-drug resistant organisms (MDRO) to staff's hands and clothing. In addition to standard precautions, gowns and gloves should be worn during the following high-contact resident care activities: wound care, providing hygiene, changing briefs/assisting with toileting, and device care or use. For enhanced barrier precautions, signage should clearly indicate the high-contact resident care activities that require the use of gowns and gloves, personal protective equipment including gowns and gloves should be made available immediately outside the resident's room, and a trash can positioned inside the resident's room and near the exit for discarding personal protective equipment after removal, prior to exiting the room or before providing care to another resident in the same room.1. Resident #37 had diagnoses including an unstageable right heel pressure ulcer, generalized edema, and adult failure to thrive. The Minimum Data Set (a resident assessment tool) dated 05/01/2025 documented the resident had moderately impaired cognition, had an ulcer, and required wound care. Review of Resident #37's Comprehensive Care Plan revised on 08/19/2025 revealed the resident had a right heel pressure ulcer. Interventions included, but were not limited to, perform wound care daily and as needed. The care plan did not include information related to enhanced barrier precautions. During an observation and interview on 09/17/2025 at 03:23 PM, there was no enhanced barrier precautions signage or personal protective equipment outside or near the Resident #37's room. When interviewed at that time, the Director of Neurobehavioral stated the resident had a deep tissue injury to their right great toe and a pressure ulcer on their right heel. During an observation on 09/23/2025 at 9:58 AM, there was no enhanced barrier precautions signage or personal protective equipment outside or near Resident #37's room. Licensed Practical Nurse Clinical Coordinator #11 performed wound care to the resident's right heel. The nurse wore gloves only and did not wear a gown. The nurse did not change gloves or perform hand hygiene between removing the soiled dressing and putting on a clean dressing. During an interview on 09/23/2025 at 10:19 AM, Licensed Practical Nurse Clinical Coordinator #11 stated they usually change gloves, but did not this time, and they were not taught to wear a gown for wound care if there was no bleeding.During an interview on 09/24/2025 at 01:48 PM, the Infection Preventionist stated staff must wear a gown for wound care and should change gloves before applying a clean dressing to prevent cross contamination. The Infection Preventionist stated this is covered in orientation, annual training, and as-needed education.2. Resident #10 had diagnoses including an unstageable pressure ulcer (a localized skin and soft tissue injury due to prolonged (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pressure), coronary artery disease (heart disease), and peripheral vascular disease (a condition of reduced blood flow to the legs or arms). The Minimum Data Set, dated [DATE], documented Resident #10 was cognitively intact, had an unhealed pressure ulcer, and received wound care. Review of Resident #10's Comprehensive Care Plan, revised 07/29/2025, revealed Resident #10 had a wound to the left toe. Interventions included, but were not limited to, perform wound care per medical orders. The care plan did not include information related to enhanced barrier precautions. During an observation on 09/22/2025 at 11:47 AM, Resident #10's room did not have enhanced barrier precautions signage and Licensed Practical Nurse #8 (LPN #8) provided wound care to the left great toe without a gown. 3. Resident #143 had diagnoses including chronic kidney disease, obstructive uropathy (urinary tract restriction which impairs the ability to urinate), and had a suprapubic catheter (a tube inserted directly into the bladder to drain urine). The Minimum Data Set, dated [DATE] documented the resident was cognitively intact.Review of Resident #143's Comprehensive Care Plan, revised 09/17/2025, revealed the resident had a suprapubic catheter placed on 09/09/2025. Interventions included, but were not limited to, catheter care per policy and to empty the catheter bag at the end of each shift. The care plan did not include information related to enhanced barrier precautions. During an observation on 09/17/2025 at 10:16 AM, a Certified Nursing Assistant emptied Resident #143's catheter drainage bag wearing only gloves. There was no enhanced barrier precautions signage outside the resident's room and no personal protective equipment was readily available. During an interview on 09/17/2025 at 10:19 AM, Registered Nurse Manager #3 stated there were residents with wounds and indwelling catheters on the unit, and no residents on enhanced barrier precautions at that time.During an interview on 09/23/2025 at 10:02 AM with the Infection Preventionist and Director of Nursing, the Infection Preventionist stated residents with known multi-drug