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	12/20/2024

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.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 47642 Based on observations, interviews, and record review conducted during the Recertification Survey and complaint investigation (NY00356480) from 12/16/2024 to 12/20/2024, for two (Residents #27 and #640) of five residents reviewed for dignity, the facility did not ensure that the residents were treated in a dignified manner. Specifically, Resident #27 could be heard moaning from the hallway with their call light on. Multiple staff members were observed walking by the resident's room without answering the call light or turned the call light off without addressing the resident's concerns or requests. Resident #640 had their call light on for an extended period of time and multiple staff went in the resident's room and turned the call light off without addressing the resident's concerns. This was evidence by the following: 1. Resident #640 had diagnoses including quadriplegia (unable to move all four limbs), neurogenic bladder (a urinary condition causing a lack of bladder control), and diabetes. The Minimum Data Set Resident Assessment, dated 09/25/2024, documented the resident was cognitively intact and incontinent of bowels. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During continuous observations on 12/19/2024 starting at 9:40 AM, Resident #640's call light went on and Certified Nursing Assistant #2 walked into the resident's room, turned off the call light without addressing the resident's concerns, and walked back to nurses' station and sat down. At 9:50 AM, Resident #640 put their call light on again and Certified Nursing Assistant #2 went into the resident's room, turned off the call light, and told Resident #640 they would let their assigned nurse know they needed assist. At 9:59 AM, Resident #640 put their call light back on, Certified Nursing Assistant #2 walked in and out of room in less than a minute. At 10:09 AM, Resident #640 put their call light back on. Unit Administrator #1 entered Resident #640's room, exited, and returned with a cup of water. During an immediate interview at 10:14 AM, Resident #640 stated they have been asking staff if they could get cleaned up and that they do not feel good and have a headache. A foul odor (stool) was present in the room at the time. The resident stated that staff often turn off their light, leave the room without assisting them, and do not come back. Observations continued, at 10:28 AM, Resident #640 put their call light on and a staff member entered the room stating they would find a nurse. At 11:00 AM, a nursing staff exited Resident #640 room. Resident #640 remained not washed up. During an immediate interview at 11:01 AM, Resident #640 stated they were still not changed, that their blood pressure was high, and it was upsetting them and pissing me off. At 11:06 AM, Resident #640 put their call light on and several different nursing staff walked into the resident's room and turned the call light off without providing assist. At 11:37 AM, Certified Nursing Assistant #4 returned to Resident #640's room with bathing supplies to assist the resident with morning care (approximately two hours after Resident #640 first put their call light on). During an interview on 12/19/24 at 12:02 PM, Certified Nursing Assistant #4 stated they floated to this unit today and have nine residents on their assignment with six residents going out for appointments. Certified Nursing Assistant #4 stated they were made aware that Resident #640 needed assistance around 9:00 AM, but it was difficult to find staff to assist when staffing is so short. During an interview on 12/20/24 at 9:25 AM, Certified Nursing Assistant #5 stated everyone is responsible for answering call lights and meeting the resident's needs. During an interview on 12/20/2024 at 10:33 AM, Licensed Practical Nurse Manager #1 stated Resident #640 can advocate for themself. They also stated the unit has a higher acuity as everyone is a two person assist, and they have recently lost multiple Certified Nurse Assistants, but all staff should answer call lights. During an interview on 12/20/24 at 11:19 AM, Unit Administrator #1 stated their primary role is a liaison between administration and the units for family and resident concerns to mitigate and provide service so that it does not happen again. They also stated they knew Resident #640 needed care in a timely manner and were told that it had been completed, but then found out later that it was not done. If a call bell goes off it should not be ignored and staff should address it promptly. 2. Resident #27 had diagnoses including dementia, diabetes, and high blood pressure. The Minimum Data Set Resident Assessment, dated 10/15/2024, documented the resident had moderately impaired cognition. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During continuous observations on 12/16/2024 starting at 10:01 AM, Resident #27 could be heard moaning from the hallway and their call light was on. At 10:04 AM, Unit Administrator #1 went into room answered the call light and told Resident #27 they would find an aide for them. At 10:08 AM, a Certified Nursing Assistant entered the room and told the resident they would be back (call light still on). At 10:12 AM, Resident #27 could be heard moaning and a staff member walked by the room without seeing what the resident needed. At 10:23 AM, the unit's nurse manager entered Resident #27's room, turned off the call light, and walked out of room. At 10:50 AM, staff were assisting Resident #27 with care. During an immediate interview, Resident #27 stated they had just been changed. During an interview on 12/20/2024 at 12:46 PM, the Director of Nursing stated call lights should be answered when they go off. If a resident is asking to get cleaned up and changed, we do our best to do the assignments and to get to the person that is asking for help. The Director of Nursing stated if a staff member is available, they should help the resident at that time. 10 NYCRR 415.3

