STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335408	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wedgewood Nursing and Rehabilitation Center	5 Church Street Spencerport, NY 14559

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 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. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observations, interviews and record review conducted during an Abbreviated Survey (Intake ID: 2621922 and 2626565) completed on 12/04/2025, for one (1) (Resident #3) of three (3) residents reviewed, the facility did not ensure each resident is treated with respect and dignity and cared for in a manner and in an environment that promotes maintenance or enhancement of their quality of life. Specifically, Resident #3 was observed in the dining room for several hours with a strong odor of bowel incontinence while in the presence of other residents. Additionally, Resident #3 requested to go to their room and staff yelled at the resident in a loud, demeaning tone and multiple residents were observed in the dining room and hallways wearing hospital gowns. The findings include:The facility policy Quality of Life - Dignity dated August 2009 included each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. Residents shall be treated with respect and dignity at all times and shall be encouraged and assisted to dress in their own clothes rather than in hospital gowns.Resident #3 had diagnoses including altered mental status, muscle weakness and cerebral infarction (stroke). The Minimum Data Set (a resident assessment tool) dated 08/27/2025 documented the resident had mild cognitive impairment, did not reject care, was always incontinent of bowel and urine, and required extensive assistance from staff with transfers, toileting hygiene, showering/bathing, and dressing. The Comprehensive Care Plan revised on 09/12/2025 included Resident #3 had an activities of daily living (ADL) self-care deficit, limited physical mobility, and bowel and bladder incontinence. Interventions included but were not limited to: extensive assistance of one (1) staff for dressing and toilet use; total dependence on one (1) staff for wheelchair mobility; extensive assistance of one (1) staff for transfers; the resident used disposable briefs and should be changed every two (2) to four (4) hours and as needed. The current Kardex (care plan used by certified nursing assistance to direct care), reviewed on 11/04/2025, included Resident #3 used disposable briefs and should be changed every two (2) to four (4) hours and as needed.During an observation on 11/03/2025 at 9:19 AM, there were two (2) residents seated in the hallway wearing hospital gowns. The remaining residents in the facility were in their rooms wearing hospital gowns, except one (1) resident who was dressed in clothing.During an observation on 11/04/2025 at 9:07 AM, there were seven (7) residents in the dining room, Resident #3 and three (3) other residents were wearing hospital gowns.During an observation on 11/04/2025 at 12:20 PM, Resident #3 was seated in the dining room with their lunch meal placed in front of them and they had a strong odor of bowel incontinence. There were other residents also seated at the table with their meals.During an observation on 11/04/2025 at 2:43 PM, Resident #3 remained seated in the dining room, in the same spot as previously observed, and continued with a strong odor of bowel incontinence. Activities staff and two (2) other residents were seated across from Resident #3. At 2:45 PM, the Director of Nursing approached the table and leaned over to speak with Resident #3.During an observation on 11/04/2025 at 3:29 PM, Resident #3 requested to go to their room. Certified Nursing Assistant #1 walked into the threshold of the dining room and yelled out you need to wait for dinner in a loud, demeaning tone and then left the dining room. At 3:30 PM, Resident #3 asked again to go to their room, the activity staff loudly replied, not yet.During an interview on 11/04/2025 at 3:48 PM, Resident #3 stated they did not remember when their last bowel movement was and did not respond when asked if they were incontinent at that time. During an interview on 11/04/2025 at 3:51 PM with the Director of Nursing and Certified Nursing Assistant #1, the Director of Nursing stated they did not notice any odors from Resident #3. The Director of Nursing directed Certified Nursing Assistant #1 to check and change Resident #3 at that time. Review of Bladder and Bowel Elimination Reports (results from certified nursing assistant documentation) revealed Resident #3 was incontinent of urine and bowel on 11/04/2025 at 3:07 AM, 10:27 AM and at 8:47 PM. There was no documented evidence Resident #3 was checked, changed, or received incontinence care at any other time on 11/04/2025. During an observation and interview on 11/04/2025 at 3:59 PM, Certified Nursing Assistant #1 and Certified Nursing Assistant #3 assisted Resident #3 to their room for incontinence care. Resident #3 was found to have a bulging brief with a rolled non-disposable incontinence pad, saturated with bowel and urine, inside the brief. Resident #3's buttocks were reddened. When interviewed at that time, Certified Nursing Assistant #1 stated Resident #3 had bowel all over them and needed to be changed.During an observation on 11/05/2025 at 8:05 AM, there were nine (9) residents in the dining room. Five (5) of the residents were wearing hospital gowns and one (1) resident was wearing pajamas. During an interview on 11/06/2025 at 2:40 PM, Registered Nurse Manager #1 stated Resident #3

