STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335197	A. Building B. Wing	10/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monroe Community Hospital	435 East Henrietta Road Rochester, NY 14620

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review conducted during an Abbreviated Survey (Incident ID: 2640065) from 10/15/2025 to 10/24/2025, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan for one (1) (Resident #1) of three (3) residents reviewed. Specifically, Resident #1 had no documented bowel movement from 09/24/2025 through 10/03/2025 and there was no documented evidence any as needed medications for constipation were administered. Resident #1 was hospitalized on [DATE] and found to have severe rectal stool burden (excessive amount of stool in the colon or rectum) requiring manual disimpaction (a procedure used to remove stool from the rectum) and stercoral colitis (an inflammatory condition of the large bowel caused by substantial stool burden). Following return from the hospital on [DATE], Resident #1 had no documented bowel movement through 10/16/2025, and there was no evidence any as needed bowel medications were administered until 10/15/2025. This facility's failure to implement an effective bowel management protocol, to follow care plan interventions, and act on documented alerts and bowel movement reports resulted in actual harm for Resident #1 and a likelihood for serious injury, serious harm, serious impairment, or death for all residents in the facility (census 403), that was Immediate Jeopardy and Substandard Quality of Care. The findings include: The facility policy titled Provision of Resident Care, revised 05/15/2023, included after care such as incontinence and bowel care is performed it is entered into the electronic medical record. The electronic medical record is programmed to provide alerts and reports for specific care-related documentation, including alerts and tasks that would prompt receiving users to initiate proper follow-up. Programmed alerts included, but are not limited to, absent bowel movements. Receiving users are expected to review and act upon alerts each shift. Programmed reports include bowel tracking and receiving users were expected to review and act upon the reports each shift.An undated facility document Bowel Movement (BM) Alert Training included if a resident has not had a documented bowel movement, an alert would trigger under the To Do list in the electronic medical record. Clinical nurse managers, administrative nurse managers, assessment nurses, supervisors, registered nurses, and nursing administration would see these alerts. Nursing should implement an appropriate bowel movement protocol and once the appropriate protocol was in place, the alert should be cleared. The facility could not provide a written bowel regimen policy, procedure, or protocol that provided monitoring timeframes or the parameters for administering as needed bowel medications. Resident #1 had diagnoses including multiple sclerosis (a disease that affects the central nervous system), depression, and generalized weakness. The Minimum Data Set (a resident assessment tool) dated 09/05/2025 included the resident was cognitively intact.Review of the comprehensive care plan last revised on 09/15/2025, revealed the resident had hypothyroidism (a condition where the thyroid gland is underactive) and a history of constipation with the use of laxatives (medications or substances that promote bowel movements) daily. Interventions included, but were not limited to, monitor bowel movements, check bowel sounds as indicated, assess abdomen for distention, and bowel management per medical orders.Review of September 2025 and October 2025 Physician Order Sheets revealed an order dated 08/29/2025 for polyethylene glycol 17 grams oral powder as needed two (2) times daily for constipation and an order dated 10/21/2024 for milk of magnesium 400 milligrams oral suspension once a day as needed for constipation. The physician orders did not specify after how many days without a bowel movement to administer as needed medications or the order in which as needed medications were to be administered.Review of the Activities of Daily Living Verification Worksheet (part of the electronic medical record used to track resident care) revealed Resident #1 had no documented bowel movement from 09/24/2025 through 10/03/2025.Review of bowel movement reports (includes the number of times residents had no bowel movement recorded or had missed documentation during the previous three (3) days), revealed Resident #1 was listed on reports dated 09/26/2025, 09/29/2025, 10/01/2025, and 10/03/2025. There was no documented evidence the reports had been reviewed or acted upon. Review of September 2025 and October 2025 Medication Administration Records revealed the as needed medications prescribed to Resident #1 for constipation were not administered from 09/24/2025 through 10/03/2025.Review of medical provider visit notes from 09/24/2025 to 10/03/2025 did not include evidence Resident #1's bowel status had been addressed. In a progress note dated 10/02/2025, Licensed Practical Nurse #4 documented Resident #1 was found wearing multiple urine-soaked briefs with a stool-contaminated dressing to the

