

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335369	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/29/2024
NAME OF PROVIDER OR SUPPLIER  Park Ridge Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49447</b></p> <p>Based on interviews and record review conducted during the Recertification Survey the facility did not ensure that all residents had the right to request, refuse, and/or discontinue treatment, and to formulate an advance directive (medical interventions in the event of a life-threatening episode) that would be honored for one (Residents #47) of one resident reviewed. Specifically, the facility did not ensure that Resident #47's advance directives (their preferred code status in the event of cardiac or pulmonary arrest) were accurately identified per their wishes. This is evidenced by the following:</p> <p>The facility policy, Advanced Directives for Long Term Care, dated [DATE] documented that the facility is committed to honoring the wishes of our patients' that include the right to accept or refuse medical or surgical treatment. Additionally, all patient's verbal or written statements about advanced directives should be accepted as expression of their wishes. The policy also documented the Social Worker will review any advanced directive wishes with the patient and/or the patient's representative and/or review those directives for completeness. Additionally, in unusual or complex situations, if it appears unclear how to proceed for a specific case, contact your supervisor. If further clarification is needed, the supervisor/off shift director is to notify the Medical Director, Director of Clinical Services, and the Manager of Social Work Services, for further instructions.</p> <p>1. Resident #47 had diagnoses that included heart failure, high blood pressure, and malnutrition. The Minimum Data Set Resident assessment dated [DATE] documented the resident was cognitively intact and had a living will.</p> <p>Review of Resident #47's Living Will dated [DATE] documented that they direct their attending physician to withhold or withdraw treatment that merely prolongs dying, if in an incurable or irreversible mental or physical condition with no reasonable expectation of recovery, including but not limited to: (a) a terminal condition; (b) a permanently unconscious condition; (c) a minimally conscious condition in which I am permanently unable to make decisions or express wishes. Additionally, if I am in the condition(s) described above I feel especially strongly about the following forms of treatment: I do not want cardiac resuscitation (CPR), I do not want mechanical respirations (breathing tube and/or ventilator), and I do not want artificial nutrition and hydration.</p> <p>Review of Resident #47's MOLST dated [DATE] and signed by the resident, a Registered Nurse witness and the Physician in the hospital documented their wishes were for Do Not Resuscitate and Do Not Intubate.</p> <p>(continued on next page)</p>

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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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Current Physician orders in the facility documented Resident #47's code status was for Full Code (to attempt cardiopulmonary resuscitation in the event their heart or breathing stopped).</p> <p>Review of the Resident #47's Baseline Care Plan, dated [DATE] included the resident advanced directives were for Full Code. Resident #47's Comprehensive Care Plan and care plan used by the Certified Nursing Assistants found in the resident's room did not include advanced directive status.</p> <p>Review of interdisciplinary progress notes since admission revealed in multiple medical and nursing notes that Resident #47 was alert and oriented and able to make their needs known.</p> <p>During an interview on [DATE] at 4:04 PM Resident #47 stated their wishes were as outlined in their Living Will and to not be resuscitated or intubated. Resident #47 stated they had (previously) completed paperwork outlining their wishes and had not changed their wishes.</p> <p>In a nursing progress note dated [DATE] (soon after admission) the Licensed Practical Nurse documented that Resident #47 was admitted with hypoxia (low oxygen in the blood) and was a DNR (Do Not Resuscitate in the event of cardiac or respiratory arrest).</p> <p>Review of the facility's Electronic Medical Record revealed a hospital progress note from a previous hospital stay (Palliative Care) dated [DATE] and written by Physician Assistant #2 that included Resident #47's, identified as having full capacity, wishes were reviewed and included Do Not Resuscitate and a Medical Orders for Life Sustaining Treatment (MOLST) form was filled out at the time with the resident's consent.