STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335467	A. Building B. Wing	05/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crest Manor Living and Rehabilitation Center	6745 Pittsford-Palmyra Road Fairport, NY 14450

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure reported concerns regarding missing personal property were investigated, documented, and addressed in accordance with facility policy for two (2) of six (6) residents reviewed (Resident #9 and Resident #39). Specifically, Resident #9 reported a missing blue fabric zip-up jacket and Resident #39 reported a missing wallet. The facility failed to complete and document investigations, failed to document findings or resolution, and failed to provide documented follow-up regarding the missing items.The findings include:The undated facility policy, Missing/Damaged Property/Suspected Crimes Reporting, included upon receiving notification of missing or damaged property, the reporting individual will notify the Social Worker during the week or designee on weekends, a form will be completed and sent to appropriate disciplines, the facility will investigate the missing property, and Social Work with assistance from nursing will complete the closure report within five (5) days.1.Resident #9 had diagnoses including chronic kidney disease (a condition in which the kidneys do not work properly over time), chronic pain syndrome (persistent pain lasting longer than expected), and diabetes (a disease that affects the body's ability to regulate blood sugar). The Minimum Data Set (a resident assessment tool) dated 03/20/2026 revealed Resident #9 was cognitively intact.Review on 05/11/2026 at 10:41 AM of a facility-provided Missing/Damaged Property Notification Form documented Resident #9 reported a missing blue fabric zip-up jacket without a hood on 03/04/2026. Documentation included searches of the resident's closet, hamper, dresser drawers, roommate's closet and drawers, and household shower rooms. Documentation further included the resident reported giving the jacket to a staff member who worked in laundry and laundry and housekeeping searched unclaimed items. The sections identified as Report Filled Out and Investigated By and Closure Report were blank. The facility was unable to provide documented evidence an investigation was completed, findings were determined, or resolution was communicated to Resident #9.During an interview on 05/08/2026 at 10:39 AM, Resident #9 stated approximately three (3) and one (1) - half months earlier, a dark blue cloth coat was given to a laundry staff member who was no longer employed by the facility. Resident #9 stated the staff member repeatedly said the coat was at the facility but never returned it. Resident #9 stated the missing coat was reported to Social Work and a previous Administrator. Resident #9 stated the facility would not compensate for the coat because proof of purchase could not be provided. Resident #9 stated follow-up was requested approximately one (1) month earlier and the coat was still not in the resident's possession.During an interview on 05/14/2026 at 11:30 AM, the Director of Social Work stated Resident #9 reported receiving the jacket from family, giving it to a laundry staff member, and not receiving it back. The Director of Social Work stated the staff member was no longer employed by the facility and the jacket had not been located. The Director of Social Work stated facility policy requires new items be added to inventory, labeled, and documented. The Director of Social Work reviewed the Missing/Damaged Property Notification Form and stated documentation should have been added regarding the outcome and resolution of the investigation.During an interview on 05/14/2026 at 4:30 PM, the Director of Nursing stated when (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	missing property is reported, a Missing Property Form should be completed and an investigation should begin immediately. The Director of Nursing stated findings of the investigation should be documented on the form and residents should receive follow-up within one (1) week. The Director of Nursing stated if a resident reported giving an item to a staff member and the item did not return, the facility would be responsible for replacement if the report was verified. The Director of Nursing stated there should have been follow-up and the Missing Property Form should have been completed.During an interview on 05/15/2026 at 9:55 AM, the Administrator stated missing property should be documented immediately on the Missing Property Form and investigated. The Administrator stated a response should generally occur within 72 hours and findings should be communicated to the resident and documented. The Administrator stated if a staff member received an item and it later went missing, the facility should replace the item. The Administrator stated the investigation should determine whether the staff member actually received the item and the follow-up should be documented.2.Resident #39 had diagnoses including left above-the-knee amputation (surgical removal of the leg above the knee), hypertension (high blood pressure), and left-sided hemiparesis and hemiplegia (weakness and paralysis affecting one (1) side of the body) following a stroke (damage to the brain caused by interrupted blood flow). The Minimum Data Set, dated [DATE] revealed Resident #39 was cognitively intact.Review of Resident #39's Comprehensive Care Plan dated 01/21/2026 and undated Kardex (care plan used by certified nursing assistants for daily care) documented the resident was observed sliding out of the wheelchair in an effort to pick up a wallet.During an interview on 05/07/2026 at 1:48 PM, Resident #39 stated the wallet had been missing for