STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335255	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elm Manor Nursing and Rehabilitation Center	210 North Main Street Canandaigua, NY 14424

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure residents and/or their representatives received information necessary to make informed decisions regarding Medicare coverage enrollment and plan changes and failed to ensure residents were treated with dignity and respect for five (5) of fourteen (14) residents reviewed (Residents #6, #8, #10, #12, and #14). Specifically, under Issue One (1) for three (3) of three (3) residents reviewed (Residents #6, #8, and #10), the facility obtained authorizations permitting the Administrator to act regarding Medicare Part D enrollment and plan changes and failed to ensure residents and/or their representatives received information regarding plan options, financial implications, reenrollment rights, and coverage changes. Under Issue Two (2) for three (3) residents reviewed (Residents #8, #12, and #14), the facility failed to maintain resident dignity by exposing Resident #8's urinary catheter collection bag, allowing Resident #14 to ambulate in the facility with visibly soiled clothing, and referring to Resident #12 as a feeder in the presence of staff and other residents.The findings include:Issue One (1)The Centers for Medicare and Medicaid Services publication, Your Rights and Protections as a Nursing Home Resident, included nursing homes must inform residents of their rights and explain those rights orally and in writing in a language the resident understands.The Centers for Medicare and Medicaid Services memorandum to Long Term Care Facilities on Medicare Health Plan Enrollment, dated October 2021, included only a Medicare beneficiary, the beneficiary's authorized or designated representative, or a party authorized to act on behalf of the beneficiary under state law may request enrollment in or voluntary disenrollment from a Medicare health or drug plan. The memorandum further included facilities must explain orally and in writing the impact to the beneficiary if coverage is changed, including loss of Medicare health plan coverage, financial obligations, prescription drug coverage information, and opportunities to change coverage while residing in the facility and following discharge.1. Resident #6 was admitted to the facility on [DATE] with diagnoses including dementia, chronic obstructive pulmonary disease (a progressive, incurable lung disease that restricts airflow and makes breathing difficult), and congestive heart failure (a chronic, progressive condition where the heart muscle is too weak or stiff to pump blood efficiently). The Minimum Data Set (a resident assessment tool), dated 09/23/2025, documented Resident #6 was cognitively intact.Review of the admission Record, effective 04/28/2026, revealed Resident #6 had Medicare Part A (an insurance that covers skilled nursing facility care) effective 12/01/2011, Medicare Part B (the medical insurance portion of Original Medicare that covers outpatient services, doctor visits, preventive care, and durable medical equipment) effective 12/01/2011, and Medicare Part D (is an optional, private insurance that covers prescription medications for individuals on Medicare) effective 07/01/2022.Review of Addendum VII, Authorization for Legal Representation for Medicare Part D, signed by Resident #6's representative on 09/26/2025 and witnessed by the Business Office Manager, permitted the Administrator to act in a limited capacity and as the resident's legal representative for Medicare Part D enrollment and plan changes.Review of a New York State Department of Health Complaint Intake, dated 12/17/2025, revealed Resident #6's representative (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 - Some	attended a meeting approximately two (2) weeks after admission with social work staff, a physical therapy coordinator, an insurance department representative, and another staff member. During the meeting, the representative was encouraged to change Resident #6's health insurance. The representative was informed the resident's insurance would cover only 20 days of physical therapy and additional days would cost more than $200.00 per day. The representative reported using the name of an insurance agent provided by the facility and changed the resident's insurance to an expensive Plan F (a comprehensive supplemental insurance plan that covers 100 percent of out-of-pocket costs for Medicare-approved services). The representative reported later learning other options were available and felt they had been taken advantage of without having all of the facts.Review of electronic mail correspondence regarding Resident #6, dated 09/29/2025 and 09/30/2025, revealed facility staff communicated with an insurance agent regarding disenrollment from the resident's WellCare Advantage plan (an all-in-one alternative to Original Medicare offered by private insurance companies that bundle Medicare Part A and Part B into a single plan and usually include Part D coverage) and enrollment into other coverage options.The facility was unable to provide documentation demonstrating a written comparison sheet was provided, plan-specific cost comparisons were reviewed, copays, deductibles, or financial implications of coverage changes were explained, or written information regarding reenrollment rights and loss of supplemental benefits was provided.2. Resident #8 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, blindness, and chronic kidney disease (kidney damage that does not allow proper filtration of blood). The Minimum Data Set, dated [DATE] documented Resident #8 was cognitively intact.Review of the admission Record, effective 05/05/2026, revealed Resident #8 had Medicare Part A effective 03/01/2005, Medicare Part B effective 03/01/2005, and Medicare Part D effective 07/01/2023.Review of Addendum VII, Authorization for Legal Representation for Medicare Part D, signed by Resident #8 on 10/28/2025 and witnessed by the Business Office Manager, permitted the Administrator to act in a limited capacity and as the resident's legal representative for Medicare Part D enrollment and plan changes.The facility was unable to provide documentation demonstrating a written comparison sheet was provided, plan-specific cost comparisons were reviewed, copays, deductibles, or financial implications of coverage changes were explained, or written information regarding reenrollment rights and loss of supplemental benefits was provided.3. Resident #10 was admitted to the facility on [DATE] with diagnoses including dementia, osteoarthritis, and chronic kidney disease. The Minimum Data Set, dated [DATE] documented Resident #10 had severe cognitive impairment.Review of the admission Record, effective 05/04/2026, revealed Resident #10 had Medicare Part A effective 01/01/2018, Medicare Part B effective 01/01/2018, and Medicare Part D effective 01/01/2025.Review of Addendum VII, Authorization for Legal Representation for Medicare Part D, documented verbal acknowledgement by Resident #10's representative on 12/29/2025 and again on 01/26/2026, witnessed by the Business Office Manager, permitting the Administrator to act in a limited capacity regarding Medicare Part D enrollment and plan changes.The facility was unable to provide documentation demonstrating a written comparison sheet was provided, plan-specific cost comparisons were reviewed, copays, deductibles, or financial implications of coverage changes were explained, or written information regarding reenrollment rights and loss of supplemental benefits was provided.During an interview on 05/06/2026 at 10:19 AM, the Business Office Manager stated they had worked at the facility for almost 50 years in several different roles. The Business Office Manager stated they explain insurance coverage, complete disenrollment forms, and work with an insurance agent. The Business Office Manager stated residents and/or representatives do not receive written information regarding new insurance coverage and are told they are being disenrolled and moved to Medicare Part D. The Business Office Manager stated families sign the forms because they want the resident to stay and receive therapy.During an interview on 05/06/2026 at 4:34 PM, the Administrator and Regional Administrator stated they were aware residents sometimes disenroll from their insurance and return to Medicare (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	coverage.Issue two (2)The undated facility policy, Resident Dignity, included every resident has the right to be treated with dignity and respect, and dignity shall be preserved in all aspects of care, services, and interactions.1. Resident #8 had diagnoses including chronic obstructive pulmonary disease, blindness, and chronic kidney disease and required an indwelling urinary catheter (a flexible tube inserted into the bladder to drain urine continuously). The Minimum Data Set, dated [DATE] documented Resident #8 was cognitively intact.A physician order dated 04/28/2026 included an indwelling urinary catheter and instructions for catheter care.During an observation on 05/01/2026 at 12:27 PM, Resident #8 was seated in the dining room with an uncovered indwelling urinary catheter bag and tubing containing urine.During an observation on 05/04/2026, Resident #8 was seated in the hallway near two (2) other residents with an uncovered indwelling urinary catheter bag containing urine.During an interview on 05/04/2026 at 10:55 AM, Resident #8 stated the uncovered catheter bag bothered them and made them feel self-conscious. Resident #8 stated they had asked staff to cover the bag and staff did not do so.During an interview on 05/04/2026 at 11:45 AM, Licensed Practical Nurse #2 stated an exposed urinary catheter bag was a dignity issue.2. Resident #14 had diagnoses including dementia, diabetes, and arthritis (inflammation, swelling, and pain in the joints). The Minimum Data Set, dated [DATE] documented Resident #14 had moderate cognitive impairment and required moderate assistance with toileting, supervision with upper and lower body dressing, and supervision with personal hygiene.Review of the Comprehensive Care Plan revised 03/15/2026 revealed Resident #14 required assistance with personal hygiene, toileting, and dressing and required cueing, supervision, and step-by-step direction.The current Kardex (care plan used by certified nursing assistants to direct daily care) reviewed on 05/01/2026 included Resident #14 required assistance with personal hygiene and toileting, clean the perineal area after each incontinent episode, and occasional bowel incontinence.During an observation and interview on 04/29/2026 at 2:52 PM, Resident #14 was ambulating in the hallway with a brown substance on the back of their pants. Certified Nursing Assistant #2 stated staff do not take care of these people because they are