</p> <p>During an interview on [DATE] at 3:04 PM with Social Worker #1 and Social Worker #2, Social Worker #1 stated advanced directives were reviewed by social work at the time of admission and discussed with the resident. Social Worker #1 stated they normally did not review Living Wills with the resident, but they kept them on file in the electronic medical record.</p> <p>During an interview on [DATE] at 1:03 PM Social Worker #1 stated they were not aware that Resident #47 had filled out a Medical Order for Life Sustaining Treatment prior to admission and was admitted as a Full Code from the hospital and did not have a Medical Orders for Life Sustaining Treatment with them when they were admitted .</p> <p>During an interview on [DATE] at 1:18 PM Physician Assistant #1 stated they review advanced directives as part of the admission process and discuss with the resident their wishes. Physician Assistant #1 stated they were not aware that Resident #47 had a Medical Orders for Life Sustaining Treatment and they must have missed it.</p> <p>During an interview on [DATE] at 9:14 AM the Director of Nursing stated advanced directives should be reviewed at the time of admission and discussed with the resident. The Director of Nursing stated that Resident #47 had stated that they wanted their Living Will followed.</p> <p>In an interdisciplinary progress note dated [DATE] at 6:03 PM (after surveyor intervention) Social Worker #1 documented that they spoke with Resident #47 regarding advanced directives and Resident #47 stated they wanted their Living Will followed, did not want cardiopulmonary resuscitation [CPR] and did not want a breathing tube or ventilator in the event of cardiac or respiratory arrest.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>46526</p> <p>Based on observations, interviews, and record review conducted during a Recertification Survey, the facility did not ensure that the resident received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices for one (Resident #22) of one resident reviewed for edema (swelling caused by excess fluid in body tissues). Specifically, the facility did not ensure that the recommendations provided by the physician consult for vascular services for a lymphedema compression pump were consistently administered per the recommendation and no documented evidence as to why not. This was evidenced by the following.</p> <p>1. Resident #22 had diagnoses including diabetes, high blood pressure, and lymphedema (an excess tissue fluid in the extremities results in swelling) of the left leg. The Minimum Data Set Resident Assessment, dated 3/14/24, revealed that Resident #22 was cognitively intact for decision making, and required the application of nonsurgical dressings and ointments/medications.</p> <p>Resident #22's current Comprehensive Care Plan and/or current Care Card (care plan used by the Certified Nursing Assistants for daily care) documented that Resident #22 had lymphedema of the left leg. Interventions included to assess their skin for color, turgor (swelling or distention), perfusion (how well blood circulates in specific part of the body), and edema and the use of tubigrips (a tubular bandage to treat swelling) on the left leg. Neither care plan included the use of any type of vascular pump.</p> <p>Review of Resident #22's Physician orders for prior six months to present did not include any orders for treatments using a lymphedema pump.</p> <p>In a vascular surgical visit progress note, dated 4/17/23, Physician #1 recommended that Resident #22 needed a Flexitouch system pneumatic compression device (a medical pump that uses air pressure to apply intermittent compression to a specific area of the body) for their left leg severe lymphedema.</p> <p>In a vascular surgical visit progress note dated 5/30/24, Physician #1 documented that Resident #22 had not received the lymphedema pump yet but had tried to elevate their leg as much as possible. Physician #1 documented that Resident #22 needed the compression pump as soon as possible to prevent skin ulcers and encouraged Resident #22 to contact the vendor.</p> <p>In a medical progress note dated 6/29/23 Nurse Practitioner #1 documented the vendor trainer for the lymphedema pump was contacted for staff education, and once the education for staff was obtained, an order for the pump would be placed in Resident #22's chart.</p> <p>In a medical progress note, dated 7/3/23, Nurse Practitioner #2 documented that the lymphedema pump was at Resident #22's bedside but staff needed training prior to using the pump and the facility was waiting for the vendor trainer to come to the facility to provide the training.</p> <p>In a medical progress note dated 7/10/23 Nurse Practitioner # 3 documented that an appointment was to be arranged the next day with the lymphedema pump vendor trainer to come to the facility and provide staff training for Resident #22's pump.