STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335423	A. Building B. Wing	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Premier Genesee Center for Nrsg and Rehabilitation	278 Bank Street Batavia, NY 14020

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	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 observation, record review and interviews during survey, the facility failed to ensure that a resident received adequate supervision and assistive devices to prevent accidents/hazards for one (Resident #1) of three residents reviewed for accidents. Specifically, on 05/01/2026, Resident #1 who had documented cognitive impairments, exit seeking and wandering behaviors, exited the facility undetected by staff approximately three hours after their admission to the facility. This resulted in no actual harm that was Immediate Jeopardy and Substandard Quality of Care with the likelihood of serious harm, serious impairment, serious injury or death to Resident #1's health and safety.The findings include: The facility policy and procedure titled Elopement Prevention dated 07/22/2025 documented the facility strives to provide an environment that is free from hazards over which the facility has control and provide supervision and assistance to each resident to prevent avoidable accidents. The facility strives to reduce the risks for elopement while optimizing residents' independence to safely attain or maintain their highest practicable physical, mental and psychosocial well-being. The facility will strive to identify residents at risk for unsafe wandering and exit seeking behavior. Assess the security of potential internal environmental hazards including but not limited to the following: elevators, exit doors, screens, stairwells, windows. Maintain door alarms and wander control systems in proper working order according to manufacturer's recommendation. Some systems track transmitter replacement manually. There are various types of electronic monitoring devices available for use in Long Term Care. The facility will follow the manufacturers' guidelines related to use, batteries, expiration dates, etc. (et cetera), based on the electronic monitoring device used on the facility. Elopement represents a risk to the resident's health and safety and places the resident at risk of heat or cold exposure, dehydration and/or medical complications, drowning, or being struck by a motor vehicle. The undated manufacturers User Manual version 2.5 provided by the facility on 05/21/2026 documented no security system can replace human vigilance. Creating a safe environment requires the combined efforts of nursing, physicians, security, and patients. No level of security can replace an informed and knowledgeable staff. Any electronic or physical security system should be considered as a supplemental deterrent. Tags (small wristwatch-sized devices worn by a resident which will activate the wander alert system) operate by internal battery and contain a visual pulse LED (light emitting diode) when activated. Over the course of normal operation, tags eventually lose battery power, and the tags will need to be replaced. The tag battery is not replaceable. For maximum protection of residents, the manufacturer recommends that tags be tested on a weekly basis. All tags are reusable but must be cleaned and sanitized between applications. To preserve battery life, tags must be turned off during storage or periods of non-use. Resident #1 had diagnoses that included dementia (a pattern of mental decline caused by different diseases or conditions), hypertension (high blood pressure) and osteoarthritis (cartilage that cushions the ends of bones in the joints gradually wears away). The hospital Discharge summary dated [DATE] documented Resident #1 was alert and oriented to self only. Review of video footage dated 05/01/2026 between 4:50 PM and 4:51 PM, provided by the facility on 05/19/2026 at 10:10 AM, revealed Resident #1 was observed (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	to walk to the double glass doors on the unit, look out the glass doors, turn around, and continued to walk on the unit without any facility staff present. The Progress Note signed and dated 05/01/2026 at 3:16 PM by Licensed Practical Nurse #1 (Nursing Supervisor), documented Resident #1 was admitted to the facility on [DATE] around 2:00 PM. The Exit seeking/Elopement/Wandering evaluation, signed and dated 05/01/2026 by Licensed Practical Nurse #2, documented Resident #1 was physically able to move about on their own; was disoriented to place; was exhibiting restlessness or agitation; had verbally expressed the desire to go home, packed belongings to go home or stayed near the exit door; had a history of elopement at home; and was at high risk for elopement. The Progress Note signed and dated 05/01/2026 at 9:26 PM by Licensed Practical Nurse #2 documented Resident #1 was socializing with staff and peers in the common area on the unit, then staff realized at approximately 5:15 PM that the resident was no longer in the area. Extensive search ensued. Supervisor updated and call to all staff made via intercom to join search. Resident had exhibited wandering behavior, made several statements to various staff that I have to get going, and repeatedly asked what time they were being picked up. Gentle