resistant organisms, and wounds or indwelling devices should be on enhanced barrier precautions. The Infection Preventionist stated there were no residents in the facility currently on enhanced barrier precautions. During an interview on 09/24/2025 at 1:29 PM, the Infection Preventionist stated they now understand enhanced barrier precautions is indicated for all residents with wounds or indwelling devices, because many people can have multi-drug resistant organisms and not know it. The Infection Preventionist stated all staff had since been educated on enhanced barrier precautions and personal protective equipment use.4. During an observation on 09/17/2025 at 3:27 PM, Licensed Practical Nurse Clinical Coordinator #11 exited an unknown resident's room still wearing their gloves and carrying a soiled brief when they approached Resident #222 who was wandering the hall. Licensed Practical Nurse Clinical Coordinator #11 touched the resident on their left shoulder while the soiled gloves were still on. Resident #222 then held on to the nurse's wrist, making direct contact with their gloves.During an interview on 09/17/2025 at 3:35 PM, Licensed Practical Nurse Clinical Coordinator #11 stated this was an infection control concern and said the trash bin in the room had no bag.During an interview on 09/24/2025 at 2:02 PM, the Infection Preventionist stated staff are trained to never wear gloves in hallways and to never touch a resident with contaminated gloves due to the risk of cross contamination.10 NYCRR 415.19(a)(1-4)(b)(1-4)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review conducted during a Recertification Survey completed on 09/25/2025 for one (1) (Resident #280) of two (2) residents reviewed, the facility did not ensure an incident was thoroughly investigated to rule out abuse, neglect, or mistreatment. Specifically, Resident #280 fell off a sidewalk curb, sustained a major injury (head strike resulting in a laceration and bleeding requiring hospitalization and sutures), and the facility was unable to provide documented evidence of a thorough investigation to rule out potential neglect. The findings are:The facility policy Abuse Investigation dated 08/16/2025 documented reporting requirements include, but are not limited to, an incident is investigated immediately and must be completed within five (5) business days. When an alleged incident of abuse or neglect is reported, a nursing department administrator will be designated to investigate the incident. The investigation report will include, but is not limited to, an interview investigation log, witness statements, statement from the resident, and the Certified Nursing Assistant (CNA) care card for the resident involved. All documentation related to the investigation and outcome will be maintained in a confidential file in the nursing office.Resident #280 had diagnoses including dementia, difficulty walking, and weakness. The Minimum Data Set (a resident assessment tool) dated 06/19/2025 included the resident was cognitively intact, used a manual wheelchair for independent mobility for at least 50 feet and moderate assistance with mobility for distances up to 150 feet.During an observation and interview on 09/17/2025 at 11:43 AM, Resident #280's left side of their face was bruised with a large bandage on their forehead. The resident stated they were outside, went to step off the curb, fell on their head, and went to the hospital for a couple of days. Review of Resident #280's Comprehensive Care Plan, last revised 09/16/2025, revealed the resident had an alteration in their thought process related to dementia, an alteration in their mobility, and had a history of falls. Interventions included, but not limited to, resident transfers with a minimal assistance from staff and with use of a front wheeled walker as ambulation is no longer functional and safe, resident can and prefers to self-propel their wheelchair short distances on the unit, needs verbal cues to scoot back further in their chair, and foot pedals are required for off unit mobility. In a progress note dated 09/11/2025, Registered Nurse Manager #5 documented Resident #280 returned from the hospital following a fall the previous evening which resulted in a head strike and facial laceration. Several skin issues were sustained including a left forehead laceration with sutures and bruising, skin tears to the left elbow and left shoulder, and abrasions to the left knee and right hand. In a facility Incident Report Form dated 09/10/2025 (not originally included with the investigative report provided by the facility), Security Guard #1 documented Resident #280 had a fall with a head laceration and bleeding which occurred as a result of negligence. The report included Recreation Therapy Assistant #1 left Resident #280 by the curb, without locking their wheelchair in place, to go get something and while Recreation Therapy Assistant #1 had their backed turned, Resident #280 rolled off the curb and fell on the ground sustaining a head laceration. Resident #280 