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In a medical progress note dated 8/10/23 Nurse Practitioner #1 documented that Resident #22 was pleased with the lymphedema pump, was tolerating it well and using daily as prescribed by the vascular surgeon.</p> <p>In a medical progress note dated 8/24/24 Nurse Practitioner #4 documented that per nursing report the pump was on hold due to it causing Resident #22 discomfort and the vendor had been contacted for pump reassessment and fitting, with a plan to continue the lymphedema pump when reassessed.</p> <p>Review of the Patient Training Checklist dated 8/30/24 and signed by the vendor trainer and Resident #22, revealed that the trainer had reassessed and reviewed the treatment plan, pump settings, pump function, conducted and completed a pump therapy session and Resident #22 demonstrated ability to operate the pump and garments with assistance from a Caretaker. The Checklist did not include who the Caretaker was.</p> <p>In a medical progress note dated 9/25/23 Nurse Practitioner #2 documented that Resident #22 continued lymphedema pump therapy.</p> <p>During an interview on 4/24/24 at 12:08 PM, Resident #22 stated that it took one to two people to assist in order to use the pump and that there was never enough staff to use it. Resident #22 said that the last time they had used the pump was about month ago for three days with a nurse who had been taught.</p> <p>Review of the Treatment Administration Records 2/1/24 to 4/18/24 did not include any treatments with the lymphedema pump.</p> <p>During an interview on 4/25/24 at 1:17 PM, Registered Nurse Manager #1 stated the facility's Resource Nurse was overseeing the use of Resident #22's lymphedema pump. Registered Nurse Manager #1 said that the medical team was aware of the use of the lymphedema pump but could not find any orders for the pump.</p> <p>During an interview on 4/25/24 at 1:34 PM, Nurse Practitioner # 1 said they have seen the lymphedema pump in Resident #22's room but there were no orders to use it and there should be.</p> <p>During an interview on 4/26/24 at 11:29 AM, Licensed Practical Nurse # 1 stated they did not get training for Resident #22's lymphedema pump but had assisted the resident with the pump. Licensed Practical Nurse # 1 stated they were not sure of the frequency for the treatment but thought it may be daily. Licensed Practical Nurse # 1 stated they could not recall when the pump had last been used.</p> <p>During an interview on 4/26/24 at 11:44 AM Registered Nurse #1 (Clinical Leader/Resource Nurse) stated that if a treatment is required, the Physician would put the order in (the electronic medical record) but they did not think there was an order for Resident #22's lymphedema pump. Registered Nurse #1 (Clinical Leader/Resource Nurse) said that if a treatment was completed or if it was refused it should be documented. Registered Nurse #1 (Clinical Leader/Resource Nurse) stated only themselves and an evening nurse had been trained on the pump and that sometimes the resident would refuse due to it being left on too long, so they stopped using it. Registered Nurse #1 (Clinical Leader/Resource Nurse) stated the pump had not been discontinued that they were aware of.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/26/24 at 3:03pm, the Director of Nursing said that use of a device would require staff education and a Physician order and if the treatment was refused it should be documented and communicated to the Physician. The Director of Nursing said use of the pump would require policy and education. The Director of Nursing said there were no orders or nursing notes regarding the lymphedema pump and there should have been.</p> <p>10 CFRR 415.12</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>39181</p> <p>Based on observations, interviews and record review conducted during the Recertification Survey, for one (Resident #40) of two residents reviewed for pressure ulcers, the facility did not ensure a resident received the necessary treatment and services consistent with professional standards of practice to promote healing and prevent new ulcers from developing. Specifically, Resident #40 was found to have an open area to their right ankle on 12/20/23. The facility was unable to provide documented evidence that the wound was consistently monitored and treated to promote healing and/or prevent worsening. This is evidenced by the following:</p> <p>Review of the facility policy and procedure Skin Inspection and Care, dated November 2019, revealed that the nurse would inspect skin integrity weekly and document the inspection on the Integumentary (an organ system that includes the skin) Flow Sheet. The Licensed Practical Nurse would notify the Registered Nurse of any changes to the resident's skin. During daily care, skin observations would be done by the primary caregiver (i.e., Certified Nursing Assistant). Any skin conditions found would be reported to the nurse. The nurse will inspect the area of concern, document, and plan interventions as appropriate. The Medical Provider would be notified of any change in skin condition requiring interventions. The Clinical Leader or Nurse Manager would be responsible for monitoring the resident's response to treatment or interventions and adjust the plan of care if necessary.