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review conducted during an Abbreviated Survey (Intake ID: 2656534, 2667467, and NY00382089/820392) completed on 12/04/2025, for one (1) of one (1) residential unit, the facility did not provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, comfortable, and homelike environment. Specifically, there were heavy urine and bowel odors upon entering the facility and, in the hallways, floors were dirty and/or in disrepair, walls had missing paint, a hand soap dispenser was broken, two (2) apex (a device used to assist residents with standing) machines were dirty and had duct tape on the frames, and the dumbwaiter (a small freight elevator used for moving items, such as laundry and food) was dirty. Additionally, the shower room was in disrepair and bathing fixtures were not available for resident use at a ratio of 1 per 20 residents. The findings are:The facility policy Use of Dumbwaiter for Soiled Laundry and Food Transport dated 04/14/2023 documented the dumbwaiter may be used to transport soiled laundry and food items under strict separation and sanitation protocols. The transport of soiled laundry must always be followed by proper containment, cleaning, and disinfection procedures before the dumbwaiter is used for food or any clean items. Each disinfection would be recorded in the dumbwaiter cleaning log, noting the date, time, and staff initials. 1. Observations on 11/03/2025 at 9:19 AM, included a heavy smell of urine and bowel upon entering the facility and the odors lingered in the hallways. Several resident room floors had different shades of dark debris. The hallway walls were painted bright blue color with many rectangular and square areas that were beige in color. During an observation and interview on 11/05/2025 at 12:26 PM, Certified Nursing Assistant #4 took a meal cart out of the dumbwaiter, the inside of the dumbwaiter had chipped paint and the back wall behind the metal bar was unclean and had debris of various colors. There was a cleaning schedule hanging on the wall outside of the dumbwaiter with only one cleaning date, 11/05/2025, documented. When interviewed at that time, Certified Nursing Assistant #4 stated the dumbwaiter was used for both dirty laundry and meal carts and they personally had never cleaned the dumbwaiter and had never seen anyone else clean it. Certified Nursing Assistant #4 stated the posted cleaning schedule had not previously been hanging there. Observations on 11/05/2025 at 1:30 PM, included soap dispensers for residential rooms #10 and #12 had soap in the dispenser but the dispenser did not function. Floor tiles in residential room [ROOM NUMBER] had several varying colors of dark, thick debris all over the floor. The hallway walls had chipped paint, and between residential rooms #12 and #14 there was an approximately two (2)-inch sharp nail partially sticking out of the wall about eight (8) inches above the handrail. The hallway walls were painted bright blue, with several areas where dispensers had been removed from the walls, and several random beige colored rectangular and square areas.Observations on 11/06/2025 at 1:08 PM, included an apex machine setting outside of residential room [ROOM NUMBER]. Both apex handles were covered with dirty duct tape with a long strip of the tape partially off one of the handles. There was debris on the base of the apex and dust on the top of both wheel coverings.During an interview on 11/06/2025 at 12:36 PM, the Director of Environmental Services stated they had received complaints that floors still looked dirty after cleaning and despite cleaning floor tiles on their hands and knees, some had old wax that trapped dirt and debris, and many needed to be replaced. The Director of Environmental Services stated there was at times a urine odor when they entered the facility, but it was typically gone by mid-morning. They stated the dumbwaiter should be cleaned each time the dirty laundry was removed, and the posted cleaning schedule was new and first placed outside the dumbwaiter on 11/05/2025. The Director of Environmental Services stated apex machines are supposed to be cleaned by nursing staff after each use and are cleaned by maintenance staff monthly. They stated the nail in the wall was a safety hazard and would be removed.During an observation and interview on 11/06/2025 at 2:22 PM, the Infection Preventionist stated both apex machines in the facility were dirty, and any equipment repaired with duct tape was difficult to clean and ensure removal of any potential organisms. During an interview on 11/06/2025 at 3:04 PM, the Director of Nursing stated the two (2) apex machines were dirty and needed a good cleaning. They stated apex machines should be cleaned after each use and duct tape should not be used as it acts like a reservoir for germs. The Director of Nursing stated missing paint, and patchwork did not make the facility a homelike environment.2. Review of a notification letter sent to residents, families and resident representatives dated 11/12/2205, revealed the primary shower room was currently undergoing renovation to improve the comfort and safety of residents. The shower room would be unavailable for