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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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review conducted during an Abbreviated Survey (Incident ID: 2640065) from 10/15/2025 to 10/24/2025, the facility failed to ensure a resident with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for one (1) of three (3) residents (Resident #1) reviewed. Specifically, the facility failed to assess, treat and prevent deterioration of Resident #1's sacral pressure ulcer from 08/30/2025 through 09/22/2025 which resulted in severe pain to the wound and the wound required sharp debridement during a hospitalization. This resulted in actual harm for Resident #1 and a likelihood for serious injury, serious harm, serious impairment, or death for 29 residents in the facility (census 403) identified as having pressure ulcers that was Immediate Jeopardy and Substandard Quality of Care. The findings include:The facility policy Skin Care Program revised 03/04/2025 included, but was not limited to, comprehensive skin assessments are completed by the registered nurse upon admission and with any significant change of condition, skin checks will be performed once weekly by the registered nurse or licensed practical nurse, daily visual checks during routine care should be completed by the certified nursing assistants and if a new area is identified the staff nurse should be notified. The staff nurse should complete an electronic incident report once a new open area is identified which triggers notification to the wound care team. The wound care team will assess the site and recommend an appropriate course of treatment. An individualize skin care plan will be developed and tailored to the resident's clinical condition and risk profile. Resident #1 had diagnoses including multiple sclerosis (a disease that affects the central nervous system), depression, and generalized weakness. The Minimum Data Set (a resident assessment tool) dated 09/05/2025 included the resident was cognitively intact.Review of the Comprehensive Care Plan revised 09/15/2025 revealed Resident #1 had the potential for alterations in their skin related to decreased mobility. Interventions included, but not limited to, assess for new skin breakdown, turn and reposition per policy, keep the skin dry and clean, and provide appropriate skin barriers.There was no documented evidence the care plan included documentation of conversations related to the resident's condition, treatment options, expected outcomes, and consequences of refusing treatment. The Resident Care Summary Assessment (care plan used by certified nursing assistants) reviewed on 10/15/2025, revealed Resident #1 required the limited assistance of one (1) staff for bed mobility, had a specialty mattress, and staff were to apply barrier cream or gel to the intact skin of the buttocks two (2) times a day, and notify the nurse for redness or irritation.The September 2025 Physician Order Sheet included an order dated 12/14/2023 to apply a thick layer of barrier cream to the right and left buttocks two (2) times a day. Resident #1 was hospitalized from [DATE] to 08/30/2025 for evaluation of stroke-like symptoms. In a hospital consult note dated 08/25/2025, Wound Care Registered Nurse #2 documented the resident had a partial thickness/Stage 2 (a type of skin injury that involves damage to the outer layer of skin) wound to their sacrum (the bony area at the top of the buttocks) related to friction and moisture and complicated by pressure and immobility. The wound measured 1.5 centimeters (length) by 0.5 centimeters (width) by 0.1 centimeters (depth). The periwound (skin surrounding the wound) had hyperpigmented (darkened) scar tissue likely related to continuous irritation or friction on the skin.The hospital After-Visit Summary dated 08/30/2025, included wound care instructions to cleanse the sacral wound bed with normal saline moistened gauze, allow to dry, and cover with a foam dressing every three (3) days and as needed. There is no documented evidence new wound care orders were entered for Resident #1 from 08/30/2025 through 09/22/2025.Resident #1 returned to the facility on [DATE]. In a Provider Visit Note dated 09/02/2025, Nurse Practitioner #1 documented Resident #1 was admitted to the hospital on [DATE] with acute encephalopathy (a change in brain function due to injury or disease), underwent a stroke workup, and was treated for a urinary tract infection. There is no documented evidence Nurse Practitioner #1 assessed Resident #1's sacral wound or reviewed the wound care recommendations from the hospital.In a nursing progress note dated 08/30/2025, Licensed Practical Nurse #2 documented the resident's arrival to the facility and an area on the sacrum measuring 2.0 centimeters by 2.0 centimeters with soft, pink, friable (thin, delicate, and easily tears or breaks) skin. A sacral foam dressing was replaced.There is no documented evidence of dressing changes from 08/31/2025 to 09/21/2025. In a Skin Check dated 09/02/2025, Registered Nurse Assistant Director of Nursing #1 documented Resident #1 had a Stage 1 pressure ulcer to the sacrum measuring 2.0 centimeters by 2.0 centimeters. There is no documented