</p> <p>Resident #40 had diagnoses including an unstageable (full thickness tissue loss where depth is unable to be measured due nonviable tissue in the wound bed) pressure ulcer of the right ankle, osteoarthritis (a breakdown of tissue within the joint that can cause pain and stiffness) of the right hip, reduced mobility, and Alzheimer's disease. The Minimum Data Set Resident Assessment, dated 1/7/24, revealed the resident had severely impaired cognition, was dependent on staff for bathing and repositioning, had no pressure ulcers or other skin conditions, and was not receiving any skin treatments to their feet.</p> <p>Review of the resident's current Comprehensive Care Plan revealed Resident #40 had unstageable pressure ulcers to their right outer foot and ankle. Interventions included, but were not limited to, turn and position every two hours, measure the ulcer weekly and document, treat the wounds per medical order, and to wear protective boots as tolerated.</p> <p>In a nursing progress note dated 12/20/23 Registered Nurse Manager #1 documented that Resident #40 had an abrasion/shearing to their right ankle, measuring 1.0 centimeters by 1.5 centimeters. The area was cleansed, and a foam dressing was applied.</p> <p>In a medical progress note dated 12/21/23 at 1:33 PM Physician Assistant #1 documented Resident #40 was seen for a small, round superficial open area to their right ankle, likely caused by shearing, with a small amount of drainage. The plan was to treat the area with a foam dressing every other day for 3 occurrences and to apply protective boots.</p> <p>In a nursing progress note dated 12/26/23 Licensed Practical Nurse #3, documented that Resident #40's skin was intact except for a healing wound on their right ankle.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Treatment Administration Record-Nursing Tasks from 12/20/23 to 3/13/24 included a dressing change (the location of the dressing change was not included in the task) scheduled twice daily was completed on 12/21/23, 12/23/23 and 12/25/23. There were no additional dressing changes documented on the Treatment Administration Record until 3/13/24.</p> <p>In a nursing progress note dated 1/25/24 Registered Nurse #1(Clinical Leader/Resource Nurse) documented the shearing to Resident #40's right ankle was healing. The area was cleansed, and a foam dressing applied.</p> <p>Review of the electronic health record for Resident #40 revealed no documentation related to any skin or wound assessment, monitoring or treatments to Resident #40's right ankle from 1/25/24 to 3/13/24.</p> <p>In a nursing progress note dated 3/13/24 Registered Nurse #1(Clinical Leader/Resource Nurse) documented while doing rounds on Resident #40, a dressing was removed from the right ankle exposing an unstageable wound containing slough (dead tissue) and a small amount of drainage that measured 2.5 centimeters by 2.3 centimeters. The wound was cleansed, and the wound bed covered with Aquacel Ag (a treatment used to promote wound healing commonly used for infected wounds) and a foam dressing.</p> <p>In a medical progress note dated 3/13/24 Nurse Practitioner #3 documented they were asked to see Resident #40 for a wound to their right ankle. Nursing reported that a foam dressing was covering a wound on the outer right ankle which had previously been dark in color, but was now open and draining with slough, drainage, and redness to the skin surrounding the wound, and possible bone exposure. The wound was tender to touch as evidenced by the resident whimpering during the exam. Additionally, there was an area of dried eschar (dead tissue) to the underside of the right foot.</p> <p>Physician orders dated 3/13/24 included to cleanse the right outer ankle with saline, pat dry, apply non-sting skin prep to the surrounding skin, place Aquacel Ag to the wound bed and cover with a foam dressing. Change every other day and as needed until healed.</p> <p>During a wound care observation on 4/26/24 at 10:53 AM, Resident #40's continued to have a right outer ankle wound that appeared to be healing with pink granulation (new, healthy tissue) in the wound bed. There were three additional unstageable wounds on the right foot.