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	10/15/2024

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

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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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 39181 Based on interviews and record review conducted during the Recertification Survey from 10/07/2024 to 10/15/2024, for seven (Residents #1, #2, #6, #26, #31, #51, and #65) of seven residents, the facility did not ensure that grievances and recommendations by the resident group (Resident Council) concerning issues of resident care and life in the facility were acted on promptly. Specifically, during a special Resident Council meeting, seven residents voiced multiple concerns. A review of the previous three months of meeting minutes included issues such as call bell response, inability to find staff during various periods of the day, staff phone use during care, dietary concerns, and missing laundry items. The facility was unable to provide their responses and rationale related to grievances brought by the resident group. This is evidenced by the following: During a special Resident Council Meeting held on 10/09/2024 at 11:00 AM with seven residents present, it was reported that the call bell system was not functioning properly and residents often had to wait a long time for staff to respond. The facility was short staff and residents often did not receive showers as scheduled. Staff often entered resident rooms wearing earbuds and engaging in personal phone conversations while performing care. Residents were frequently missing clothing items and sometimes waited two to three weeks for clothing to be returned from laundry, if at all. Residents continued to receive cold food items at mealtimes and did not consistently receive all items listed on their meal tickets. The resident group stated the facility did not address any concerns that were brought up during Council meetings, did not feel there was ever any resolution, and the answer they always received was we are working on it. The resident group was not certain who the Grievance Official was, but stated they frequently reported their concerns to the Director of Social Work. Review of Resident Council meeting minutes for June 2024, July 2024, and September 2024 revealed the residents reported concerns including, but not limited to, waiting long times for call bells to be answered, difficulty finding aides various times during the day, residents missing morning activities due to aides not assisting them with morning care, staff using phones while assisting with care, lack of variety of menu items, food items cold, and tray times varying daily, missing/damaged laundry items, and laundry not returned to residents timely. Each of the meeting minutes included that the previous month's minutes were read and accepted and the department staff who were present. The meeting minutes did not include follow-up from staff regarding the resident's concerns or rationales for staff responses. (continued on next page)