so busy. At 2:59 PM, Resident #14 was again ambulating in the hallway with a brown substance on their pants in front of the nursing station with three (3) certified nursing assistants and two (2) nurses present. Certified Nursing Assistant #2 looked at the back of the resident's pants and continued walking down the hallway.During an interview on 05/04/2026 at 11:45 AM, Licensed Practical Nurse #2 stated Resident #14 required encouragement, reminders, and assistance after bowel movements. Licensed Practical Nurse #2 stated they would not allow a resident to walk through the facility with soiled pants and would assist the resident to get cleaned up.3. Resident #12 had diagnoses including Parkinson's disease (a progressive neurological disorder that affects movement and the nervous system), congestive heart failure, and major depressive disorder (a serious mood disorder). The Minimum Data Set, dated [DATE] documented Resident #12 had severe cognitive impairment and required moderate assistance with eating.Review of the Comprehensive Care Plan revised 01/27/2026 revealed Resident #12 required total assistance with eating and staff were to provide feeding assistance and verbal cues.During an observation on 04/29/2026 at 12:34 PM, the Director of Nursing stood in the dining room doorway and asked a certified nursing assistant across the dining room if Resident #12 was a feeder while pointing at the resident.During an interview on 04/29/2026 at 3:04 PM, the Director of Nursing stated they referred to Resident #12 as a feeder because the resident required feeding assistance.During an interview on 05/06/2026 at 2:42 PM, the Regional Director of Nursing stated referring to a resident as a feeder in front of others was inappropriate and could be embarrassing. The Regional Director of Nursing stated an exposed catheter bag, allowing a resident to walk with soiled pants, and failing to protect resident privacy and dignity were dignity issues.Title 10 New York Codes, Rules and Regulations 415.3(d)(1)(i)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on interviews and record review, the facility failed to ensure that the interdisciplinary team determined the resident's right to self-administer medications was clinically appropriate for one (1) (Resident #1) of one (1) residents reviewed. Specifically, Resident #1 was found to have been managing their diabetes with their own supplies including self-supplied insulin (a medication used to regulate blood glucose levels) and a continuous glucose monitoring system (a device implanted into the skin that monitors blood sugar in real-time), and the facility could not provide documented evidence that they appropriately assessed the resident to self-administer insulins. Additionally, the facility could not provide documented evidence that they consistently monitored the resident to ensure order parameters were followed, that the correct medications and doses were administered, or that they consistently tracked the resident's blood glucose readings. The findings include:The undated facility Insulin Administration Policy and Procedure included that the facility had to ensure the safe, accurate, and timely ordering, storage, administration, monitoring, and documentation of insulin therapy. Additionally, the policy included that nursing staff should verify insulin type, dose, and timing, confirm the blood glucose result prior to administration, and administer insulin within appropriate timeframes related to meals. The facility policy Administering and Storage of Medications dated 12/13/2025, included residents could self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, had determined that they had the decision-making capacity to do so safely.Resident #1 had diagnoses including diabetes, organ transplant (kidney and pancreas), and end-stage kidney disease. The Minimum Data Set (a resident assessment tool) dated 03/27/2026, included the resident was cognitively intact and utilized insulin. Resident #1's Comprehensive Care Plan reviewed on 04/28/2026 included an intervention for diabetes medication as ordered by a doctor (initiated on 12/18/2025) and did not include medication-self administration, the use of self-supplied insulin, or the use of a continuous glucose monitoring system. The facility could not provide documented evidence that Resident #1 had been assessed to safely self-administer medications or have the ability to keep their medications at their bedside. Review of Resident #1's medical orders revealed the following: Humalog insulin (fast acting insulin) one (1) unit subcutaneously before meals for self-directed diabetic monitoring and insulin administration utilizing their own continuous glucose monitor and home-dosing of insulin, revised on 01/08/2026. Insulin glargine (long acting insulin) four (4) units subcutaneously at bedtime for supervised self-administration; Nursing to record all blood glucose readings and amount administered by patient, initiated on 01/03/2026. Review of Resident #1's Medication Administration Record from 03/01/2026 to 04/30/2026 revealed 29 occasions in which blood glucose monitoring, administration of Humalog, or administration of insulin glargine were not documented as given, and 49 occasions in which staff documented that Resident #1 refused. In addition, there was no documented evidence of the amount of Humalog Resident #1 gave themselves for each scheduled dose. During the onsite visit, Resident #1 was unavailable for observation due to attending dialysis sessions and hospitalization. During an interview on 05/04/2026 at 11:45 AM, Licensed Practical Nurse #2 stated Resident #1 managed their insulin and blood sugar using their own supplies, which they kept in a bag at their bedside. Licensed Practical Nurse #2 stated they did not regularly check how much insulin the resident was administering, and they would not be in the room when the resident administered their insulin. During an interview on 05/05/2026 at 12:00 PM Licensed Practical Nurse #6 stated the nurses did not have an option to document if medications were unavailable, so they would document that the resident refused and would put in a note that the medication was unavailable. During a telephone interview on 05/05/2026 at 3:27 PM, the Medical Director stated they were unaware that Resident #1 was managing their own insulin and blood sugar using their own supplies and it was a problem that staff were not tracking when the resident was administering insulin or the amount. During an interview on 05/06/2026 at 2:42 PM with the Regional Director of Nursing, they stated they were (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unaware that Resident #1 was self-administering their insulin, and it was a problem because of the risk of the resident under-or-over dosing their insulin. Additionally, they were unsure if the resident was storing their insulin and supplies properly, and they could not monitor the effectiveness of the insulin. During a telephone interview on 05/13/2026 at 3:05 PM, Resident #1 stated they used their own insulin supply (not the facility's), they gave themselves insulin three (3) to four (4) times per day, and the nursing staff would ask maybe once a day what their blood sugar was and how much insulin they gave themselves. Title 10 New York Codes, Rules and Regulations, Section 415.12(l)(1)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure the development of a comprehensive, person-centered care plan with measurable goals, timeframes, and interventions for three (3) (Residents #1, #8, and #10) of 14 residents reviewed. Specifically, Resident #1 was prescribed insulin (a medication used to regulate blood glucose levels), Resident #8 had an indwelling urinary catheter (device that is inserted into the bladder to drain urine from the body), and Resident #10 required frequent incontinence care, and none of the residents' care plans included associated goals or interventions to address risks and care needs. The findings include: The facility's undated Comprehensive Care Plan (CCP) Policy included each resident had an interdisciplinary, comprehensive care plan that summarized the team approach to active and/or potential problems or concerns and included measurable objectives to meet a resident's medical, nursing, mental, and psychosocial needs. 1. Resident #1 had diagnoses including diabetes, kidney transplant, and end-stage kidney disease. The Minimum Data Set (a resident assessment tool) dated 03/27/2026 documented the Resident #1 was cognitively intact and utilized insulin. Resident #1's Comprehensive Care Plan included goals and interventions related to the resident's diagnosis of diabetes (initiated on 12/18/2025) and did not include interventions for glucose monitoring or insulin management.Review of Resident #1's current medical orders included the following: Humalog insulin (fast-acting insulin) one (1) unit subcutaneously before meals, initiated 01/08/2026. Insulin glargine (long-acting insulin) four (4) units subcutaneously at bedtime, initiated 01/03/2026. 2. Resident #8 had diagnoses including benign prostatic hyperplasia (prostate enlargement that can affect urination), chronic kidney disease, and the presence of an indwelling urinary catheter. The Minimum Data Set, dated [DATE] included Resident #8 was cognitively intact. Resident #8's Comprehensive Care Plan reviewed on 04/30/2026 did not include goals or interventions related to the presence of an indwelling urinary catheter. Additionally, Resident #8's Kardex (care plan used by the certified nursing assistants to direct patient care) as of 05/05/2026 did not include the presence of an indwelling urinary catheter. 3. Resident #10 had diagnoses including dementia, muscle weakness, and pressure ulcers. The Minimum Data Set, dated [DATE] revealed the resident had severe cognitive impairment, required substantial assistance with toileting hygiene, and was frequently incontinent of urine and bowel. Resident #10's Comprehensive Care Plan included the resident required extensive assistance of one (1) staff member with toileting (as of 01/05/2026) and did not include goals or interventions related to the need for frequent incontinence care. During an interview on 05/06/2026 at 2:42 PM, the Regional Director of Nursing stated care plans should include incontinence care including checking and changing every two (2) hours and as needed, and insulin should be included in the care plan. During an interview on 05/06/2026 at 04:35 PM with the Regional Administrator and the Administrator, the Administrator stated that Quality Assurance Performance Improvement (QAPI) committee was unaware of issues regarding care plans. During a telephone interview on 05/20/2026 at 11:09 AM, the Regional Director of Nursing stated a urinary catheter should be included in the care plan so that proper catheter care and monitoring is done.Title 10 New York Codes, Rules and Regulations, Section 415.11(c)(1)