</p> <p>During an interview on 4/26/24 at 9:49 AM, Registered Nurse Manager #1 stated they noticed an abrasion to Resident #40's right ankle on 12/20/23 and notified the medical provider who examined the resident on 12/21/23 and ordered a foam dressing for three days. Registered Nurse Manager #1 stated they reported the skin condition to Registered Nurse #1(Clinical Leader/Resource Nurse) and informed them that the wound was something that needed to be monitored. Registered Nurse Manager #1 said that Registered Nurse #1(Clinical Leader/Resource Nurse) wrote progress notes on 1/25/24 and 3/13/24 and told them they were monitoring the wound but that there was no additional documentation in the electronic health record and no treatment orders from 1/25/24 until 3/13/24.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/26/24 at 11:11 AM, Registered Nurse #1(Clinical Leader/Resource Nurse) stated they were not made aware of Resident #40's area of shearing to their right ankle until they returned to work in early January 2024 and that they did monitor the wound weekly. They said they reported changes in the wound to a Nurse Practitioner and discussed the treatment plan on or around 1/25/24 but had not followed up with the Nurse Practitioner to ensure that medical orders were written. Registered Nurse #1(Clinical Leader/Resource Nurse) stated they performed the dressing changes without an order in place and did not document the wound condition following weekly checks which was an oversight.</p> <p>During an interview on 4/26/24 at 3:49 PM, Nurse Practitioner #1 stated the medical team was made aware of the open wound to Resident #40's right ankle on 3/13/24. If a wound did not appear to be healing, they would expect the nurse to notify the medical team to examine the wound and determine if new treatment orders were needed. Nurse Practitioner #1 stated that if a wound was being monitored, the wound's progress should be documented in the resident's medical record.</p> <p>During an interview on 4/29/24 at 9:58 AM, the Director of Nursing stated they would expect that all care staff were monitoring residents for new skin conditions at least weekly. The Director of Nursing said that Certified Nursing Assistants had the responsibility of monitoring resident's skin daily during care and report any new skin issues to the nurse and that the nurses were responsible for performing weekly skin checks. Once a new skin condition was identified, it should be placed on the weekly skin log and monitored by the Registered Nurse on weekly wound rounds and that all skin and wound monitoring should be documented in the electronic health record.</p> <p>10 NYCRR 415.12(c)(1)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>39181</p> <p>Based on observations, interviews, and record review conducted during a Recertification Survey, it was determined that for four of four resident cottages the facility did not store, prepare, distribute, and serve food in accordance with professional standards for food service safety. Specifically, potentially hazardous foods (raw shell eggs) were not being fully cooked. The findings are:</p> <p>Review of the facility policy titled 'Production Recipe Egg Bkfst' last revised 4/23/2024 included the following: Fresh Egg, cook to a minimum internal temperature of 145 F (71 degrees C) for 15 seconds. The policy also included that if shell eggs are used, follow instructions according to state safe handling specifications. Use of pasteurized eggs is recommended unless egg is served directly from grill to plate. A second policy titled 'Egg Fried bkfst (fresh)' included: Cook over low heat, turning once during cooking, until yolks are set and whites are firm. Cook to a minimum internal temperature of 145 F (63 C) for 15 seconds.</p> <p>Observations on 4/22/24 at 1:24 PM included two flats of unpasteurized raw shell eggs in the refrigerator in the kitchen of Cottage 100. In an interview at this time the Therapy Assistant/Certified Nursing Aide stated they cooked eggs to order, including, over-easy eggs regularly.</p> <p>In an interview on 4/22/24 at 1:42 PM the Food Service Manager, stated that they thought if raw shell eggs were fresh they could cook them to order, and also confirmed that the eggs were not pasteurized.</p> <p>Observations on 4/22/24 from 2:00 PM to 3:15 PM included raw shell eggs in the kitchen refrigerators of Cottage 200, Cottage 300, and Cottage 400.</p> <p>An interview on 4/23/24 at 9:40 AM the Therapy Assistant/Certified Nursing Aide stated that they did not take the temperature of over-easy or poached eggs, and there were at least two residents that always ordered over-easy eggs.</p> <p>In an interview on 4/24/24 at 12:25 PM Shahbaz/Certified Nursing Aide #1 stated that they had a lady that got over-easy eggs and thought there was at least one person on the other side of the kitchen that got over-easy eggs regularly.</p> <p>10NYCRR: 415.14(h);</p> <p>10NYCRR: Subpart 14-1.31(c), 14-1.82(d)</p> <p>CMS Ref: S&amp;C 14-34-NH</p>		