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

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/11/2024 at 2:05 PM, the Director of Social Work stated that department representatives, including laundry staff, had attended resident council meetings and they and the Ombudsman were always in attendance. The Director of Social Work stated while some resident-specific grievances were documented, they were not sure if the Activities Director (who records meeting minutes monthly) was ever trained on how to take notes for the Council meeting minutes. During an interview on 10/15/2024 at 11:11 AM with the Administrator and Regional Administrator, the Regional Administrator stated the Quality Assurance committee was not aware of concerns related to grievances and a lack of responses to the resident group. They stated Social Work attends the meeting. 10 NYCRR 415.5 (c)(6)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 46526 Based on interviews and record review conducted during a Recertification Survey and complaint investigation (ACTS Reference Number: NY00319641), for one (Resident #51) of three residents reviewed, the facility did not ensure that an incident resulting in a major injury was thoroughly investigated in order to rule out potential abuse, neglect, mistreatment, or care plan violation. Specifically, Resident #51 fell while being assisted in the bathroom by a staff member resulting in a patella fracture (broken kneecap). The facility was unable to provide evidence (including, but not limited to, statements from the resident, involved staff members or potential witnesses) that the incident was thoroughly investigated to rule out potential abuse, neglect, mistreatment, or care plan violation. This is evidenced by the following: The undated facility policy Accident and Incident Reporting documented the facility would provide an accurate record of all incidents occurring on the premises involving any resident, staff, vendors, visitors, volunteers, or clinical students. An incident would be any event which was not consistent with the routine operation of the facility or the routine daily pattern of the care of a resident. It may be an accident, a situation which could have resulted in an accident, or an unusual physical finding. Any time where a resident touched the floor (e.g., a fall) an Accident-Incident (A-I) report must be done. The Accident-Incident report is to include the Registered Nurse (RN) assessment, if necessary, based on nursing judgement, on-call medical provider notification, and statements from all staff who were present and will be gathered within 24-48 hours. The charge nurse or supervisor is to complete the report, review it, and forward it to the nurse manager or designee for root cause analysis investigation and care plan updates. Resident #51 had diagnoses that included anxiety, depression, and a history of falling. The Minimum Data Set Resident Assessment, dated 07/09/2024 documented Resident #51 was cognitively intact. The Minimum Data Set Resident Assessment, dated 04/24/2024 (prior to the fall), documented the resident required supervision or touching assistance for toilet transfers and ambulation with a walker. The Comprehensive Care Plan, revised 07/21/2024 (after the fall), documented that Resident #51 was a moderate fall risk related to deconditioning, gait/balance problems and psychoactive drug use. Resident #51 had an actual fall on 07/06/2024, while being assisted by a staff member with their walker, the resident's knees gave out and the resident fell on to their knees resulting in a patella (knee) fracture. During an interview on 10/07/2024 at 10:54 AM, Resident #51 said they fell while in the shower room and sustained a fractured knee cap. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interdisciplinary team progress note, dated 07/06/2024 at 6:06 PM, Licensed Practical Nurse #9 documented that they were alerted to respond to a witnessed fall in a bathroom. Upon entering, Resident #51 was on their knees on the floor. The Certified Nursing Assistant reported that they were attempting to pull the (resident's) brief up and pivot the resident back to their wheelchair when the resident's knees buckled, and the resident fell to the floor. The Director of Nursing was notified, and the resident was assisted to a standing position with the assist of four staff. The medical provider was notified and x-rays were ordered of both knees. In a follow-up progress note at 9:10 PM, Licensed Practical Nurse #9 documented the radiology report was reviewed with the on-call medical provider, an inferior patellar fracture of the left knee was confirmed, and Resident #51 was sent to the emergency room for an orthopedic evaluation. Review of a #2242 Witnessed Fall Report (accident report) in Resident #51's electronic medical record, dated 07/06/2024 and completed by Licensed Practical Nurse #9, revealed that Resident #51 was unable to properly articulate the incident due to complaints of bilateral knee pain, which they rated 10 out of 10. The fall report listed five staff members' names and those statements had been obtained. The fall report did not include the staff members' actual statements, did not identify the Certified Nursing Assistant who was present during the resident's fall, or their statement pertaining to the events of the incident. The fall report did not include the resident's statement. A summary, completed by the Director of Nursing, dated 08/08/2024, documented the resident fell while attempting to transfer in the bathroom, an x-ray revealed a patella fracture, and the resident would follow-up with Orthopedics. During an interview on 10/11/2024 at 2:13 PM, Licensed Practical Nurse Manager #2 said resident-involved incidents that should be investigated included, but not limited to, a resident fall to determine if there was a break from the care plan (care plan not followed). Licensed Practical Nurse Manager #2 stated investigations consisted of obtaining witness statements, measuring a wound, obtaining x-rays, or anything that would be required to find out what happened. Licensed Practical Nurse Manager #2 said they or the nursing supervisor would investigate resident incidents, talk to the resident, and obtain statements from witnesses. Licensed Practical Nurse Manager #2 said everything (information related to the incident) is then given to the Director of Nursing. Licensed Practical Nurse Manager #2 said they were not in the facility at the time of Resident #51's fall on 07/06/2024. During an interview on 10/15/2024 at 8:51 AM, the Director of