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 49686 Based on observations, record review, and interviews conducted during the Recertification Survey from 12/16/2024 to 12/20/2024, the facility did not ensure that the medical team was notified when there was a significant change in the resident's condition for one (Resident #186) of one resident reviewed. Specifically, Resident #186 had a potential serious complication with their tracheostomy (a surgical procedure that creates an opening in the neck to provide an airway to assist with breathing) tube. This is evidenced by the following: The facility policy Notification of Change, revised April 2021, documented the appropriate department will immediately consult with the resident's physician when there is a significant change in the resident's physical status. Resident #186 had diagnoses including anoxic brain damage (a condition when the brain has a lack of oxygen), dysphagia (difficulty swallowing), gastrostomy (a surgical procedure to create an external opening into the stomach to receive nutrition), and a tracheostomy tube. The Minimum Data Set Resident Assessment, dated 11/18/2024, documented the resident had severely impaired cognition, was dependent for all activities of daily living and tracheostomy care, including suctioning of the tracheostomy tube, and the resident had a feeding tube. Review of Resident #186's current physician's orders revealed tracheostomy suctioning every four hours and as needed and tube feeding (via the feeding tube) four times a day. The orders also included that the resident was on aspiration precautions (interventions in place to prevent substances from entering the airway or lungs). During observations on 12/18/2024 at 9:27 AM and again on 12/19/2024 at 11:35 AM, Resident #186's tracheostomy cannister (container to collect secretions suctioned from the tracheostomy tube) had greater than 450 milliliters of tan colored secretions. During an observation on 12/20/2024 at 9:36 AM, Resident #186 had thick tan/yellow secretions in their oxygen tubing that was attached to Resident #186's tracheostomy. In a medical progress note, dated 11/14/2024, Nurse Practitioner #1 documented Resident #186 had clear sputum (mucous) and to continue to monitor the resident and report changes in condition. In an interdisciplinary progress note, dated 12/13/2024 at 10:46 AM, Respiratory Therapist #1 documented Resident #186 was suctioned for thin, tan secretions. In an interdisciplinary progress note, dated 12/13/2024 at 8:48 PM, Licensed Practical Nurse #3 documented that Resident #186 was suctioned for tan secretions with tube feeding chunks in it. In an interdisciplinary progress note, dated 12/15/2024 at 4:20 PM, Respiratory Therapist #2 documented that Resident #186 was suctioned five times for large amounts of thick secretions possibly mixed with tube feeding liquid (also tan in color) and Resident #186 appeared to continue to aspirate (inhalation of food/liquids into the airway). (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interdisciplinary progress note, dated 12/17/2024 at 9:59 AM, Respiratory Therapist #3 documented that Resident #186 was suctioned for large amounts of tan secretions. During an interview on 12/19/2024 at 9:19 AM, Licensed Practical Nurse #3 stated the medical provider should be notified if anything was not at baseline for the resident or the possibility of aspiration (inhalation of tube feeding into the resident's airway). During an interview on 12/19/2024 at 12:10 PM, Licensed Practical Nurse Manager #1 stated that a physician should be notified if a resident had excessive sputum, more than usual, as the resident is at risk for aspiration more than other residents. If the medical team had been notified, it should be documented in the communication log (a log to communicate information to the medical team). During a follow-up interview on 12/20/2024 at 9:23 AM, Licensed Practical Nurse Manager #1 stated they were unable to find any documentation that the physician has been notified about Resident #186's excessive secretions or potential aspiration. During an interview on 12/19/2024 at 11:08 AM, Physician #1 stated they were not aware that Resident #186 may have tube feeding liquid in their tracheostomy tubing which is a serious complication, and they should have been notified if this was a possibility. During an interview on 12/20/2024 at 11:07 AM, the Respiratory Therapy Manager stated that if a resident had secretions that looked like tube feeding, the respiratory therapists should have notified the nurse manager, and the nurse manager should have notified the medical provider. 