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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)		
<p>F 0842</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45200</p> <p>Based on interviews and record review conducted during the Recertification Survey, the facility did not maintain medical records on each resident that were readily accessible. Specifically, the facility did not provide the survey team with timely access to all resident electronic health records that included all medical record information and instructions on how to access and use the electronic records by the end of the first day of survey. This is evidenced by the following:</p> <p>During the Entrance Conference meeting on [DATE] at 9:31 AM with the Operations Manager and the Director of Nursing, the following items were requested by the end of the first day of survey:</p> <ol style="list-style-type: none"> <li>1.To provide each surveyor with access to all resident electronic health records</li> <li>2.To not exclude any information that should be a part of the resident's medical record, and</li> <li>3.To complete the Electronic Health Record Information form that gives specific instructions on how to access information in the electronic health record.</li> </ol> <p>During an interview on [DATE] at approximately 11:45 AM, the Operations Manager was informed that the survey team was unable to access Answers on Demand (a part of the electronic health record system that held the Minimum Data Set Resident Assessments and Pre-Admission Screen Resident Review information) and Care Tracker (a part of the electronic health record system where direct care staff documented resident care information) which was necessary to complete the Initial Pool portion of the survey process. At that time, the Operations Manager informed the survey team that their passwords had expired after 24 hours. All surveyors were not granted full access to all portions of the electronic medical record until [DATE] (two days after the start of the survey) due to security issues.</p> <p>During an interview on [DATE] (five days after the start of the survey) at approximately 9:00 AM after failure of the surveyors to access resident's Treatment Administration Records in the electronic health record, the Director of Nursing stated they were unable to locate the Treatment Administration Record using the surveyors' access. The Director of Nursing and Registered Nurse Manager #2 stated that the survey team did not have access to the Treatment Administration Record portion of the resident's health record.</p> <p>During an interview on [DATE] at approximately 9:15 AM the Director of Nursing informed the Survey Team Leader that per the [NAME] President of Long Term Care Operations, the addition of the Treatment Administration Record to the survey team access profile could not be accomplished during this survey but could be corrected moving forward.</p> <p>On [DATE] at 9:17 AM printed copies of Resident #22's and Resident #40's Treatment Administration Records for approximately the past one to four months were requested. The requested documentation was not received until approximately four and a half hours later and included a 131-page document for Resident #40 and a 98-page document for Resident #22.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>During an interview on [DATE] at 8:44 AM, the Director of Nursing stated the facility did not have the ability to run reports in the current electronic health record and therefore each date had to be printed separately to accommodate the Treatment Administration Record request. The Director of Nursing stated that it was understood that the survey team needed to have access to the entire resident medical record, and it was something that needed to be done at a higher level within the Information Technology department.</p> <p>During an interview on [DATE] at 8:48 AM with the Operations Manager, the Director of Nursing, the Assistant Director of Nursing, the Infection Preventionist, the [NAME] President and Chief Nursing Officer of Long Term Care, and the [NAME] President of Long Term Care Operations, the facility reported that the Information Technology Department would be working on updating the surveyor access profile and providing step-by-step instructions to make resident's medical records readily accessible moving forward.</p> <p>10 NYCRR 415.22(a),(d+[DATE])</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46526</p> <p>Based on observation, interviews and record review conducted during the Recertification Survey the facility did not ensure they established and maintained an Infection Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p> <p>Specifically:</p> <p>Issue #1: The facility was unable to provide documented evidence of the current status for three (Residents #62, #88 and #352) of five residents reviewed for vaccinations (influenza and/or pneumococcal) or that education was consistently provided on the risks/benefits of vaccinations.