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	335255	A. Building B. Wing	05/20/2026

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to provide the residents who were unable to carry out activities of daily living, the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for three (3) (Residents #5, #10, and #11) of seven (7) residents reviewed. Specifically, the facility could not provide documentation that Resident #5 had received a shower during their admission, Resident #10 did not receive incontinence care in a timely manner, and Resident #11 was observed on multiple occasions to have unwanted facial hair. The findings include:The undated facility policy Activities of Daily Living included appropriate care and services would be provided for residents who were unable to carry out activities of daily living including but not limited to bathing, grooming, and toileting. If a resident refused a shower, the refusal must be documented in a progress note and on the resident's care plan.1. Resident #11 had diagnoses including difficulty swallowing, stroke, and muscle weakness. The Minimum Data Set (a resident assessment tool) dated 04/07/2026 included the resident was cognitively intact and required supervision and/or touch-assistance for personal hygiene activities.Resident #11's Comprehensive Care Plan (revised on 04/01/2026) and Kardex (a care plan used by certified nursing assistants to direct patient care) (as of 05/05/2026) included the resident required limited assistance of one (1) staff member for personal hygiene activities and did not include that the resident refused care. Review of Resident #11's Documentation Survey Reports (care task records) from 04/01/2026 to 05/05/2026 revealed staff documentation that the resident required set-up/clean up assistance, supervision/touch-assistance, or moderate assistance for completing personal hygiene activities.An Occupational Therapy note dated 05/01/2026 included Resident #11 required set-up assistance for hygiene and grooming activities.Review of Resident #11's progress notes from 04/01/2026 to 04/30/2026 did not reveal any documented evidence of the resident refusing care.During an observation on 04/28/2026 at 10:17 AM, Resident #11 had approximately one-quarter (1/4) inch long and thick facial hair on their chin while being assisted to their room by a staff member.During an observation on 04/29/2026 at 9:19 AM, Resident #11 had long, thick facial hair on their chin while talking to staff members in the hallway.During an interview on 04/30/2026 at 10:33 AM, Resident #11 stated the staff were supposed to help them with removing their facial hair, they should not have had facial hair because of their gender, and the staff allowed their facial hair to grow out for two (2) weeks before taking care of it that morning.During an interview on 05/04/2026 at 11:12 AM, Certified Nursing Assistant #1 stated Resident #11 required set-up assistance for taking care of their facial hair, and the resident would have told them if they wanted their facial hair removed.During an interview on 05/06/2026 at 2:42 PM with the Regional Director of Nursing, they stated facial hair should be addressed weekly and they expected that staff would have taken care of Resident #11's facial hair.2. Resident #10 had diagnoses including dementia, muscle weakness, and pressure ulcers. The Minimum Data Set, dated [DATE] included the resident had severe cognitive impairment, required substantial assistance with toileting hygiene, and was frequently incontinent of urine and bowel. Resident #10's Comprehensive Care Plan (revised on 01/05/2026) and Kardex (as of 05/04/2026) included the resident required extensive assistance of one (1) staff member with toileting.The facility could not provide documented evidence that Resident #10 had received regular incontinence care or had refused incontinence care from 04/01/2026 to 05/05/2026. During an observation on 04/30/2026 at 12:10 PM, Resident #10 was seen sitting in the hallway in a Geri-chair. The resident was placed back in bed at 1:32 PM and did not receive incontinence care (for urine and stool) until 1:55 PM when nursing staff was providing wound care.During an observation and interview on 05/01/2026 at 9:36 AM, Resident #10 was in bed with a saturated incontinence brief and was yelling out that they needed to go to the bathroom. Certified Nursing Assistant #4 came into the resident's room and provided incontinence care. Following the care, Certified Nursing Assistant #4 stated they were unsure when (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #10 had last been changed and it was before the start of their shift at 8:00 AM.During an interview on 05/01/2026 at 1:10 PM, the Director of Nursing stated that residents should be checked and changed every two (2) hours or sooner.During an interview on 05/01/2026 at 2:42 PM, the Regional Director of Nursing stated Resident #10 should have been checked every two (2) hours and as needed.3. Resident #5 had diagnoses including muscle weakness, chronic obstructive pulmonary disease (a condition that affects flow of air through the lungs), and malnutrition. The Minimum Data Set, dated [DATE] noted the resident had moderate cognitive impairment and required supervision with showering.Resident #5's Comprehensive Care Plan (revised on 12/10/2025) and Kardex (as of 05/05/2026) included the resident required extensive assistance of one (1) staff member with showering.Review of Resident #5's Documentation Survey Reports and progress notes from 12/09/2025 to 12/19/2025 revealed no documented evidence that the resident had received or refused a shower.Resident #5 was no longer at the facility at the time of the on-site visit.During an interview on 05/05/2026 at 1:37 PM, Certified Nursing Assistant #3 stated staff were to document showers, bathing, and grooming in the electronic medical record.During an interview on 05/06/2026 at 5:02 PM, Certified Nursing Assistant #5 stated residents did not always get showers due to lack of staff.During an interview on 05/06/2026 at 4:34 PM with the Regional Administrator and the Administrator, the Administrator stated they were unaware of residents not receiving assistance with activities of daily living at the facility, and showers should have been documented in the electronic medical record.Title 10 New York Codes, Rules and Regulations, Section 415.12(a)(3)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure a resident with a pressure ulcer 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 two (2) residents reviewed (Resident #10). Specifically, Resident #10 had an unstageable (a wound where full-thickness skin and tissue loss has occurred, but the true depth of the damage cannot be determined because it is covered by dead tissue) pressure ulcer to the sacral area with a physician order for daily wound packing and dressing. Resident #10 was observed without wound packing or a dressing in place for over two (2) hours after staff were notified, while the resident was incontinent of urine and stool.The findings include:The undated facility policy Dressing Changes included dressing changes were to be performed safely, consistently, and in accordance with physician orders, evidence-based practice, and infection prevention standards to promote wound healing and prevent infection. Dressing changes should be recorded in the medical record, including the date and time of the dressing change, wound assessment findings, dressing applied and treatment provided, and any abnormalities or notifications made.Resident #10 had diagnoses including dementia, myoclonus (sudden, uncontrolled muscle movements), and an unstageable pressure ulcer of the sacral region. The Minimum Data Set, dated [DATE] revealed Resident #10 had severely impaired cognition, an unstageable pressure ulcer, and received pressure ulcer care.Review of the Comprehensive Care Plan dated 02/12/2026 revealed Resident #10 had an unstageable pressure ulcer to the sacrum and was at risk for further skin breakdown related to immobility and incontinence. Interventions included monitoring the dressing to ensure it remained intact and reporting loose dressings to nursing staff.Review of physician orders dated 02/21/2026 revealed an order to soak gauze with Vashe wound cleanser, pack the sacral wound, and apply a dressing daily.Review of the April 2026 Treatment Administration Record revealed the ordered wound treatment was not documented as completed on 04/03/2026, 04/04/2026, 04/05/2026, 04/08/2026, and 04/15/2026.Review of progress notes from 04/01/2026 through 04/30/2026 revealed no documentation explaining why the ordered wound treatments were not completed.Review of wound assessment notes revealed the sacral wound was documented as healing without signs of infection on 04/03/2026, 04/10/2026, 04/17/2026, and 04/24/2026.During an observation on 04/30/2026 at 1:55 PM, Licensed Practical Nurse #6 completed a dressing change to Resident #10's sacral wound. During an observation and interview on 05/01/2026 at 9:36 AM, Resident #10 was in bed calling out for assistance. Certified Nursing Assistant #4 provided care to the resident who was incontinent of urine and stool. There was no dressing covering the sacral wound and no wound packing visible. Certified Nursing Assistant #4 stated they started work at 8:00 AM, did not know when Resident #10 had last been changed, and did not observe a dressing in the brief or on the wound. Certified Nursing Assistant #4 notified Licensed Practical Nurse #6 that the wound was uncovered.During an observation on 05/01/2026 at 9:54 AM, Licensed Practical Nurse #6 entered the room and, after being informed the dressing was absent, stated they were in the middle of a medication pass and would address it later.During an observation on 05/01/2026 at 11:15 AM, Resident #10 was receiving physical therapy in bed and the sacral wound dressing remained absent.During an interview on 05/01/2026 at 11:22 AM, Licensed Practical Nurse #6 stated they had not yet completed Resident #10's dressing change.During an observation and interview on 05/01/2026 at 12:06 PM, the Wound Care Physician, Director of Nursing, and Regional Director of Nursing entered Resident #10's room for wound rounds. Resident #10 remained incontinent of urine and stool. No dressing was present over the wound and no wound packing was present. The Wound Care Physician cleaned the wound, packed the wound with Vashe-soaked gauze, and applied a new dressing. The Wound Care Physician stated Resident #10's brief should have been changed when soiled and the wound should have had a dressing covering it.During an interview on 05/06/2026 at (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335255	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elm Manor Nursing and Rehabilitation Center	210 North Main Street Canandaigua, NY 14424

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11:08 AM, Licensed Practical Nurse #3 stated there were times when only one (1) nurse was assigned to the day shift and not all treatments, including wound dressing changes, could be completed. Licensed Practical Nurse #3 stated if treatments were not completed, they would notify the next shift nurse. Licensed Practical Nurse #3 stated there had been occasions when they went to change Resident #10's dressing and found no dressing in place.During an interview on 05/06/2026 at 2:42 PM, the Regional Director of Nursing stated wound care should be completed according to physician orders and should not go undone because only one (1) nurse was working. The Regional Director of Nursing stated Resident #10 should not remain without a dressing to the sacral area because prolonged exposure to urine and feces could cause infection, delay healing, or contribute to additional skin breakdown.Title 10 New York Codes, Rules and Regulations 415.12(c)(1)