was transported to the hospital via ambulance. In an undated witness statement, Recreation Therapy Assistant #1 documented they brought Resident #280 to the sidewalk, locked the right wheelchair brake, and returned up the ramp to retrieve a phone and resident list that had fallen out of their pocket. Review of an undated Investigative Report revealed on 09/10/2025 Resident #280 was wheeled from Cottage 3 to an outside event and placed on the sidewalk by Recreation Therapy Assistant #1. Recreation Therapy Assistant #1 locked the right side of the resident's wheelchair and returned to the Cottage to retrieve paperwork they had dropped during the transport. As Recreation Therapy Assistant #1 turned to walk back to Cottage 3, Resident #280's wheelchair began to slowly roll off the curb. Recreation Therapy Assistant #1 and Security Guard #1 ran to the resident's side. Resident #280 had a laceration above their left eye with bruising, multiple staff responded to assist, emergency medical services (911) were called, and the resident was sent to the hospital. The investigation included Resident #280 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	usually self-propelled the wheelchair around their Cottage (residential unit), leg rests were placed on the wheelchair to attend an event, and the left side of the wheelchair was not locked by Recreation Therapy Assistant #1 which may have contributed to the fall. Following review of the incident, Recreation Therapy Assistant #1 was counseled, and the recreation therapy team was educated on wheelchair safety. The investigative report did not include documentation of Resident #280's plan of care (including any supervision or mobility requirements), a comprehensive listing of injuries sustained, a complete listing of witnesses and their statements, a statement from the resident, or a conclusion or determination ruling out abuse, neglect, or mistreatment. During an interview on 09/24/2025 at 11:04 AM, Registered Nurse Manager #5 stated they would start an investigation, look into things a little bit and then bring what they had found to the Director of Nursing. Registered Nurse Manager #5 stated the Director of Nursing completed the investigation for Resident #280's fall on 09/10/2025 as it involved staff they did not supervise. During an interview on 09/24/2025 at 1:39 PM with the Director of Nursing, Assistant Director of Nursing, and the Administrator who all stated they were not at the facility when Resident #280 fell on [DATE]. The Director of Nursing stated either they or the Nurse Managers investigate falls, the nurses complete the incident reports, the managers type up the investigations, and the Director of Nursing reviews them. The Director of Nursing stated Security Guard #1 was directing traffic at the time of Resident #280's fall and video footage showed the guard walking over right after the resident fell. The Director of Nursing stated the security staff complete their own incident reports with statements and the facility does not include them in their investigation files. During an interview on 09/24/2025 at 3:08 PM, Recreation Therapy Assistant #1 stated they were taking Resident #280 outside of Cottage 3 when their phone and a resident list fell out of their pocket in the doorway of the Cottage. They wheeled the resident down the ramp and around the corner, locked the right brake on the resident's wheelchair, and went to go back to the Cottage door to pick up the items they dropped. Recreation Therapy Assistant #1 stated they heard something and ran back toward Resident #280 as they were falling off the sidewalk curb onto the street. Recreation Therapy Assistant #1 stated they do not know how the resident fell because a building pillar blocked their view of the resident. During an interview on 09/25/2025 at 8:42 AM, the Director of Nursing stated they should have provided Security Guard #1 statement to the State Surveyor when asked for the complete investigation. The Director of Nursing stated they ruled out abuse and neglect based on staff statements and watching the video footage. From the video footage, the Director of Nursing stated they were unable to determine what Resident #280 was doing immediately prior to falling as full view of the resident was obstructed by a pillar. The Director of Nursing stated they should have included in their investigative report that no abuse, neglect, mistreatment, or care plan violation was determined. 10 NYCRR 415.4(b)(3)