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observations, interviews and record review conducted during an Abbreviated Survey (Intake ID: 2621922, 2656534, NY00382613/820391, and NY00384361/820393) completed on 12/04/2025, for one (1) (Resident #3) of nine (9) residents reviewed, the facility did not ensure residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Specifically, Resident #3 was not checked or changed for extended periods, was observed in the dining room with a strong bowel odor for several hours and was later found with a saturated brief and non-disposable incontinence pad inside the brief, with redness noted to the buttocks. Furthermore, the facility did not revise Resident #3's care plan to address their chronic loose stools and increasing incontinence care needs, and staff documentation did not reflect care consistent with the resident's needs or the facility's required frequency of incontinence care.The findings include:The undated facility policy Activities of Daily Living (ADL), Supporting included appropriate care and services would be provided for residents who were unable to carry out activities of daily living independently including care with hygiene and toileting. Resident #3 had diagnoses including altered mental status, muscle weakness, and malignant neoplasm of colon (cancer of the large intestine). The Minimum Data Set (a resident assessment tool) dated 08/27/2025 documented the resident had mild cognitive impairment, was always incontinent of bowel and urine, and required extensive assistance from staff with transfers, toileting hygiene, showering/bathing, and dressing. The Comprehensive Care Plan revised on 09/12/2025 included Resident #3 had an activities of daily living (ADL) self-care deficit and bowel and bladder incontinence. Interventions included but were not limited to: extensive assistance of one (1) staff for toilet use, the resident used disposable briefs and should be changed every two (2) to four (4) hours and as needed.Review of Bladder and Bowel Elimination Reports (results from certified nursing assistant documentation) revealed Resident #3 was incontinent of urine and bowel on 11/04/2025 at 3:07 AM, 10:27 AM and at 8:47 PM. There was no documented evidence Resident #3 was checked, changed, or received incontinence care at any other time on 11/04/2025. Review of Toileting Hygiene Reports (certified nursing assistant documentation related to the level of assistance provided during incontinence care) from 10/01/2025 to 11/05/2025 revealed Resident #3 had documented assistance with incontinence episodes no more than four (4) times daily. There was no documented evidence incontinence care was provided on 11/03/2025 and documented evidence incontinence care was provided one (1) time daily on four (4) days, two (2) times daily on 17 days, and three (3) times daily on 12 days.During an observation on 11/04/2025 at 12:20 PM, Resident #3 was seated in the dining room with their lunch meal placed in front of them and they had a strong odor of bowel incontinence. There were other residents also seated at the table with their meals. During an interview on 11/04/2025 at 3:48 PM, Resident #3 stated they did not remember when their last bowel movement was and did not respond when asked if they were incontinent at that time. During an interview on 11/04/2025 at 3:51 PM with the Director of Nursing and Certified Nursing Assistant #1, the Director of Nursing stated they did not notice any odors from Resident #3. The Director of Nursing directed Certified Nursing Assistant #1 to check and change Resident #3 at that time. During an observation and interview on 11/04/2025 at 3:59 PM, Certified Nursing Assistant #1 and Certified Nursing Assistant #3 assisted Resident #3 to their room for incontinence care. Resident #3 was found to have a bulging brief with a rolled non-disposable incontinence pad, saturated with bowel and urine, inside the brief. Resident #3's buttocks were reddened. When interviewed at that time, Certified Nursing Assistant #1 stated Resident #3 had bowel all over them and needed to be changed. Certified Nursing Assistant #1 stated they did not know how the incontinence pad got inside of Resident #3's brief but it should not have been there. During an interview on 11/05/2025 at 7:03 AM, Certified Nursing Assistant #2 stated Resident #3 was consistently incontinent of bowel and required frequent incontinence care. Certified Nursing Assistant #3 stated staff had tried using two (2) briefs, larger sized briefs, and disposable incontinence pads, but nothing seemed to manage Resident #3's incontinence. Certified Nursing Assistant #3 stated all nursing staff were aware of Resident #3's frequent incontinence needs, but they were not aware of any interdisciplinary discussions about alternative interventions for the resident. There was no documented evidence in the care plan, progress notes, or interdisciplinary notes that alternative interventions were developed or implemented to address Resident #3's frequent loose stools and episodes of incontinence. During an interview on 11/06/2025 at 3:04 PM, the Director of Nursing stated Resident #3 had a history of chronic loose bowels and the resident should not have had a non-disposable incontinence pad