</p> <p>Issue #2: The facility did not ensure appropriate signage or mask use on one (transitional care unit) of five residential care units due to a current positive covid-19 infection.</p> <p>Issue #3: The facility was unable to provide documented evidence of staff vaccination status and/or eligibility for 4 of 10 staff reviewed for influenza vaccine and 10 of 10 staff reviewed for pneumococcal vaccine, including provision of education of risks/benefits and declinations.</p> <p>The findings include but not limited to the following:</p> <p>Issue #1:</p> <p>The policy Influenza and Pneumococcal Immunization dated December 2021 documented all inpatients aged 18 and older will be screened to determine eligibility for influenza and/or pneumococcal vaccination. The admitting nurse is responsible for initiation of the influenza/pneumococcal assessment and immunization records and for reviewing the immunization history in the electronic medical record. If the patient or family member does not remember dates of vaccination, the Primary Care Physician office should be called to obtain the information. If the Primary Care Physician office does not have record of either injection, the nurse can offer vaccine and documentation of the efforts made to obtain the data should be made.</p> <p>Resident #352 was admitted to the facility approximately several weeks prior and had diagnoses that included hypertension, atrial fibrillation (irregular heart rate), and a left hip fracture. The Minimum Data Set Resident assessment dated [DATE] included Resident #352 was cognitively intact.</p> <p>Review of Resident #352's electronic medical record revealed no documented evidence that the resident had been vaccinated, had been offered, had been educated regarding vaccines, or had declined the covid booster, influenza and/or pneumococcal vaccinations.</p> <p>Resident #62 was admitted to the facility approximately four months ago and had diagnoses that included dementia, and osteoarthritis. The Minimum Data Set Resident assessment dated [DATE] included the resident had severe cognitive impairment.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #62's electronic medical record revealed no documented evidence that the resident had been vaccinated, had been offered, had been educated regarding vaccines, or had declined the influenza vaccine for this year's flu season. Review of the vaccination flow sheet provided by the Infection Preventionist revealed Resident #62's influenza vaccine was last administered on 10/23/18.</p> <p>Resident #88 was admitted to the facility approximately eight months ago and had diagnoses that included Alzheimer's dementia with psychotic disturbance, a stroke, and frequent falls. The Minimum Data Set Resident assessment dated [DATE] included the resident had moderate cognitive impairment.</p> <p>Review of Resident #88's electronic medical record revealed no documented evidence that the resident had been vaccinated, had been offered, had been educated or had declined the pneumococcal vaccine.</p> <p>Review of the facility provided influenza and pneumococcal vaccination spreadsheet revealed for 23 of 116 residents, the facility had no information related to the resident's influenza status, education of or declination of for this year's flu season. For 19 of 116 residents, the facility could not provide documentation of the residents' eligibility, current status, education of, or declination for the pneumococcal vaccine.</p> <p>In an interview with Assistant Director of Nursing and the Infection Preventionist on 4/25/24 at 11:02 AM the Infection Preventionist stated that upon admission to the facility they would try to obtain vaccination dates through the electronic medical record (included hospital documentation) and the resident's Primary Care Physician and request documentation of the resident's immunizations. The Infection Preventionist stated they offered residents vaccinations yearly and were working on getting letters out to families regarding the pneumococcal vaccinations. The Infection Preventionist said that a third-party contractor, that fell under Human Resources, was responsible for all employee screening, provision of vaccinations and tracking.</p> <p>In an interview on 4/25/24 at 1:37 PM Registered Nurse Manager #2 stated the resource/admission nurse is the person currently getting vaccination dates when residents are admitted to the Transitional Care Center usually within a week. Registered Nurse Manager #2 said that Resident #352 slipped through the cracks.