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	335255	A. Building B. Wing	05/20/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, the facility failed to ensure the resident environment remained as free of accident hazards as possible and did not ensure adequate supervision and assistive devices were provided to prevent accidents for three (3) (Residents #8, #10 and #11) of four (4) residents reviewed. Specifically, Residents #8, #10, and #11 had medical orders for mechanically altered diets and were observed to have been eating food provided by the facility of the incorrect texture and consistency. The findings include: The undated facility policy Altered Diets and Diet Texture Modifications, included to ensure residents received safe, appropriate, and individualized altered diets based on assessed needs, orders, and interdisciplinary team recommendations, and staff would verify diet accuracy prior to meal delivery. 1. Resident #8 had diagnoses including difficulty swallowing, weakness, and blindness. The Minimum Data Set (a resident assessment tool) dated 04/02/2026 included the resident was cognitively intact, had difficulty swallowing, and required a mechanically altered diet. Resident #8's Comprehensive Care Plan (revised on 04/28/2026) included that the resident was on a low potassium, mechanical soft, ground-texture diet. Resident #8 had a medical order placed on 04/27/2026 for a low potassium, mechanical soft, ground-texture diet.A Speech Therapy note dated 04/23/2026 included a recommendation for Resident #8 to be on a mechanical soft, ground-texture diet. During an observation and interview on 04/28/2026 at 12:31 PM, Resident #8 was in the dining area and was provided a meal tray with a ticket that included soft ground consistency, and the meal's entree was a chicken patty cut into small cubes. While eating, Resident #8 began repeatedly coughing and clearing their throat. Licensed Practical Nurse #1 approached the resident to see if they were okay and encouraged them to take smaller bites, lift their arms over their head and take deep breaths. The meal tray was not removed from the resident, and they continued to eat it. Following the observation, Licensed Practical Nurse #1 stated Resident #8's meal ticket said soft ground consistency, the food provided was chopped, the chicken patty was not soft, and providing a tray with a different food consistency was an aspiration and choking risk. During an interview on 04/29/2026 at 1:05 PM, the Regional Food Service Director said if a resident was on a ground diet, they could have a bun with ground meat and gravy. The day prior, they did an in-service on meal consistencies because a resident's ticket noted mechanical ground diet and the chicken they received was cut in the form of chopped instead of ground.2. Resident #11 had diagnoses including difficulty swallowing, stroke, and muscle weakness. The Minimum Data Set, dated [DATE] included the resident was cognitively intact and required a mechanically altered diet. Resident #11's Comprehensive Care Plan (revised on 04/02/2026) included an intervention for a mechanical soft, chopped-texture diet. Resident #11 had a medical order dated 04/01/2026 for a mechanical soft, chopped-texture diet. A progress noted authored by Speech Therapy dated 04/01/2026 documented Resident #11 required mechanically altered solid foods. During an observation and interview on 04/29/2026 at 12:43 PM, Resident #11 was observed in the dining area, was provided a meal tray with a whole hamburger cut into quarters, and the meal ticket included mechanical soft consistency. During the observation, Certified Nursing Assistant #3 stated Resident #11's hamburger was not chopped and then walked away. The Regional Director of Nursing observed Resident #11's hamburger, stated that it was cut into quarters and was not chopped, and that it was a choking risk. Resident #11's hamburger was not removed, and they continued to eat it.During an interview on 05/01/2026 at 10:00 AM, the Regional Director of Nursing staff should be checking to make sure meal trays matched the diet consistency listed on the ticket, that staff should remove a tray with the incorrect food consistency from a resident because of a risk for aspiration, and Resident #10's sandwich should have been cut up into bite-size pieces. 3. Resident #10 had diagnoses including difficulty swallowing, stroke, and dementia. The Minimum Data Set, dated [DATE] included the resident had severe (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335255	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elm Manor Nursing and Rehabilitation Center	210 North Main Street Canandaigua, NY 14424

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cognitive impairment and required a mechanically altered diet. Resident #10's Comprehensive Care Plan included an intervention last updated 02/19/2026 for a mechanical soft, chopped-texture diet. Resident #10 had a medical order dated 02/19/2026 for a mechanical soft, chopped-texture diet. A Speech Therapy note dated 02/10/2026 included a recommendation for Resident #10 to be on a mechanical soft, chopped-texture diet. During an observation and interview on 05/01/2026 at 12:55 PM, Resident #10 was observed in the dining area and requested a sandwich to eat instead of the provided meal. An unidentified staff member provided Resident #10 with a whole peanut butter and jelly sandwich, the Director of Nursing cut it in half, and the resident began to take large bites. Licensed Practical Nurse #6 was aware that Resident #10 was eating a sandwich cut in half, they stated that the sandwich was not mechanically soft because it was dry, and proceeded to cut the resident's sandwich into smaller pieces. During a telephone interview on 05/05/2026 at 3:27 PM, the Medical Director stated they expected ordered diet consistencies to be followed, and if a resident was eating the wrong consistency meal, the staff would not allow them to continue eating it.Title 10 New York Code of Rules and Regulations, Section 415.12 (h)(1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335255	A. Building B. Wing	05/20/2026

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure sufficient nursing staff were available to provide nursing services necessary to attain or maintain the highest practicable physical, mental, and psychosocial well-being of residents for three (3) of three (3) sampled residents reviewed (Residents #1, #8, and #13), and additional residents identified through facility-generated medication administration audit reports. Specifically, the facility failed to consistently meet staffing levels identified in its Facility Assessment, staffing records reflected repeated discrepancies regarding licensed nursing coverage, and residents experienced delayed medication administration during periods of inadequate staffing.The findings include:The facility policy Staffing, dated 09/20/2024, included licensed nursing staff were available 24 hours a day to provide direct resident care services, and staffing numbers of direct care staff were determined by resident needs.The Facility Assessment, reviewed 02/25/2026, documented the facility was licensed for 37 beds and identified minimum staffing requirements of one (1) Registered Nurse, one (1) to two (2) Licensed Practical Nurses, and three (3) to five (5) Certified Nursing Assistants on the day shift from 7:00 AM to 3:00 PM; one (1) to two (2) Licensed Practical Nurses and three (3) to five (5) Certified Nursing Assistants on the evening shift from 3:00 PM to 11:00 PM; and one (1) Licensed Practical Nurse and one (1) to two (2) Certified Nursing Assistants on the night shift from 11:00 PM to 7:00 AM.At entrance on 04/27/2026 at 8:45 AM, the facility census was 37 residents.Resident #1 had diagnoses including diabetes, end stage renal disease (level of kidney function when they can no longer filter waste and excess fluid), and organ transplant recipient (kidney and pancreas transplant recipient). The Minimum Data Set, dated [DATE] revealed Resident #1 was cognitively intact.Resident #8 had diagnoses including stage five (5) chronic kidney disease (kidneys severely damaged), anemia (low levels of healthy red blood cells), and muscle weakness. The Minimum Data Set, dated [DATE] revealed Resident #8 was cognitively intact.Resident #13 had diagnoses including congestive heart failure (a chronic condition where the heart muscle is too weak or stiff to pump blood efficiently), chronic kidney disease, and diabetes. The Minimum Data Set, dated [DATE] revealed Resident #13 was cognitively intact.Review of nursing schedules and direct care staff time punch records from 12/01/2025 through 05/05/2026 revealed repeated staffing shortages and discrepancies between scheduled and actual staffing levels. The review included 156 days and 468 shifts. Comparison of actual staffing to minimum staffing levels identified in the Facility Assessment revealed at least 26 day shifts, seven (7) evening shifts, and four (4) night shifts where licensed nursing staffing was below the facility's identified minimum staffing levels. The review also revealed 32 day shifts and 43 evening shifts where Certified Nursing Assistant staffing was below the facility's identified minimum staffing levels.Review of facility-generated Medication Administration Audit Reports, which identified medications administered one (1) hour or greater after the scheduled administration time, revealed delayed medication administration on dates where staffing records reflected staffing shortages and staffing discrepancies.Review of Medication Administration Audit Reports for April 2026 revealed, but was not limited to, the following: Resident #1 experienced repeated delayed medication administration during periods where staffing records reflected staffing shortages and staffing discrepancies. Delayed medications included respiratory treatments, immunosuppressive medications (medications that weaken the immune system) prescribed following kidney and pancreas transplantation, and medication prescribed for diabetic gastroparesis (a chronic condition where high blood sugar damages the vagus (nerve that controls bodily functions, such as heart rate and digestion) nerve, causing the stomach to empty food much slower than normal). Delays ranged from more than one (1) hour to more than five (5) hours. Resident #8 experienced repeated delayed medication administration during periods where staffing records reflected staffing shortages and staffing discrepancies. Delayed (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335255	A. Building B. Wing	05/20/2026

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	medications included medications prescribed to treat chronic kidney disease, hyperkalemia (high potassium levels), anemia (a common blood condition where your body lacks enough healthy red blood cells or hemoglobin to carry oxygen to its tissues), and hypertension (a common blood condition where your body lacks enough healthy red blood cells or hemoglobin to carry oxygen to its tissues). Delays ranged from more than one (1) hour to more than 24 hours. Resident #13 experienced repeated delayed medication administration during periods where staffing records reflected staffing shortages and staffing discrepancies. Delayed medications included insulin and other diabetic medications, medications prescribed for congestive heart failure and hypertension, blood clot prevention medication, edema (swelling) medication, and glaucoma (a group of eye diseases that damage the optic nerve, typically due to a buildup of fluid in the eye) eye drops. Delays ranged from more than one (1) hour to almost four (4) hours.Review of facility-generated Medication Administration Audit Reports for April 2026 also identified delayed medication administration for additional residents including Residents #11, #15, #16, #17, #18, and #19. Delayed medications included respiratory treatments, anticoagulants (medications used to prevent blood clots), blood pressure medications, pain medications, psychiatric medications, immunosuppressive medications (medications used to prevent organ rejection), and other physician-ordered medications.During a telephone interview on 05/13/2026 at 3:05 PM, Resident #1 stated there had been nights when they walked the halls and could not find staff, and other residents would yell for help for hours during the night.During an interview on 05/04/2026 at 11:12 AM, Certified Nursing Assistant #5 stated there were often only two (2) Certified Nursing Assistants on the unit during the day and staff did not have enough time to complete all required duties when short staffed.During an interview on 05/05/2026 at 1:37 PM, Certified Nursing Assistant #3 stated there had been times residents requested medications and there was not a nurse immediately available to administer them, and staff were fortunate if there were three (3) Certified Nursing Assistants working during the day.During an observation and interview on 04/30/2026 at 11:26 AM, Licensed Practical Nurse #4 was observed passing medications and stated they were still administering medications scheduled for 8:00 AM and 9:00 AM.During an interview on 05/04/2026 at 11:45 AM, Licensed Practical Nurse #2 stated there were day shifts with only one (1) nurse and two (2) aides working.During a telephone interview on 05/05/2026 at 1:20 PM, Licensed Practical Nurse #7 stated there were times nurses worked without aide support.During an interview on 05/06/2026 at 11:08 AM, Licensed Practical Nurse #4 stated there had been occasions where staffing coverage was inadequate, evening or night nurses left before relief staff arrived, they had been called in because staffing coverage was insufficient, and they frequently worked alone.During a telephone interview on 05/13/2026 at 12:31 PM, Licensed Practical Nurse #2 stated they frequently worked double shifts or came into work during the night because of staffing issues and it was impossible to complete all assigned tasks on time when working as the only nurse.During an interview on 05/05/2026 at 11:44 AM, the Staffing Coordinator stated staffing expectations included two (2) nurses on day and evening shifts, one (1) nurse on night shift, four (4) Certified Nursing Assistants on day and evening shifts, and two (2) Certified Nursing Assistants on night shift.During an interview on 05/06/2026 at 2:42 PM, the Regional Director of Nursing stated they were not aware of periods where licensed nursing coverage could not be verified through staffing records and stated a situation with no nursing coverage in the facility would be unsafe.During a telephone interview on 05/20/2026 at 11:09 AM, the Regional Director of Nursing stated understaffing of nursing staff and Certified Nursing Assistants could result in delayed medication administration and reduced assistance with activities of daily living for residents.During an interview on 05/06/2026 at 4:34 PM with the Regional Administrator and Administrator, the Administrator stated staffing had been an issue and there should be adequate nursing coverage at all times.Review of complaint investigations conducted during the survey period revealed three (3) of eight (8) complaints included allegations related to insufficient staffing and five (5) complaints included allegations related to delayed or missed medication administration.Title 10 New York Codes, Rules and Regulations 415.13(a)