10 NYCRR 415.3(f)(2)(ii)(b)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 39181 Based on interviews and record review conducted during the Recertification Survey from 12/16/2024 to 12/20/2024, for 11 (Residents #24, #35, #136, #158, #246, #257, #357, #374, #375, # 378, #380) of 11 residents reviewed, the facility did not ensure that the baseline care plan (care plan developed within 48 hours of admission that includes the minimum healthcare information necessary to properly care of the immediate needs of the resident) was completed within the required time frame and that a summary of the baseline care plan was provided to the resident and/or their representative. Specifically, for Residents #35, #136, and #257, the facility could not provide evidence that a baseline care plan was developed within 48 hours of the residents' admission. For Resident #246, the baseline care plan was not completed within 48 hours of the resident's admission and the facility could not provide evidence that a summary of the baseline care plan, that included the minimum healthcare information such as physician's orders, was provided to the resident and/or resident representative. For Residents #24, #158, #357, #374, #375, #378, and #380, the facility could not provide evidence that a summary of the baseline care plan, that included the minimum healthcare information such as physician's orders, was provided to the resident and/or resident representative. This is evidenced by, but not limited to the following: Review of the facility policy Admission Policy & Procedure, revised August 2023, included the baseline care plan would be developed within 48 hours of admission, and the resident or health care proxy would be provided a copy of the baseline care plan. Review of the facility's electronic baseline care plan form included a statement of acknowledgement that a copy of the baseline care plan would be provided to the resident and/or their representative but did not include confirmation of receipt or reviewed date of the baseline care plan by the resident and/or their representative. 1. Resident #35 had diagnoses that included quadriplegia (a condition where both arms and both legs are paralyzed), dependence on a respirator, and dysphagia (difficulty swallowing). The Minimum Data Set Resident Assessment, dated 09/13/2024, documented the resident was cognitively intact. Review of Resident #35's electronic health record revealed no documented evidence that a baseline care plan had been developed within the required timeframe following admission and the facility was unable to provide evidence of its completion. During an interview on 12/20/2024 at 3:00 PM, Registered Nurse Manager #1 stated Resident #35 should have had a baseline care plan initiated when admitted from the hospital. 2. Resident #257 had diagnoses that included multiple sclerosis (a chronic disease that affects the central nervous system), anxiety, depression, and chronic pain. The Minimum Data Set Resident Assessment, dated 12/02/2024, documented the resident was cognitively intact. Review of Resident #257's electronic health record revealed no documented evidence that a baseline care plan had been developed following the resident's admission within the required timeframe and the facility was unable to provide evidence of its completion. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident #246 had diagnoses that included Alzheimer's disease, chronic kidney disease, and adult failure to thrive. The Minimum Data Set Resident Assessment, dated 10/09/2024, documented the resident had severely impaired cognition. Review of Resident #246's electronic health record included a baseline care plan, signed by facility staff on 07/25/2023 (greater than 48 hours after the resident's admission). The facility was unable to provide any documented evidence that a summary of Resident #246's baseline care plan, including physician's orders, had been provided to or reviewed with the resident's representative. 4. Resident #24 had diagnoses that included high blood pressure, sarcopenia (gradual loss of muscle strength), and major depressive disorder. The Minimum Data Set Resident Assessment, dated 10/17/2024, documented that the resident was cognitively intact. Review of Resident #24's electronic health record revealed no documented evidence that a summary of the baseline care plan, including physician's orders, had been provided to the resident and/or their representative. During an interview on 12/20/2024 at 9:21 AM, Registered Nurse Manager #3 stated the facility's baseline care plan form was completed by the nurse manager and saved in the computer for reference, but no further documentation was completed. During an interview on 12/20/2024 at 1:25 PM, Registered Nurse Manager #5 stated the baseline care plan was initiated on day two of the resident's admission and focused primarily on nursing care the resident should receive on the unit. Registered Nurse Manager #5 stated the baseline care plan did not include physician's orders or medication orders which were generally reviewed during the initial comprehensive care plan meeting (that could be as late as 21 days after admission) or sooner if the resident/representative had specific medication-related questions or concerns. During an interview on 12/20/2024 at 2:00 PM, the Director of Nursing stated they were aware that the facility's electronic baseline care plan form implied but did not confirm review or receipt of the baseline care plan. 10 NYCRR 415.11