approximately two (2) months. Resident #39 stated the wallet had been given to a staff member for safekeeping and the staff member later stated it could not be found. Resident #39 stated family was aware the wallet was missing and had spoken with Social Work regarding the concern.During an interview on 05/12/2026 at 1:04 PM, the Director of Social Work stated Resident #39 reported the missing wallet the week prior to survey. The Director of Social Work stated when residents report missing items, an email is sent to determine whether anyone has information regarding the item and a missing item report is completed. The Director of Social Work stated an email was sent on 05/05/2026 regarding the missing wallet. The Director of Social Work stated a missing item report was not completed and there had been no follow-up communication with the resident or family.During an interview on 05/12/2026 at 1:16 PM, Resident #39 stated the wallet had been given to Certified Nursing Assistant #2. Resident #39 stated Certified Nursing Assistant #2 later stated they could not remember where the wallet was placed. Resident #39 stated the concern was reported to the Director of Social Work but there was no follow-up. Resident #39 stated feeling angry and unable to trust anyone at the facility.During an interview on 05/12/2026 at 1:24 PM, the Director of Nursing reviewed the Kardex and confirmed documentation regarding the resident reaching for a wallet was entered on 01/21/2026 by the Quality Assurance Registered Nurse.During an interview on 05/12/2026 at 1:40 PM with the Quality Assurance Registered Nurse and the Director of Nursing, the Quality Assurance Registered Nurse stated the resident's missing wallet had been reported. The Director of Nursing stated even if a resident was confused, facility protocol should be followed and an investigation should be completed once a wallet was reported missing. The Quality Assurance Registered Nurse and Director of Nursing stated family would typically be notified when a resident's belongings were missing, but family had not been contacted regarding Resident #39.During an interview and observation on 05/14/2026 at 12:16 PM, the Director of Nursing stated Certified Nursing Assistant #2 provided a statement documenting discussion of a wallet with the resident but denying possession of the wallet. The Director of Nursing stated sending an email alone would not constitute a complete investigation. The Director of Nursing stated additional follow-up should have occurred with the resident and documentation should have been completed. The Director of Nursing reviewed the electronic health record and confirmed there were no nursing or social work notes documenting family notification regarding the missing wallet.Title 10 New York Codes, Rules and Regulations 415.3(d)(1)(i)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good grooming and personal hygiene for two (2) of six (6) residents reviewed (Residents #15 and #73). Specifically, Resident #73, who required staff assistance with grooming, bathing, dressing, and personal hygiene, was observed on multiple occasions with a significant amount of facial hair, unclean fingernails containing dark debris underneath, broken and jagged fingernails, and stained clothing. Resident #15, who required staff assistance with showering and personal hygiene, was observed on multiple occasions with noticeable facial hair on the chin, long fingernails, and greasy hair.The findings include:The facility policy Increasing Resident Independence, dated 12/19/2022, included direct healthcare providers shall assist, support, and encourage residents to maintain good standards of personal hygiene and grooming, including bathing, hair care, nail care, and assistance with dressing as necessary.The facility policy Resident Rights, dated 12/19/2022, included residents have the right to be treated in a respectful manner that supports dignity in a manner and environment that promotes maintenance or enhancement of quality of life, recognizes individuality, and contributes to a positive self-image.1.Resident #73 had diagnoses including heart failure, stage three (3) chronic kidney disease (a long-term condition in which the kidneys do not function properly), and hepatic encephalopathy (a decline in brain function caused by severe liver disease or liver failure). The Minimum Data Set (a resident assessment tool), dated 12/23/2025, documented Resident #73 had severely impaired cognition, required staff assistance with personal hygiene and dressing, and did not exhibit behaviors or rejection of care.Review of Resident #73's Comprehensive Care Plan, dated 10/13/2025, revealed Resident #73 had a functional mobility and activity of daily living deficit related to hepatic encephalopathy and staff were to provide extensive assistance with grooming and total assistance with bathing and dressing.Review of Resident #73's nursing progress notes in the electronic health record from 03/27/2026 through 05/14/2026 did not included documented evidence of showers, nail care, personal grooming, or care refusals.During an observation and interview on 05/07/2026 at 9:49 AM, Resident #73 had a significant amount of facial hair and stated staff had not offered to shave them and they would like to be shaved. Resident #73's fingernails on the right hand contained dark debris underneath. Tremors (involuntary shaking movements) were observed in both hands.During an observation on 05/08/2026 at 10:58 AM, Resident #73 was in the hallway on the way to physical therapy. Resident #73 was wearing the same gray sweatpants observed the previous day. The sweatpants contained a large, brownish-colored stain on the front left side. Resident #73's fingernails on the right hand remained unclean with dark