</p> <p>In an interview on 4/26/24 at 1:50 PM the Director of Nursing stated that they were aware of issues with resident vaccinations, and that it was the responsibility of the Assistant Director of Nursing (with assist from the Infection Preventionist who is part time) to maintain the Infection Prevention Control Program, monitor the line list and follow up on these concerns (as brought up by the survey team). The Director of Nursing stated there was a breakdown in tracking and monitoring.</p> <p>Issue #2:</p> <p>The facility policy Infection Prevention- Transmission Based Precautions Policy dated February 2024 documented that since the infecting agent often is not known at the time of admission to a healthcare facility, transmission-based precautions are used empirically, until modified pathogen is identified, or etiology is ruled out.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During entrance conference on 4/22/24 at 9:31 AM with the Assistant Administrator and the Director of Nursing, the Director of Nursing stated that masking was required for all staff on covid-19 units. Immediately following the entrance conference, the Assistant Director of Nursing confirmed there was one resident in their transitional care center that had been positive for covid-19 but was recently discharged and there were no other residents currently in the facility positive with covid-19.</p> <p>Observations conducted during the survey process from 4/22/24 through 4/25/24 revealed that Resident #60 had signage located outside their room that indicated they were on transmission-based precautions and that Personal Protective Equipment was required with N95 (specialized respiratory masks used to prevent respiratory infections) or surgical mask, gloves, gowns, and goggles. There was no signage on the unit entrances (from outside or from the hospital) or at the nurse's station informing staff and visitors of masking requirements or of positive covid-19 on the unit.</p> <p>Observations on 4/22/24 through 4/25/24 on the positive covid-19 unit revealed multiple direct care staff and environmental service staff on the covid-19 unit with no mask on or wearing their mask below the nose or below the chin exposing both their mouth and nose.</p> <p>In an interview on 4/25/24 at approximately 1:00 PM a facility staff member stated that they were unaware of when and where to wear a mask as they are never notified regarding positive covid-19 residents on the unit.</p> <p>In an interview with the Assistant Director of Nursing and Infection Preventionist Nurse on 4/25/24 at 1:36 PM the Assistant Director of Nursing stated that wearing mask pulled down under nose, or under chin was not appropriate. Staff education had included appropriate mask wearing.</p> <p>In an interview on 4/25/24 at 1:37 PM Registered Nurse Manager #2 stated signs should be placed at the entrance doors coming into the unit from outside and at the entrance coming from the hospital. Registered Nurse Manager #2 stated there was a small sign on the table next to the sign in book. Registered Nurse Manager #2 stated that Resident #60 was positive for covid-19 and was currently on a 10-day quarantine.</p> <p>In an interview on 4/26/24 at 1:50 PM the Director of Nursing stated they were aware that there was mask fatigue and that it has been a constant battle to enforce.</p> <p>Issue #3:</p> <p>The facility policy Flu Vaccinations dated 9/7/23, documented all personnel must submit documentation of one of the following by December 15th of each new calendar year, as per instructed in flu campaign communications of influenza vaccine administered by the facility or elsewhere with documentation to support or documentation of declination of influenza vaccine.</p> <p>Review of a random list of 10 employee's influenza and pneumococcal vaccinations for the current flu season revealed 4 of 10 employees were listed as non-applicable for the influenza vaccine with three of them direct care staff and one staff member from environmental services (access to all resident units/rooms) and no evidence that any education of the risks/benefits had been provided. 10 of 10 staff reviewed for pneumococcal vaccination had no documentation related to eligibility, their current status, that they had been offered, or that education had been provided on risks/benefits for the pneumococcal vaccine.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 4/26/24 at 12:37 PM the Director of Nursing stated any follow up with staff not vaccinated is the responsibility of Park Ridge leadership. The Director of Nursing said it was the Assistant Director of Nursing's role to maintain the Infection Prevention Control Program and that they had not been monitoring the line list sheet and did not have a tight grip on the Infection Control Program related to these (the above) concerns.</p> <p>10 NYCRR: 415.19(a)(1-3)</p>		