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	335255	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elm Manor Nursing and Rehabilitation Center	210 North Main Street Canandaigua, NY 14424

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interviews and record review, the facility failed to use the services of a registered nurse for at least eight (8) consecutive hours per day, seven (7) days per week. Specifically, the facility was unable to provide documented evidence of registered nurse coverage within a 24-hour period on three (3) separate days, and (8) hours or more of registered nurse coverage on two (2) separate days during the five (5) months reviewed. The findings include: Review of Employee Paired Punches (direct care staff time punches provided by the facility) from 12/01/2025 to 05/05/2026 revealed that there was no registered nurse within a 24-hour period on 12/15/2025, 12/16/2025, and 12/18/2025. Additionally, there were less than eight (8) consecutive hours of registered nurse coverage on 12/17/2025 and 02/24/2026. During an interview on 05/05/2026 at 11:44 AM, the Staffing Coordinator stated that there had to be a registered nurse in the building for at least eight (8) hours per day, but the hours did not have to be consecutive. During an interview on 05/06/2026 at 2:42 PM, the Regional Director of Nursing stated they were aware that there had to be a registered nurse in the building for eight (8) out of 24 hours, they were aware that there were times that there was no registered nurse in the building, and the facility occasionally utilized an on-call registered nurse who would come to the building if there were any issues. During an interview on 05/06/2026 at 4:34 PM, with the Regional Administrator and the Administrator, the Administrator stated they were not aware of the lack of registered nurse coverage.Title 10 New York Codes, Rules and Regulations 415.13(b)(1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335255	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure residents were free of significant medication errors for five (5) (Residents #1, #8, #9, #10, and #13) of seven (7) residents reviewed. Specifically, there was no documented evidence that Residents #1, #8, #10 and #13 received multiple significant ordered medications over the course of several days including but not limited to insulin (used to treat high blood sugar levels), anti-rejection medications (used for kidney and pancreas transplants), anticoagulants (blood thinner), anti-seizure medications (used to treat myoclonic jerks), cardiac medications (used to treat heart conditions), antibiotics (used to treat infections), and bronchodilators (a medication used to treat coughing, difficulty breathing or chest tightness). In addition, review of the Medication Administration Audit Reports revealed several medications to multiple residents (Residents #1, #8, #9 and #10) were administered outside the ordered timeframes and there was no documented evidence that a medical provider was notified. The findings include:The facility policy Administering and Storage of Medications dated [DATE], included staffing schedules were arranged to ensure that medications were administered without unnecessary interruptions. Medications were administered in accordance with prescriber orders, including any required time frame. The policy noted that medications were administered within one (1) hour of the prescribed time. Residents could self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, had determined that they have the decision-making capacity to do so safely.The undated facility Insulin Administration Policy and Procedure included the facility was to ensure the safe, accurate, and timely ordering, storage, administration, monitoring and documentation of insulin therapy for residents requiring insulin. Insulin should be administered in accordance with physician orders and evidence-based practices. The policy also included that all insulins must be ordered by a licensed provider and include the type of insulin, dose and timing, blood glucose monitoring frequency, parameters for holding or notifying the provider and treatment instructions for hypo- and hyperglycemia (low and high blood sugar). Blood glucose monitoring checks should be performed as ordered by the provider. Additionally, the policy noted that insulin should be stored according to manufacturer guidelines, in a secure medication refrigerator or designated area, and labeled with the date opened. Missed, refused or unavailable insulin doses must be documented in the Medication Administration Record and reported to the Nurse Manager and provider as appropriate.The undated facility Provider Notification Policy included nursing staff must notify a provider with any medication errors with potential adverse outcome to the resident, refusal of essential medications and/or treatments, and any condition requiring new or revised orders. Providers should be notified immediately if emergent, within one (1) hour if urgent, or within 24 hours for routine concerns. The policy also noted that documentation should be completed indicating the reason for notification and orders received and actions taken. 1. Resident #1 had diagnoses including diabetes, end stage renal disease, and organ (kidney and pancreas) transplant recipient. The Minimum Data Set (a resident assessment tool) dated [DATE] revealed the resident was cognitively intact and received insulin injections.Review of current physician orders revealed Resident #1 was prescribed the following (but not limited to): CellCept (medication to prevent organ rejection) 250 milligrams twice daily ordered [DATE]. Lispro insulin (a short-acting insulin used to treat high blood glucose levels) inject one (1) unit subcutaneously before meals for self-directed diabetic monitoring and insulin administration. Patient may self-direct blood glucose monitoring and insulin administration utilizing their monitor and home-dosing of Lispro insulin based on nutritional scale with an additional custom sliding scale (a method of insulin administration where the dose is calculated based on a person's blood sugar level at that specific moment) in conjunction with nutrition ordered [DATE]. Glargine Insulin (a long-acting insulin used to treat high blood glucose levels) inject four (4) units subcutaneously at bedtime supervised self-administration. Resident #1 may self-administer blood (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335255	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elm Manor Nursing and Rehabilitation Center	210 North Main Street Canandaigua, NY 14424

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	glucose monitors and all insulins. Nursing is to record all blood glucose readings and amount of insulin administered by Resident #1 ordered [DATE]. Ipratropium-Albuterol Solution (used to prevent wheezing, difficulty breathing, chest tightness and coughing) inhale three (3) milliliters every four (4) hours for shortness of breath ordered [DATE], discontinued on [DATE]. Prednisone (medication given due to kidney transplant) five (5) milligrams in the afternoon ordered [DATE]. Tacrolimus (medication to prevent organ rejection) one half (0.5) milligrams two (2) times daily ordered [DATE].Review of Resident #1's Medication Administration Record from [DATE] through [DATE] revealed 25 occurrences in which medications for organ transplant and anti-rejection (Prednisone, Tacrolimus and CellCept) were not documented as administered, and additional two (2) occurrences were documented as resident refused. There were 30 occurrences in which insulins (Humalog and glargine) were not documented as administered and 51 additional occurrences were documented as resident refused. Review of the Medication Administration Audits (system-generated audits from the electronic health record used to verify medication safety, compliance and accuracy) from [DATE] to [DATE] revealed Resident #1 had 276 occurrences where their medications were administered at least over one (1) hour late. In addition, there were 11 occurrences in which the Ipratropium-Albuterol nebulizer was administered less than two (2) hours apart and for eight (8) of those occurrences the medication was administered two (2) minutes apart. Review of the Comprehensive Care Plan dated [DATE] included Resident #1 had diabetes and an intervention to administer medications as ordered by the physician. Additionally, the Comprehensive Care Plan did not include any education, training, evaluation, or mention of Resident #1 self-directing their own blood glucose monitoring and/or administering their own insulin.Review of the facility records did not include documented evidence that a medical provider was notified when medications were omitted or administered outside the ordered timeframe for Resident #1. Additionally, there was no documented evidence that Resident #1 had been assessed to safely self-administer medications or have the ability to keep their medications at their bedside.During a telephone interview on [DATE] at 3:27 PM, the Medical Director stated that they were not aware of the missed anti-rejection transplant medications and that those medications needed to be given on time. The Medical Director stated they were not aware that Resident #1 was giving themselves insulin and that they should have been medically cleared to check their own blood glucose and administer insulin. The Medical Director stated they were not sure when Resident #1 was taking the insulin or how much, and the lack of awareness of the staff with Resident #1's insulin was a big problem as there was not a way to track and maintain their regimen.During an interview on [DATE] at 2:42 PM, the Regional Director of Nursing stated they were not aware Resident #1 was administering their own insulin and that the facility did not have a protocol in place for them to self-administer. The Regional Director of Nursing stated that they did not know if the insulin had been properly stored, if Resident #1 was overdosing or underdosing the insulin, or the effectiveness of it. Additionally, the insulin should have been properly secured. During a telephone interview on [DATE] at 3:05 PM, Resident #1 stated that staff did not give them their medications unless they asked for them, there were times that they did not receive the medications needed for having organ transplants, and the nebulizer was only given if one of the better nurses were working. Resident #1 stated that they had been checking their own blood glucose and administering their own insulin three (3) to four (4) times daily. Resident #1 stated the nurses would only ask them about their blood glucose readings and the amount of insulin given about once a day. Resident #1 stated that they felt the staff were reckless, and that they were in danger due to staff not giving them their medications correctly. 2. Resident #8 had diagnoses including stage five (5) chronic kidney disease (kidneys severely damaged), anemia (low levels of healthy red blood cells), and muscle weakness. The Minimum Data Set, dated [DATE] revealed the resident was cognitively intact.Review of current physician orders revealed Resident #8 was prescribed the following (but not limited to): Cefdinir (medication to treat infection) 300 milligrams daily for two (2) days ordered [DATE]. Cefpodoxime proxetil (used to treat pneumonia) 200 milligrams two (2) times daily for seven (7) days ordered [DATE]. Doxycycline (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335255	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elm Manor Nursing and Rehabilitation Center	210 North Main Street Canandaigua, NY 14424