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review conducted during an Abbreviated Survey (Intake ID: 2626565, NY00382613/820391) completed on 12/04/2025, for two (2) (Residents #3 and #8) of two (2) residents reviewed, the facility did not 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. Specifically, for Resident #3 staff did not perform hand hygiene after assisting with incontinence care and prior to touching multiple surfaces and equipment. For Resident #8, 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) and there was an observation of staff 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 for high-contact care. The findings include:The facility policy Handwashing/Hand Hygiene dated August 2019 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, and after contact with blood or bodily fluids. Hand hygiene is the final step after removing and disposing of personal protective equipment.1. Resident #3 had diagnoses including altered mental status, muscle weakness and cerebral infarction (stroke). The Minimum Data Set (a resident assessment tool) dated 08/27/2025 documented the resident had mild cognitive impairment, did not reject care, was always incontinent of bowel and urine, and required extensive assistance from staff with transfers, toileting hygiene, showering/bathing, and dressing. During an observation and interview on 11/04/2025 at 3:59 PM, Certified Nursing Assistant #1 and Certified Nursing Assistant #3 assisted Resident #3 to their room for incontinence care. Certified Nursing Assistant #1 removed the dirty brief and incontinence pad, cleansed stool and urine off the resident, and did not remove their gloves or wash their hands prior to touching multiple surfaces in the resident's room including, but not limited to, the resident's clothing, the resident's closet, the mechanical standing lift, and the resident's wheelchair. Certified Nursing Assistant #1 then wheeled Resident #3 into the dining room and touched the table, where other residents were seated, with their gloved hands. When interviewed at that time, Certified Nursing Assistant #1 stated Resident #3 had bowel all over them and needed to be changed. Certified Nursing Assistant #1 stated they should have removed their gloves and washed their hands before placing a clean shirt on the resident and touching all of the surfaces. During an interview on 11/05/2025 at 1:52 PM, the Director of Nursing stated staff should wash their hands before and after care and when going from dirty to clean areas. The Director of Nursing stated not performing hand hygiene and proceeding to touch surfaces was cross-contamination and went against infection control guidelines. The facility policy Enhanced Barrier Precautions dated August 2022 included Enhanced Barrier Precautions are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms to residents. Enhanced Barrier Precautions are indicated for residents with wounds and/or indwelling medical devices regardless of multi-drug resistant organisms.2. Resident #8 had diagnoses including left above the knee amputation, muscle weakness, and adult failure to thrive. The Minimum Data Set, dated [DATE] documented the resident had moderate cognitive impairment, the presence of a surgical wound and an unstageable pressure ulcer, and received ulcer/wound care.Review of Resident #8's Comprehensive Care Plan last revised 09/26/2025 included the resident had a wound to their left stump secondary to a recent above knee amputation and an unstageable pressure ulcer to the sacral (tailbone) area. Interventions included, but were not limited to, administer treatments as ordered. The care plan did not included Enhanced Barrier Precautions.During an observation on 11/03/2025 at 9:19 AM, there were no Enhanced Barrier Precautions signs on any resident room doors or Personal Protective Equipment carts in hallways or in close proximity to resident rooms. During an observation and interview on 11/05/2025 at 1:14 PM, Licensed Practical Nurse #1 and Certified Nursing Assistant #4 both put on a pair of gloves only and entered Resident #8's room. Licensed Practical Nurse #1 cleansed the resident's sacral area and applied zinc (a medicated cream) to Resident #8's sacral wound. When interviewed at that time, Licensed Practical Nurse #1 stated the facility did not use Enhanced Barrier Precautions and they would only