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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. Based on observations, interviews, and record review conducted during a Recertification Survey completed on 09/25/2025, the facility did not ensure services were provided to meet professional standards of quality for one (1) (Resident #333) of five (5) residents reviewed. Specifically, Licensed Practical Nurse #9 was observed giving Resident #333 metoprolol tartrate (a heart medication used to treat high blood pressure) without checking the resident's blood pressure or heart rate before administering the medication as ordered by the medical provider. Additionally, review of the electronic medical record revealed on several days the metoprolol was documented as administered with no recorded blood pressures or heart rates from 08/01/2025 to 09/23/2025.The findings are:Resident #333 had diagnoses including atrial flutter (a condition where the heart's upper chambers beat too quickly), diabetes, and high blood pressure. The Minimum Data Set (a resident assessment tool) dated 09/04/2025 revealed the resident had severely impaired cognition.During a medication administration observation on 09/23/2025 at 8:23 AM, Licensed Practical Nurse #9 placed metoprolol tablets in a medication cup and gave them to Resident #333. The nurse did not check or document the resident's blood pressure or heart rate before giving the medication.Current medical orders for Resident #333 reviewed on 09/23/2025 included metoprolol tartrate 25 milligrams, give 1.5 tablet by mouth two times a day for hypertension. The order included to hold the medication if the systolic blood pressure (top number) was less than 100 or the heart rate was less than 60, and to notify a medical provider.Review of Resident #333's Medication and Treatment Administration Records from 08/01/2025 to 09/23/2025 revealed no documented blood pressures or heart rates.Review of the electronic health record's Vital Signs tab from 08/01/2025 to 09/23/2025 revealed no documented blood pressures or heart rates for 94 out of 107 opportunities when metoprolol was given.During an interview on 09/23/2025 at 11:35 AM, Licensed Practical Nurse #9 said nurses are supposed to check blood pressure or heart rate before giving medications with hold parameters. Licensed Practical Nurse #9 said she did not check Resident #333's blood pressure or heart rate because she did not notice any hold parameters in the order at that time.During an interview on 09/23/2025 at 12:16 PM, Registered Nurse Manager #1 said nurses must follow the doctor's orders and hold parameters tell the nurse when not to give a medication. Registered Nurse Manager #1 said the system usually requires the nurse to enter the vital signs before giving the medication, but she did not see any vital signs documented for this resident.During an interview on 09/24/2025 at 2:49 PM with the Director of Nursing and Administrator, the Director of Nursing said hold parameters tell the nurse when not to give a medication and that nurses must check and document blood pressure or heart rate before giving medications with those parameters. The Director of Nursing said giving a medication without checking the hold parameters is considered a medication error.10 NYCRR 415.11(c)(3)(i)

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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. Based on observations, interviews, and record review conducted during a Recertification Survey completed on 09/25/2025, the facility did not ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good grooming and personal hygiene for one (1) (Residents #196) of one (1) resident reviewed. Specifically, Resident #196 was observed on several occasions with dark brown debris underneath multiple fingernails and long facial hair on their chin. The findings are:The facility policy Bathing dated 08/19/2025 included, but was not limited to, residents can have a shower or bath at their request and the ADIR (Certified Nursing Assistant) will provide nail care (fingers and toes) with bathing as assigned. Resident #196 had diagnoses including dementia, adult failure to thrive, and Parkinson's disease (a progressive neurological disorder that affects movement, balance, and coordination). The Minimum Data Set (a resident assessment tool) dated 07/21/2025, documented the resident had severely impaired cognition, required staff assistance with showering and personal hygiene, and had no rejection of care. Review of Resident #196's Comprehensive Care Plan, revised 09/11/2025, revealed the resident had a self-care deficit related to hemiparesis (weakness and paralysis on one side of the body) and Parkinson's disease. Interventions included, but were not limited to, follow the Activities of Daily Living (ADL) sheet and encourage the resident to participate in their care to the extent possible. The care plan did not include interventions related to nail care or grooming. Review of Resident #196's current Kardex (care plan used by certified nursing assistance to guide daily care) reviewed on 09/19/2025, included showers and daily routine per the resident's preference and request, and staff were to provide total assistance daily when completing activities of daily living and hygiene care. Review of the nursing progress notes for Resident #196 from 08/26/2025 to 09/25/2025 did not include documentation of a shower, bed bath, nail care, personal grooming or rejection of care. During an observation on 09/18/2025 at 10:55 AM, Resident #196 had facial hair on their chin and brown