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hyclate (used to treat pneumonia) 100 milligrams two (2) times daily for seven (7) days ordered [DATE]. Hydralazine hydrochloride (medication to treat high blood pressure) ten (10) milligrams three (3) times a day ordered [DATE].Review of Resident #8's Medication Administration Record from [DATE] through [DATE] revealed six (6) occurrences in which antibiotic medications (cefdinir, cefpodoxime proxetil, and doxycycline hyclate) were not documented as administered, and seven (7) occurrences in which hydralazine was not documented as given. Review of the Medication Administration Audits from [DATE] to [DATE] Resident #8 had 516 occurrences where their medications were administered at least over one (1) hour late. During a telephone interview on [DATE] at 10:14 AM, the Medical Director stated that they were not aware Resident #8 did not receive the ordered antibiotic and stated that since it was ordered they should have received it.3. Resident #10 had diagnoses including dementia, myoclonus (uncontrolled sudden muscle movements), and an unstageable pressure ulcer of the sacral region. The Minimum Data Set, dated [DATE] revealed the resident had severely impaired cognition, and was taking anticoagulant and anticonvulsant medications.Review of physician orders revealed Resident #10 was prescribed the following (but limited to): Apixaban (an anticoagulant medication used to prevent blood clots) five (5) milligrams every morning and at bedtime, ordered on [DATE]. Baclofen (a medication used to relax certain muscles) five (5) milligrams three (3) times daily was ordered on [DATE] and was discontinued on [DATE] at 4:27 PM. Baclofen seven and a half (7.5) milligrams three (3) times daily was ordered on [DATE] for 30 days (until [DATE]). Divalproex sodium (used to treat myoclonic muscle jerks) 125 milligrams twice daily, ordered on [DATE].Review of Resident #10's Medication Administration Record from [DATE] through [DATE] revealed 13 occurrences in which baclofen was not documented as administered and was last given on [DATE] at 1:00 PM. Additionally, there were nine (9) occurrences in which divalproex sodium was not documented as administered and two (2) occurrences in which apixaban was not documented as administered.Review of nursing progress notes dated [DATE] through [DATE] revealed multiple nurses documented the baclofen was on order (not available).Review of the Medication Administration Audits from [DATE] to [DATE] Resident #10 had 741 occurrences where their medications were administered at least over one (1) hour late. During a telephone interview on [DATE] at 10:14 AM, the Medical Director stated that Resident #10's baclofen should not have lapsed and the fact that it fell off the Medication Administration Record was not good. The Medical Director stated they re-ordered the medication last week and that they did not know why it was not re-ordered in time. 4. Resident #9 had diagnoses included transient ischemia attack (blood supply to the brain was blocked for only a short timeframe), hemiplegia (weakness one side of the body), and neuropathy (pain caused by damaged nerves). The Minimum Data Set, dated [DATE] revealed the resident was cognitively intact and was taking antidepressant, anticoagulant, opioid, antiplatelet, and anticonvulsant medications.Review of physician orders revealed Resident #9 was prescribed the following (but not limited to): Gabapentin (medication used to treat neuropathy) 600 milligrams three (3) times daily at 9:00 AM, 12:00 PM, and 6:00 PM ordered [DATE]. Levothyroxine Sodium 125 micrograms daily ordered [DATE]. Fluoxetine Hydrochloride (medication used to treat depression) 40 milligrams daily ordered [DATE]. Trazodone Hydrochloride (medication used to treat depression and insomnia) 100 milligrams at bedtime ordered [DATE]. Warfarin Sodium (medication used to prevent blood clots) five (5) milligrams daily in the evening ordered [DATE].Review of the Medication Administration Audits from [DATE] to [DATE] Resident #9 had two hundred eighty-five (285) occurrences where their medications were administered at least over one (1) hour late. Additionally, gabapentin doses were given within three (3) hours apart on 25 occasions, with four (4) of those occurrences being given within three (3) minutes apart and in two (2) of those occurrences the 9:00 AM dose was given at 12:14 PM and the 12:00 PM dose was also given within the one (1) hour timeframe. Additionally, all medications scheduled to be given on [DATE] were signed out as administered on [DATE] at 4:01 PM. The facility was unable to provide a medication administration audit for all medications given to Resident #9; the facility could only (continued on next page)

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	335255	A. Building B. Wing	05/20/2026

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	provide an audit of missed or late medications. During an interview on [DATE] at 12:43 PM, Resident #9 stated that their medications were always given late and one (1) of the nurses calls themselves the better late than never nurse. Resident #9 stated that they typically did not get their morning medications until 12:00 PM and the nurses would give the morning and afternoon medications at the same time. Resident #9 stated that sometimes they do not get their medications because the order expired, or the pharmacy did not deliver them. During an observation and interview on [DATE] at 11:26 AM, Licensed Practical Nurse #3 was standing at a medication cart preparing medications and stated that they were still passing 8:00 AM and 9:00 AM medications. In a follow-up interview at 3:12 PM, Licensed Practical Nurse #3 stated that they were the only nurse in the facility until 8:30 AM that day and they had started late passing their medications. Licensed Practical Nurse #3 stated there was not anyone to tell when they were running behind on administering their medications and Administration knew that the facility was short staffed. Licensed Practical Nurse #3 stated they typically did not notify providers of medications being administered late as the provider communication log was not available.During an interview on [DATE] at 12:00 PM, Licensed Practical Nurse #6 stated that the code 17 on the Medication Administration Record was to be used for medications held per physician order, but the nurses did not have an option to document if medications were unavailable. Licensed Practical Nurse #6 said they would document that the resident refused and would put in a note that the medication was unavailable. During a telephone interview on [DATE] at 3:27 PM, the Medical Director stated they would expect the nurse practitioner to be notified if medications were missed or if significant medications were given late. The Medical Director stated that there was a problem with nurse staffing at the facility which was why medications could not be given on time. The Medical Director stated if medications were not available, the nurses should not be documenting that medications were refused, as it would come across to us (the medical providers) differently and they would be putting the ownness on the residents and not the facility for why the medications were not given. The Medical Director said residents should not miss doses of medications, and staff should go through the pharmacy, and notify the providers. During an interview on [DATE] at 4:33 PM, Licensed Practical Nurse #8 stated that regularly scheduled medications were often not available because either they were not re-ordered, or they had not arrived from the pharmacy. Licensed Practical Nurse #8 stated that the electronic health record did not have an option for the nurses to document that a medication was not available, the previous Director of Nursing told the nurses to either document resident refusal or leave it blank and write a note. During an interview on [DATE] at 1:10 PM, the Director of Nursing said that nurses can give medications an hour before and an hour after the scheduled time. During an interview on [DATE] at 2:42 PM, the Regional Director of Nursing stated that they were made aware periodically that medications were not available and that the nurses should have been notifying providers and documenting the conversations in progress notes. The Regional Director of Nursing stated that medications to be given three (3) times a day should generally be administered eight (8) hours apart and that the nurses should be putting the administration times on the Medication Administration Record. The Regional Director of Nursing stated that residents not receiving medications as prescribed could put them in danger. The Regional Director of Nursing stated that there were times where they were aware that there was only one (1) nurse on a day shift and if nurses were not able to complete medications, they should have notified a nurse manager or the Director of Nursing, or tried to call other nurses to come into the facility. The Regional Director of Nursing stated that medications may not have been available because it may not have arrived from the pharmacy yet and that there were times that they had the Administrator use the company credit card to buy over the counter medications. During a telephone interview on [DATE] at 10:14 AM, the Medical Director stated missing one (1) dose of a medication, or getting a late dose here and there would not be an issue, but if they missed them consistently, it should be reported to a medical provider. The Medical Director stated when providers order medications, they pick the administration time from times that are available (in the system). (continued on next page)

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	335255	A. Building B. Wing	05/20/2026

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Additionally, there were not good time sets for medications to be given three (3) times a day and that needed to be addressed with the facility. The Medical Director stated that residents should not be consistently receiving their medications late or not at all, the providers were not being made aware of late or missed medications, and the providers should have been made aware. The Medical Director stated that there could be a system-based issue.Title 10 New York State Code Rules and Regulations 415.12(m)(2)

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	335255	A. Building B. Wing	05/20/2026

