STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335369	A. Building B. Wing	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Ridge Nursing Home	1555 Long Pond Road Rochester, NY 14626

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observations, interviews, and record review, the facility failed to ensure a medication error rate of less than five (5) percent for one (1) of three (3) residents reviewed (Resident #23). Specifically, Resident #23's scheduled 9:00 AM doses of chlorhexidine (an antimicrobial oral rinse used to reduce oral bacteria and prevent infection), fluoride sodium 1.1 percent paste (a prescription-strength fluoride dental medication used to prevent tooth decay), and zinc oxide-white petrolatum paste (a topical skin protectant medication used to treat and prevent skin irritation) were not administered and documented within the facility's established medication administration timeframe. There were three (3) medication errors out of 32 opportunities, resulting in a medication error rate of 9.375 percent.The findings include:Review of the facility policy Medication Administration, dated July 2025, revealed medications were to be administered following a valid physician order entered into the Electronic Medical Record (an electronic system used to maintain resident health information), which linked to the Medication Administration Record (a record used to document medication administration). The policy included the seven (7) rights of medication administration as the right patient, right medication, right dose, right time, right route, right reason, and right documentation. Medications administered and required clinical assessment information were to be documented on the Medication Administration Record. Omissions were to be documented on the Medication Administration Record with an explanation in the comment section, and medications not administered at the ordered time but administered later were to be documented with the actual administration time.Resident #23 had diagnoses including Parkinson's disease (a progressive neurological disorder affecting movement), poly - osteoarthritis (degeneration of cartilage and bone within joints causing pain and impaired movement), and anxiety. The Minimum Data Set (a resident assessment tool) dated 03/06/2026 revealed Resident #23 had severely impaired cognition.Review of current physician orders last reviewed by a provider on 04/27/2026 and Medication Administration Record as of 04/30/2026 revealed the following medications were scheduled for administration at 9:00 AM: Chlorhexidine 0.12 percent solution, 15 milliliters swish and spit two (2) times daily for mouth infection prevention. Fluoride (sodium) 1.1 percent paste, one (1) dental application two (2) times daily for dental plaque prevention. Zinc oxide-white petrolatum 17-57 percent paste, one (1) topical application two (2) times daily to the buttocks and sacrum for skin irritation.Review of the physician orders and Medication Administration Record revealed the orders did not include instructions permitting administration anytime during the shift.During a medication administration observation on 04/30/2026 from 9:33 AM to 9:57 AM, Licensed Practical Nurse #2 did not administer chlorhexidine, fluoride paste, or zinc oxide-white petrolatum paste to Resident #23.During review of Resident #23's Medication Administration Record on 04/30/2026 at 1:45 PM, chlorhexidine, fluoride paste, and zinc oxide-white petrolatum paste remained undocumented as administered for the scheduled 9:00 AM administration time.Review of Medication Administration Record administration information on 04/30/2026 at 1:46 PM revealed Licensed Practical Nurse #2 documented the following: Chlorhexidine scheduled for 9:00 AM was administered at 12:10 PM. Zinc oxide-white petrolatum paste scheduled for 9:00 AM was administered at 12:10 PM. Fluoride paste scheduled for 9:00 AM was administered at 1:45 PM.During an interview on 05/01/2026 at 10:35 AM, Registered (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse Manager #2 stated nurses were expected to follow the rights of medication administration, including administering medications at the correct time and documenting administration when the medication was administered. Registered Nurse Manager #2 stated if a medication could not be administered within the acceptable timeframe, nursing staff were expected to notify the nurse manager who would notify the medical provider, document the reason the medication was not administered, and complete a progress note. Upon review of Resident #23's Medication Administration Record, Registered Nurse Manager #2 stated chlorhexidine and zinc oxide-white petrolatum paste administered at 12:10 PM for a scheduled 9:00 AM administration time were not administered within acceptable timeframes. Registered Nurse Manager #2 stated staff should have notified the nurse manager when medications were not administered within the expected timeframe and there was no documentation a medical provider was notified.During an interview on 05/01/2026 at 11:39 AM, Registered Nurse Clinical Leader #1 stated nurses determine medication administration times from the Medication Administration Record and medications should be documented immediately after administration. Registered Nurse Clinical Leader #1 stated if a medication could not be administered within the expected timeframe, nursing staff were expected to notify the medical provider for further direction.During an interview on 05/01/2026 at 12:15 PM, the Director of Nursing stated nurses were expected to follow physician orders and the rights of medication administration when administering medications. The Director of Nursing stated medications not administered within the acceptable administration timeframe would be considered medication errors and nursing staff were expected to notify a nurse supervisory staff and the medical provider when medications could not be administered as ordered.Title 10 New York Codes, Rules and Regulations 415.12(m)(1)