reminders that they will be staying at the facility for now and attempts to redirect resident and engage in solo and group activities. They were also given many snacks and drinks. Wander alert device placed on resident's left wrist at 4:30 PM for safety. During an interview on 05/19/2026 at 12:48 PM, Licensed Practical Nurse #1 stated they were working as the nursing supervisor on 05/01/2026 when Licensed Practical Nurse #2 requested a wander alert device for Resident #1. Licensed Practical Nurse #1 removed a wander alert device from the box, saw the red-light blinking, which indicated the device was activated and gave the device to Certified Nurse Aide #1 to take to Licensed Practical Nurse #2 for Resident #1. During a telephone interview on 05/19/2026 at 2:43 PM, Certified Nurse Aide #1 stated they retrieved the wander alert device from the nursing supervisor on 05/01/2026 to take to Licensed Practical Nurse #2. They stated they did not recall any audible alarms or resetting alarms when they entered/exited the elevator nor the unit, but they were unsure if they would specifically remember that secondary to frequently resetting alarms on elevator and entering/exiting units. During a telephone interview on 05/19/2026 at 3:26 PM, Licensed Practical Nurse #2 stated when they received the wander alert device from Certified Nurse Aide #1, the device was flashing red which indicated the device was activated. They placed the device on Resident #1's left wrist and were unaware Resident #1 had exited the unit, as no wander alert device alarms were activated on the unit. During a telephone interview on 05/19/2026 at 3:36 PM, Police Officer #1 stated they responded to the facility on [DATE] at 6:28 PM for a resident that had been missing from the facility for over an hour. They stated a Silver Alert (missing senior) was issued by State Police with several local agencies responding to assist in the search for Resident #1. They stated Resident #1 was located at approximately 10:00 PM by emergency responders approximately 2.3 miles from the facility in an area with no sidewalks, no streetlights, and speed limits of 45-55 miles per hour. During an interview on 05/20/2026 at 8:27 AM, the Assistant Director of Nursing stated the wander alert device tags are kept in the Nursing Supervisors office and all the tags kept in storage are deactivated. Staff have to activate the tag every single time one is removed from the Nursing Supervisor office. Additionally, they stated the tags that are in use are tested weekly per the manufacturers' recommendations, but the tags located in the Nursing Supervisor office are not tested weekly as the tags in storage should not be activated. During an interview on 05/20/2026 at 9:10 AM, the Director of Nursing stated they completed the facility investigation. Licensed Practical Nurse #1 reported the tag was activated when it was removed from storage and Licensed Practical Nurse #2 reported the tag was activated when they placed it on Resident #1's left wrist. They stated tags are supposed to be deactivated prior to placing back in storage and the tags in storage are not included in the weekly checks for functionality. They stated the facility did not maintain any logs of the tags such as activation/deactivation, confirming functionality or confirming tags are in good working order. Additionally, they stated the facility did not have a policy related to the wander alert device system nor the manufacturers user manual. During a telephone interview on (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	05/21/2026 at 9:05 AM, the Medical Director stated when resident exhibits exit-seeking behaviors, they expect staff to initiate a wander alert device and increase supervision. They would expect the facility to have a policy on the wander alert device system. Additionally, there are hazards a resident could experience when they exit a building without staff knowledge such as tripping, falling, and getting lost. During an interview on 05/20/2026 at 9:36 AM, the Administrator stated proper protocol was followed upon admission and a wander alert device was appropriately placed for Resident #1. Additionally, they stated the facility did not have a policy specific to the wander alert device system and expected staff to follow the manufacturers' recommendations on the system usage. During a follow up interview on 05/21/2026 at 11:43 AM, the Administrator stated what we have found when a situation like this happens is that it's a human error and not a systems problem. I don't think any of us were aware there could be activated tags in the nursing office. New York Code Rules and Regulations 415.12(h)(1)(2) The Survey team determined the immediacy was removed on 05/22/2026 at 12:01 PM based on the following corrective actions taken by the facility:- Resident #1 was moved to a non-ground floor unit when returned to the facility.- The facility conducted a full audit of residents with wander alert device system on 05/21/26.- The facility revised the policy Elopement Prevention/Electronic Monitoring Devices.- Implementation of weekly testing of wander alert device with documentation of date of activation, resident name, device serial number, and battery status.- 100% of licensed nursing staff reeducation on proper use and management of the wander alert device system.