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations, interviews, and record review, the facility failed to ensure food and drink were provided that was at a safe and appetizing temperature for one (1) of one (1) test tray and for one (1) (Resident #9) interviewed. Specifically, food and beverages during the meal were served at suboptimal temperatures and were not palatable.The findings include:During an interview on 04/28/2026 at 12:43 PM, Resident #9 stated that the food was typically cold, did not taste good and that the buns would be soggy from the vegetables being put on the same plate.During observations and interview on 04/29/2026 at 11:53 AM, the lunch meal tray line started. Meal trays were placed and covered on the tray cart which included the test tray. The tray cart was open and had no insulating doors. Cold food and drink items were held pre-portioned and pre-poured on the meal trays. The last cart left the kitchen at 12:41 PM and residents were served their lunch at 12:50 PM. A test tray was completed with the Regional Food Service Director and Dietary Aide #1 for temperatures and palpability. The temperatures were taken by the surveyor using the surveyor's digital thermometer. After the temperatures were taken, the Regional Food Service Director and Dietary Aide #1 attempted to clean up and remove the meal tray (prior to taste testing). When asked who would be tasting the meal, the Regional Food Service Director and Dietary Aide #1 initially declined, and the Regional Food Service Director subsequently completed the taste test with the surveyor. The results were as follows:-Hamburger was 131.5 degrees Fahrenheit, tasted lukewarm and was not palatable.-Sweet potatoes were 126.1 degrees Fahrenheit, tasted cold, hard, bland and was not palatable.-Milk was 53.6 degrees Fahrenheit and not cold but lukewarm.-Juice was 54.7 degrees Fahrenheit and not cold but lukewarm.During observations and an interview immediately following the test tray observation, a meal cart in the hallway had ten (10) collected trays, and eight (8) of the trays had visible plates that appeared untouched; the burgers and sweet potatoes had small bites taken out of them. A meal cart outside of the dining room looked the same as the one down the hallway. The Regional Food Service Director stated the Kitchen Department had been short staffed and that they had been coming to the facility periodically for the previous year. The Regional Food Service Director stated that they saw that a lot of residents did not eat their lunch meal, they typically do not observe tray line in the kitchen, and what they saw that day bothered them. The Regional Food Service Director stated that the Food Service Director had to leave for an appointment and that they or the chef should have been cooking, not Dietary Aide #1. They stated that tray line took a lot longer than it should have. During an interview on 05/01/2026 at 1:29 PM, Resident #9 stated that the other day they could not eat the hamburger as it was cold and tough. They stated that they did not like their lunch, did not eat it and were not offered anything else to eat.During an interview on 05/01/2026 at 1:38 PM, Certified Nursing Assistant #4 stated that sometimes the residents do not like the food, they will ask for sandwiches, and that none of the residents liked to eat the hamburgers. During an interview on 05/06/2026 at 4:34 PM with the Regional Administrator and the Administrator, the Administrator stated that food concerns had been discussed in Resident Council and that a food committee had been created. The Administrator stated they wanted residents to eat and to them food was more important than medications.Title 10 New York Codes, Rules and Regulations, Section 415.14(d)(1)(2)

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	335255	A. Building B. Wing	05/20/2026

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety. Specifically, a liquid substance drained from the kitchen sink plumbing onto the floor during tray line (lunch meals were being prepared for the residents) and staff did not wash their hands in-between glove use or prior to touching ready to eat food after cleaning up the liquid on the floor. Additionally, the dumbwaiter (a small freight elevator used for moving items, such as food) was dirty, dried white debris was seen around the ice machine grate, and an ice scoop was observed resting inside a cooler of ice. The findings include:The facility's undated Handwashing/Hand Hygiene policy included all personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. Staff should use an alcohol-based hand rub containing at least 62 percent alcohol; or alternatively, soap and water after, but not limited to, the following situations: before handling food and after removing gloves. Hand hygiene is the final step after removing and disposing of personal protective equipment. The facility's undated Use and Cleaning of Dumbwaiter policy included the dumbwaiter was designated to transport clean laundry and meal trays (clean and soiled) only. Strict cleaning and disinfection procedures were required between transport of clean and soiled items. Clean laundry must be transported covered and soiled trays must be contained to prevent spills and debris. Additionally, each cleaning must be documented in the dumbwaiter cleaning log including date, time and staff initials.During an observation on 04/28/2026 at 9:56 AM, an ice scoop was seen sitting on ice that was inside a cooler on a cart in the hallway. During an observation on 04/29/2026 at 9:47 AM, the Head Lead of the Laundry Department opened the dumbwaiter door and removed hanging, uncovered resident clothes that appeared to be clean. At 9:48 AM, Certified Nursing Assistant #6 opened the kitchenette door, wheeled a food cart full of uncovered, used meal trays, and sent it down on the dumbwaiter. The dumbwaiter floor and walls were unclean, had dark debris, and scattered hair. The Ice Scoop Daily Cleaning Log was seen hanging on the wall in the kitchenette, and included areas for dates and if it was cleaned. There was no documented evidence that the ice scoop was cleaned on 04/05/2026, 04/07/2026, 04/11/2026, 04/24/2026 through 04/29/2026. During an observation on 04/29/2026 at 11:35 AM, the Daily Checklist for Cleaning the Dumbweighter, seen hanging in the kitchen, had blanks for all three (3) columns on 04/12/2026, 04/13/2026, 04/14/2026, 04/20/2026, 04/21/2026, 04/26/2026, 04/27/2026, 04/28/2026 and 04/29/2026. During an observation on 04/29/2026 at 11:57 AM, a liquid substance drained from the kitchen sink plumbing onto the floor during tray line (lunch meals were being prepared for the residents). Dietary Aide #2 put towels on the floor, picked up the wet soaking towels and put them in a bin. They removed their gloves and put on a new pair without washing their hands. Dietary Aide #2 continued to touch trays, meal tickets, cut hamburgers, and put them on resident's trays. During an interview on 04/29/2026 at 1:29 PM, Dietary Aide #2 stated that they try to change their gloves in-between handling food and cleaning, and stated they changed their gloves after cleaning up the floor. Dietary Aide #2 stated that they did not know that they should wash their hands in-between glove use and stated that they did not remember any training on infection control.During an observation and interview on 05/01/2026 at 10:37 AM, the Head Lead of the Laundry Department was shown a Daily Cleaning Log that was attached to the side of the ice machine with the last date of cleaning documented as 02/25/2026. Dried, white debris was seen around the grate of the ice machine. The Head Lead of the Laundry Department stated that they did not know who was responsible for cleaning it daily, as it used to be the laundry staff until the previous Administrator stated it should not be the Laundry Department's responsibility. During a telephone interview on 05/01/2026 at 3:17 PM, the Infection Preventionist stated the ice machine should be cleaned weekly because of the germs that could get in there. They stated that the ice (continued on next page)

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	335255	A. Building B. Wing	05/20/2026

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	scoop should be cleaned daily and kept in a separate bucket, not in/on the ice. The Infection Preventionist stated that staff should wash their hands and change their gloves when they go from dirty to clean, and before touching food. The Infection Preventionist stated that if staff were not washing their hands correctly, it would put residents at risk for an infection and germs. During an interview on 05/06/2026 at 1:37 PM, Certified Nursing Assistant #3 stated that they had never cleaned the dumbwaiter or the ice scoop. They stated that Housekeeping was responsible for cleaning the dumbwaiter and the kitchen staff was responsible for cleaning the ice container and the scoop. During an interview on 05/06/2026 at 2:42 PM, the Regional Director of Nursing stated that the dumbwaiter, the ice machine, and the ice scoop should be cleaned by Housekeeping and if they were not cleaned it could cause cross contamination.During an interview on 05/06/2026 at 4:34 PM with the Administrator and the Regional Administrator, when shown pictures taken of the dumbwaiter, the Administrator stated it looked dirty and that it should have been cleaned. Title 10 New York Codes, Rules and Regulations, Section 415.14(h)

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	335255	A. Building B. Wing	05/20/2026

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure it was administered in a manner which enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically, the facility failed to ensure administrative systems, including staffing oversight, medication administration monitoring, and quality assurance processes, were implemented and functioning to identify and correct deficient practices, resulting in a pattern of noncompliance across multiple areas of care, including but not limited to sufficient nursing staffing, medication administration, food service, resident rights, accident hazards, and activities of daily living (basic tasks for self-care and daily functioning), as evidenced by new and repeat deficiencies cited during the prior Recertification Survey completed on 08/27/2024 and continued noncompliance identified during the Abbreviated Survey completed on 05/20/2026. The findings include: The facility's Quality Assurance and Performance Improvement Plan included that it was designed to continuously monitor clinical care, resident safety, regulatory compliance, and operation performance by identifying opportunities for improvement and implementing corrective actions. Review of the Facility assessment dated [DATE] included, but was not limited to, services provided by the facility were short-term rehabilitation, long-term skilled nursing, and structure, activities, and equipment to best serve elderly residents. The facility was licensed for 37 beds. Care and services offered based on resident needs included but were not limited to activities of daily living, management of medical conditions, and medications. Review of prior survey history revealed the facility was cited for repeat deficiencies during the Recertification Survey completed 08/27/2024, including F677 (Care Provided for Activities of Daily Living), F689 (Accident Hazards), F725 (Sufficient Nursing Staff), and F812 (Sanitary Food Procurement, Storage, Preparation, and Service). Despite prior corrective actions and monitoring efforts, noncompliance in these areas persisted during the most recent Abbreviated Survey.During the recent Abbreviated Survey, the facility was cited for additional deficiencies including but not limited to F550 (Resident Rights) and F760 (Significant Medication Errors). For additional information see Centers for Medicare and Medicaid Services Form 2567, reference F550 (Resident Rights):Issue One (1), for three (3) of three (3) residents reviewed (Residents #6, #8, and #10), the facility obtained authorizations permitting the Administrator to act regarding Medicare Part D enrollment and plan changes and failed to ensure residents and/or their representatives received information regarding plan options, financial implications, reenrollment rights, and coverage changes. Under Issue Two (2), for three (3) residents reviewed (Residents #8, #12, and #14), the facility failed to maintain resident dignity by exposing Resident #8's urinary catheter collection bag, allowing Resident #14 to ambulate in the facility with visibly soiled clothing, and referring to Resident #12 as a feeder in the presence of staff and other residents.For additional information see Centers for Medicare and Medicaid Services Form 2567, reference F677 (Care Provided for Activities of Daily Living), which is a repeat deficiency: Resident #11 was observed on multiple occasions with long, thick facial hair, the resident verbalized that the facial hair was unwanted, and they required assistance from staff for facial hair removal. Resident #10 was frequently incontinent of bowel and bladder, requiring frequent incontinence care, and the resident was observed to have waited long periods of time without receiving incontinence care. Resident #5 required assistance with showering, and the facility was unable to provide documented evidence they had received or refused a shower during their 10-day admission. For additional information see Centers for Medicare and Medicaid Services Form 2567, reference F689 (Accident Hazards), which is a repeat deficiency:Resident #8 was observed to be served a meal of the incorrect texture consistency and experienced an episode of coughing and clearing their throat while eating. Residents #10 and #11 were observed on different days being served meals of the incorrect texture consistency. For additional information see Centers for Medicare and Medicaid Services Form (continued on next page)