debris underneath.During an interview and observation on 05/12/2026 at 12:16 PM, Certified Nursing Assistant #1 stated Resident #73 did not have a history of refusing care and would not know to ask for assistance with cleaning their hands and fingernails. Certified Nursing Assistant #1 stated staff were trained to perform hand hygiene for residents who could not complete it independently or ask for assistance. Certified Nursing Assistant #1 stated residents should receive weekly showers, nail care, and facial hair removal. Certified Nursing Assistant #1 observed Resident #73's hands and stated the fingernails were unclean.During an observation and interview on 05/14/2026 at 11:20 AM, Resident #73 was seated in their room wearing dark blue sweatpants with dry flakes and stains on the front. Resident #73 had a significant amount of facial hair and stated they had not been shaved and would like to be shaved. Resident #73's fingernails on both hands contained dark debris underneath. Two (2) fingernails on the right hand were broken and jagged. Resident #73 was observed leaning forward in the wheelchair scratching the lower legs and arms.During an interview on 05/14/2026 at 12:44 PM, the Director of Nursing stated shower day should include nail care and shaving. The Director of Nursing stated staff were expected to provide personal grooming if needed, even when it was not the resident's scheduled (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	shower day. The Director of Nursing stated if a resident refused care, staff were expected to reapproach, document the refusal, and update the care plan. The Director of Nursing stated Resident #73 should have received a shave and should have been provided clean clothing before attending physical therapy. The Director of Nursing stated adequate staff were available for residents to receive showers, nail care, and shaving as needed.2.Resident #15 had diagnoses including chronic obstructive pulmonary disease (a progressive lung disease that makes breathing difficult), chronic systolic heart failure (a condition in which the left side of the heart cannot pump blood effectively), and chronic kidney disease (a long-term condition in which the kidneys do not function properly). The Minimum Data Set, dated [DATE], included Resident #15 had moderate cognitive impairment, required staff assistance with showering and personal hygiene, and did not exhibit rejection of care.Review of Resident #15's Comprehensive Care Plan, revised 04/19/2026, revealed activities of daily living deficits related to chronic kidney disease. Two (2) staff were to provide assistance with showers and one (1) staff was to provide assistance with grooming.Review of Resident #15's Kardex (care plan reference tool used by staff to guide daily care), effective 05/14/2026, documented weekly showers on the Friday evening shift with assistance from two (2) staff.Review of Resident #15's Treatment Administration Record from 05/01/2026 through 05/15/2026 revealed showers were recorded on 05/01/2026 and 05/08/2026.During an observation and interview on 05/07/2026 at 1:09 PM, Resident #15 had multiple visible hairs on the chin, fingernails approximately one-quarter (1/4) inch in length, and greasy hair. Resident #15 stated the facial hair had not been shaved since the previous week.During an observation and interview on 05/12/2026 at 9:54 AM, Resident #15 continued to have multiple visible hairs on the chin, fingernails approximately one-quarter (1/4) inch in length, and greasy hair. Resident #15 stated they had not received a bath on 05/08/2026.Additional record review did not include documented evidence nursing staff recognized missed hygiene care or implemented follow-up to ensure completion of care.During an interview on 05/15/2026 at 11:52 AM, Certified Nursing Assistant #3 stated staff were expected to ask residents each shift if they wanted a shave, hair washing, or nail trimming, regardless of existing documentation, if the resident appeared to need the care. Certified Nursing Assistant #3 stated all care and refusals were documented in Point of Care (an electronic health record documentation system used to record hygiene care including combing hair, brushing teeth, shaving, applying makeup, and washing and drying the face and hands). Certified Nursing Assistant #3 stated staff would reapproach residents four (4) to five (5) times to provide care and nurses were informed of refusals.During an interview on 05/15/2026 at 12:06 PM, Licensed Practical Nurse #1 stated if a resident was documented as having received care but had not, nursing staff would ask the aide to provide the care, reapproach the resident if the resident had refused, and provide the care if necessary. Licensed Practical Nurse #1 stated refusals were documented in a progress note.During an interview on 05/15/2026 at 12:16 PM, Registered Nurse Supervisor #1 stated residents routinely received shaving, hair washing, and nail trimming on shower days. Registered Nurse Supervisor #1 stated staff were expected to follow up when residents had not received personal care or grooming and ensure care was provided. Registered Nurse Supervisor #1 stated Certified Nursing Assistants were expected to report refusals to nursing staff and nurses were expected to document refusals in a progress note.During an interview on 05/15/2026 at 1:20 PM, the Director of Nursing stated shaving, hair washing, and nail trimming should be provided daily when needed. The Director of Nursing stated if a resident refused care, the Certified Nursing Assistant was expected to document the refusal in Point of Care, report the refusal to the nurse, and the nurse would document the refusal in a progress note.Title 10 New York Codes, Rules and Regulations 415.12(a)(3)