debris underneath their right index fingernail and thumbnail.During an observation and interview on 09/22/2025 at 1:17 PM, Resident #196 had a significant amount of facial hair on their chin. Their right index fingernail and thumbnail had dark brown debris underneath, and nearly all their fingernails were broken, with sharp, jagged edges. When interviewed at that time, Licensed Practical Nurse #4 stated an unknown staff person had pointed out the resident's fingernails a few minutes prior. During an observation on 09/23/2025 at 11:50 AM, Resident #196's fingernails were trimmed, their right index fingernail and thumbnail continued with dark brown debris underneath, and there was a significant amount of facial hair on their chin, approximately one inch in length. During an interview on 09/23/2025 at 11:58 AM, ADIR/Certified Nursing Assistant #4 stated Resident #196's last shower was on the evening of 09/19/2025 but they were unsure when the resident last received nail care. They stated staff should perform nail care on the resident's shower day and each morning. ADIR/Certified Nursing Assistant #4 stated Resident #196 was unable to complete nail care independently. During an observation on 09/24/2025 at 9:22 AM, Resident #196 continued with a significant amount of facial hair on their chin. During an interview on 09/24/2025 at 11:07 AM, ADIR/Certified Nursing Assistant #5 stated personal care consisted of washing the face and body, nail, feet and hair care, and facial hair removal for men and women. ADIR/Certified Nursing Assistant #5 stated they did not notice Resident #196's facial hair and the resident did not have a history of refusing care. They said if staff noticed a resident had dirty nails, they should be cleaned while cleaning the resident's hands. During an interview on 09/24/2025 at 11:20 AM, Registered Nurse Manager #4 stated Resident #196 used to go to the salon for facial hair removal but no longer did so the ADIRs/Certified Nursing Assistants should have removed it. Registered Nurse Manager #4 stated Resident #196 was not a diabetic so the ADIRs/Certified Nursing Assistants should have cleaned underneath their fingernails.During an interview on 09/24/2025 at 11:34 AM, the Director of Nursing stated they would expect staff to have cleaned Resident #196's nails and there should not be debris (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335105	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jewish Home of Rochester	2021 Winton Road South Rochester, NY 14618

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	under any resident's fingernails. The Director of Nursing stated the ADIRs/Certified Nursing Assistants should remove all facial hair on the resident's shower day and document once it is complete. This care should be completed for all resident, including those on hospice, since it was important to maintain the resident's comfort and dignity. 10 NYCRR 415.12(a)(3)

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	335105	A. Building B. Wing	12/11/2025

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review conducted during a Recertification Survey completed on 09/25/2025, for two (2) (Residents #85 and #280) of nine (9) residents reviewed, the facility did not ensure the resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents. Specifically, Resident #85 required assistance with meals, had an order for no straws, and was observed drinking from a straw. Resident #280 was left in their wheelchair on the sidewalk, fell off the curb striking their head on the street, and sustained injuries including a head laceration requiring sutures. Additionally, Resident #280's current comprehensive care plan did not include the level of supervision required for mobility while on and/or off the residential unit in their wheelchair. The findings are:The facility policy Accident Incident Reporting and Monitoring dated 08/16/2025 included an incident can be a fall, discovery of a resident on the floor, or observation of a resident in a potentially unsafe situation. The Assistant Director of Nursing reviews reports to ensure complete documentation, appropriate evaluation, and corrective actions are implemented. 1. Resident #280 had diagnoses including dementia, difficulty walking, and weakness. The Minimum Data Set (a resident assessment tool) dated 06/19/2025 included the resident was cognitively intact, used a manual wheelchair for independent mobility for at least 50 feet and moderate assistance with mobility for distances up to 150 feet.Review of Resident #280's Comprehensive Care Plan, last revised 09/16/2025, revealed the resident had an alteration in their thought process related to dementia, an alteration in their mobility, and had a history of falls. Interventions included, but not limited to, resident transfers with a minimal assistance from staff and with use of a front wheeled walker as ambulation is no longer functional and safe, resident can and prefers to self-propel their wheelchair short distances on the unit, needs verbal cues