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	335255	A. Building B. Wing	05/20/2026

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2567, reference F725 (Sufficient Nurse Staffing), which is a repeat deficiency: The facility did not consistently meet its own identified minimum staffing levels, and there were multiple instances in which there was not a licensed nurse in the building.For additional information see Centers for Medicare and Medicaid Services Form 2567, reference F760 (Significant Medication Errors): Residents #1, #8, #9, #10, and #13 experienced numerous omissions of ordered medications and/or significantly late medication administrations, including high-risk medications. For additional information see Centers for Medicare and Medicaid Services Form 2567, reference F812 (Sanitary Food Procurement, Storage, Preparation, and Service), which is a repeat deficiency: A liquid substance was observed to be draining onto the floor from a sink in the kitchen while food was being served. Kitchen staff were observed to not perform hand hygiene between glove changes prior to touching ready-to-eat food for the residents. The dumbwaiter (a small freight elevator used for moving items, such as food) was observed to be soiled with hair and debris. The ice scoop was observed to be inside of a cooler containing ice. During an interview on 05/06/2026 at 04:35 PM with the Regional Administrator and the Administrator, the Regional Administrator stated the Quality Assurance and Performance Improvement committee was not aware of issues regarding altered diet texture consistency or the absence of a nurse in the building for periods of time and was aware of insufficient staffing. The Administrator stated the Quality Assurance and Performance Improvement committee was not aware of issues regarding activities of daily living, resident's rights, or the cleanliness of food service, and was unsure if the committee was aware of medications being omitted and/or late. Title 10 New York Codes, Rules and Regulations, Section 415.26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335255	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elm Manor Nursing and Rehabilitation Center	210 North Main Street Canandaigua, NY 14424

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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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to maintain a Quality Assessment and Assurance Committee consisting at a minimum of the Director of Nursing Services, the Medical Director or his/her designee, at least three (3) other members of the facility's staff, one (1) of who must be an individual in a leadership role, and the Infection Preventionist. Specifically, the facility could not provide documented evidence that the Infection Preventionist attended the Quality Assurance and Performance Improvement meetings on a regular basis (quarterly).The findings include:The facility's Quality Assurance and Performance Improvement Program policy revised April 2014, included the primary purpose of the Quality Assurance and Performance Improvement Program was to establish data-driven, facility-wide processes that improved the quality of care, quality of life and clinical outcomes of the residents. Steps that would be employed to support and enhance the facility's Quality Assurance and Performance Improvement (QAPI) program included recognizing patterns in systems of care that could be associated with quality problems, gathering and using data in areas that may be appropriate to monitor and evaluate, which included clinical outcomes such as pressure ulcers and infections. The facility's undated Quality Assurance and Performance Improvement Plan policy included the facility would maintain a Quality Assurance and Performance Improvement Program designed to continuously monitor clinical care, resident safety, regulatory compliance and operational performance. The program applied to all departments, services, contracted providers and staff. The Quality Assurance and Performance Improvement Plan focused on areas identified through the infection control surveillance and Infection Prevention was reviewed annually. The policy listed committee members which included the Assistant Director of Nursing/Infection Preventionist and that the committee met monthly.The Facility assessment dated [DATE] included the facility had an infection prevention and control program, which was headed by a certified Infection Preventionist. Infection prevention and control related education, training and competencies would cover hand hygiene, isolation standard universal precautions including the use of 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), and environmental cleaning. The Facility Assessment did not include reporting to the Quality Assurance and Performance Improvement committee. Review of the Quality Assurance and Performance Improvement quarterly meeting attendance records from 05/30/2025 to 02/25/2026 revealed no documented evidence that the Infection Preventionist was present for the meetings.During an interview on 05/06/2026 at 4:34 PM with the Regional Administrator and the Administrator, the Regional Administrator stated that it was important for the Infection Preventionist to attend the Quality Assurance and Performance Improvement meetings, that they were aware of the regulation, and that they did not know why the Infection Preventionist wad not attended the meetings at least quarterly.Title 10 New York Codes, Rules and Regulations, Section 415.27(a-c)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, interviews, and record review, the facility failed to 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 for one (1) (Resident #10) of seven (7) residents reviewed for activities of daily living. Specifically, facility staff did not perform hand hygiene after assisting Resident #10 with incontinence care and prior to touching multiple surfaces and equipment. In addition, 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) for Resident #10, who had a wound, and staff were observed not using 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 during high-contact care. Lastly, staff did not wash their hands in between changing gloves after handling soiled towels from the floor and touching ready to eat food.The findings include: The facility's undated Handwashing/Hand Hygiene policy included all personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. Staff should use an alcohol-based hand rub containing at least 62 percent alcohol; or alternatively, soap and water after, but not limited to, the following situations: before and after direct contact with residents, before moving from a contaminated body site to a clean body site during resident care, after contact with blood or bodily fluids, before handling food and after removing gloves. Hand hygiene is the final step after removing and disposing of personal protective equipment. The facility's Enhanced Barrier Precautions policy dated August 2022, included enhanced barrier precautions were used as an infection prevention and control intervention to reduce the spread of multi-drug-resistant organisms for residents with wounds. Staff were to wear gloves and a gown when performing high contact resident care activities which included changing briefs, bathing, dressing, and transferring.Issue One (1)Resident #10 had diagnoses including dementia, myoclonus (uncontrolled sudden muscle movements), and an unstageable pressure ulcer of the sacral region. The Minimum Data Set (a resident assessment tool) dated 03/10/2026 included the resident had severely impaired cognition and had an unstageable pressure ulcer.Review of the Comprehensive Care Plan dated 12/09/2025 revealed Resident #10 required extensive staff assistance for bathing, toileting, transferring and dressing. Additionally, the Comprehensive Care Plan dated 02/17/2026 revealed Resident #10 required enhanced barrier precautions related to their wound.During an observation and interview on 05/01/2026 at 9:36 AM, Certified Nursing Assistant #4 put on a pair of gloves, cleansed stool and urine off the resident, did not change their gloves prior to washing the resident's face or body, and did not remove their gloves or wash their hands prior to touching multiple surfaces in the resident's room. The surfaces included, but were not limited to the resident's closet, the controls at the end of the bed, the call light and the resident's clean gown. Certified Nursing Assistant #4 left Resident #10's room twice, walked in the hallway with the same pair of gloves on, and touched multiple surfaces in the hallway including the closet door, clean sheets, clean towels and a glove box. When interviewed at that time, Certified Nursing Assistant #4 stated Resident #10's pressure ulcer did not have a cover/dressing in or on the wound and they were trying to find the nurse to let them know. Certified Nursing Assistant #4 stated Resident #10 was incontinent of stool and urine, and they should have removed their gloves, washed their hands and put on a new pair of gloves before washing the resident and touching all the surfaces. When shown the enhanced barrier precautions sign outside of Resident #10's door, Certified Nursing Assistant #4 stated that they were never asked to wear a gown when providing care to Resident #10 and they only wore a gown if a resident was positive for Covid-19. After reading the sign, Certified Nursing Assistant #4 stated that they should have worn a gown when providing care. Issue Two (2)During an observation on 04/29/2026 at 11:57 AM, a liquid substance drained from the kitchen sink plumbing onto the floor (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	during tray line (lunch meals were being prepared for the residents). Dietary Aide #2 put towels on the floor, picked up the wet soaking towels and put them in a bin. They removed their gloves and put on a new pair without washing their hands. Dietary Aide #2 continued to touch trays, meal tickets, cut hamburgers, and put them on resident's trays. During an interview on 04/29/2026 at 1:29 PM, Dietary Aide #2 stated that they try to change their gloves in-between handling food and cleaning, and stated they changed their gloves after cleaning up the floor. Dietary Aide #2 stated that they did not know that they should wash their hands in-between glove use and stated that they did not remember any training on infection control.During a telephone interview on 05/01/2026 at 3:20 PM, the Infection Preventionist stated that if a resident had a wound or any medical equipment coming from their body, staff should wear a gown and gloves when providing close contact care, remove their gown and gloves after care, and perform hand hygiene. The Infection Preventionist stated that staff should wash their hands and change their gloves when they go from dirty to clean, before and after care, and before touching food. The Infection Preventionist stated that if staff were not wearing gowns, gloves, and/or washing their hands correctly, it puts residents at risk for an infection and germs. The Infection Preventionist stated that all staff receive infection control education, and it was concerning they were not taking in the information.During an interview on 05/06/2026 at 2:42 PM, the Regional Director of Nursing stated that staff not wearing gowns, not changing gloves correctly or washing hands could put the residents at risk for cross-contamination and infection. Staff walking in the hallway wearing dirty gloves put everyone else at risk.During an interview on 05/06/2026 at 4:34 PM with the Administrator and the Regional Administrator, the Administrator stated they had concerns if staff were not following infection control protocols, as infections could spread unnecessarily. Title 10 New York Codes, Rules and Regulations, Section 415.19(a)(1-4)(b)(1-4)