to scoot back further in their chair, and foot pedals are required for off unit mobility. The care plan did not include the level of supervision Resident #280 required for mobility while on and/or off the residential unit in their wheelchair. During an observation and interview on 09/17/2025 at 11:43 AM, Resident #280's left side of their face was bruised with a large bandage on their forehead. The resident stated they were outside, went to step off the curb, fell on their head, and went to the hospital for a couple of days. In progress note dated 09/11/2025, Registered Nurse Manager #5 documented Resident #280 returned from the hospital following a fall the previous evening which resulted in a head strike and facial laceration. Several skin issues were sustained including a left forehead laceration with sutures and bruising, skin tears to the left elbow and left shoulder, and abrasions to the left knee and right hand. During an interview on 09/24/2025 at 3:08 PM, Recreation Therapy Assistant #1 stated they were taking Resident #280 outside of Cottage 3 when their phone and a resident list fell out of their pocket in the doorway of the Cottage. They wheeled the resident down the ramp and around the corner, locked the right brake on the resident's wheelchair, and went to go back to the Cottage door to pick up the items they dropped. Recreation Therapy Assistant #1 stated they heard something and ran back toward Resident #280 as they were falling off the sidewalk curb onto the street. Recreation Therapy Assistant #1 stated they do not know how the resident fell because a building pillar blocked their view of the resident.During an interview on 09/25/2025 at 8:42 AM, the Director of Nursing stated they should have provided Security Guard #1 statement to the State Surveyor when asked for the complete investigation. The Director of Nursing stated they ruled out abuse and neglect based on staff statements and watching the video footage. From the video footage, the Director of Nursing stated they were unable to determine what Resident #280 was doing immediately prior to falling as full view of the resident was obstructed by a pillar. 2. Resident #85 had diagnoses including Alzheimer's Disease, adult failure to thrive, and seizure disorder. The Minimum Data Set, dated [DATE] documented the resident had severely impaired cognition and was dependent (continued on next page)

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	335105	A. Building B. Wing	12/11/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of staff for eating assistance.The facility policy Dysphagia/Aspiration Protocol dated 07/20/2023 included, but was not limited to, all members of the interdisciplinary team were to identify residents at risk for aspiration precautions and refer to the medical record or diet roster to determine diet orders and guidelines prior to giving food or drink.During an observation and interview on 09/17/2025 at 12:17 PM, Certified Nursing Assistant #3 was assisting Resident #85 with drinking using a cup with a straw. When interviewed at that time, Certified Nursing Assistant #3 stated Resident #85 had an order for no straws, and they had not checked Resident #85's Kardex or the Diet Roster prior to assisting the resident but should have.Review of Resident #85's current Comprehensive Care Plan last revised 09/10/2025 and current Kardex (a care plan used by certified nursing assistants to provide daily care) revealed the resident had an alteration in their nutrition and was at risk for malnutrition. Interventions included, but were not limited to, diet orders for pureed foods, nectar thick liquids, and no straws, and to maintain aspiration precautions (safety measures to prevent choking).Review of the facility's Resident Diet Roster (a tool used for staff to provide care during meals) last updated on 09/15/2025 revealed Resident #85 was on aspiration precautions with pureed foods, nectar thick liquids and no straws. During an interview on 09/23/2025 at 11:01 AM, Registered Nurse Manager #2 stated staff should read the Resident Diet Roster and Kardex before each meal. They stated Certified Nursing Assistant #3 should have checked the Resident Diet Roster before assisting Resident #85 with their meal to prevent choking. During an interview on 09/24/2025 at 9:28 AM, the Registered Dietician stated they would expect staff to be familiar with the resident they were assisting and to review the care plan, diet roster, and any dietary guidelines. They stated Resident #85 was recently downgraded to nectar thick liquids following staff request and staff may have used the straw for Resident #85's comfort, but typically straws are not used for nectar thick liquids, and a recommendation for no straws is usually in place to prevent aspiration. During an interview on 09/24/2025 at 10:00 AM, the Director of Nursing stated Certified Nursing Assistant #3 should have checked Resident #85 Kardex for dietary orders before assisting Resident #85 for safety and to prevent choking.10 NYCRR 415.12(h)(1-2)