Nursing said investigations into resident incidents consisted of talking to resident(s) and staff to get statements to find out what happened. The Director of Nursing stated unit managers and nursing supervisors help with the investigations, and if there are any questions, the Director of Nursing interviews staff to determine what occurred. The Director of Nursing stated Resident #51 was in the bathroom with a Certified Nursing Assistant, who was helping the resident pull up their pants (when the resident fell). The Director of Nursing said Resident #51's statement included that they were pulling up their pants when they fell to their knees. The Director of Nursing said a statement was obtained from the involved Certified Nursing Assistant on paper, but they could not find it and the employee was no longer employed by the facility. The Director of Nursing stated it was not a complete investigation without the involved Certified Nursing Assistant's statement and they did not know if the involved Certified Nursing Assistant followed the resident's care plan. 10 NYCRR 415.4(b)(1)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 49447 Based on interviews and record review conducted during the Recertification Survey from 10/07/2024 to 10/15/2024, for 10 (Residents #25, #26, #46, #62, #64, #68, #71, #72, #73, and #75) of 10 residents reviewed, the facility did not ensure that the baseline care plan (care plan developed within 48 hours of admission that includes the minimum healthcare information necessary to properly care for the immediate needs of the resident) or summary was reviewed or provided to the residents and/or their representative. Specifically, the facility was unable to provide evidence that a summary of the baseline care plan was reviewed or provided to the resident or the resident representative following admission and prior to the comprehensive care plan meeting. The findings include, but not limited to, the following: Review of the facility policy Baseline Care Plan, dated June 2018, included the baseline care plan would be developed within 48 hours of admission and would include the instructions needed to provide effective and person-centered care of the resident that meets professional standards quality of care. The baseline care plan will be provided to the resident and/or their representative by the nurse (or designee) developing the care plan. 1. Resident #25 had diagnoses that included diabetes, high blood pressure, and end stage kidney disease. The Minimum Data Set Resident Assessment, dated 07/25/2024, documented the resident was cognitively intact. Review of the electronic medical record for Resident #25 did not include any evidence that the baseline care plan had been provided or reviewed with the resident or the resident's representative following admission to the facility. 2. Resident #62 had diagnoses that included cerebral palsy (a disorder that affect a person's ability to move, balance, and maintain posture), seizures, and intellectual disability. The Minimum Data Set Resident Assessment, dated 08/05/2024, documented the resident had severely impaired cognition. Review of the electronic medical record for Resident #62 did not include any evidence that the baseline care plan had been provided or reviewed with the resident's representative. 3. Resident #71 had diagnoses that included Parkinson's disease, dementia, and major depressive disorder. The Minimum Data Set Resident Assessment, dated 08/27/2024, documented the resident had moderately impaired cognition. Review of the electronic medical record for Resident #71 did not include evidence that the baseline care plan had been provided or reviewed with the resident or the resident's representative following admission. During an interview on 10/11/204 at 10:10 AM, Licensed Practical Nurse Manager #1 stated they would complete the nursing sections of the baseline care plan and a copy was given to the resident or their representative by the Director of Social Work or the Director of Nursing. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/11/2024 at 10:12 AM, the Director of Social Work stated each department completes their section of the baseline care plan and that nursing is usually responsible for reviewing the baseline care plan with the resident or their representative, and noting in the electronic medical record that it had been reviewed and a copy was given to the resident or their representative. During an interview on 10/11/2024 at 02:43 PM, the Director of Nursing stated the nurse managers for each unit were responsible for reviewing the baseline care plan and providing a copy of it to the resident or their representative, but no one was documenting this. During an interview on 10/15/24 at 11:11 AM, the [NAME] President of Operations stated they were aware baseline care plans were not being reviewed with the resident and/or representative consistently. The facility was unable to provide any documented evidence the baseline care plans or a summary had been reviewed or provided to the resident or their representative. 10 NYCRR 415.11

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 40803 Based on observations, interviews, and record review conducted during the Recertification Survey from 10/07/2024 to 10/15/2024, for two (Resident #19 and Resident #38) of five residents reviewed, the facility did not implement a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs. Specifically, Resident #19 had a history of falls, was care planned to have a fall mat (a floor mat that helps prevent injuries and is often used for people at risk for falling) in place and was observed with the mat improperly placed near their bed. Resident #38, who had a history of falls, was care planned to have a low bed in place and call bell within reach, and was observed in a bed not in the low position and call bell not within reach. This is evidenced by the following: 1. Resident #38 had diagnoses of dementia, depression, anxiety, and a right above the knee amputation. The Minimum Data Set Resident Assessment, dated 07/23/2024, included the resident had severely impaired cognition, was dependent on staff for assistance with bed mobility and transfers, and had no recent falls. Review of the Comprehensive Care Plan, last revised 07/25/2024, and current Kardex (care plan used by Certified Nursing Assistants to direct daily care) revealed Resident #38 had a functional mobility deficit and was at risk for falls. Interventions included, but were not limited to, total assistance of two staff with bed mobility and transfers using a mechanical lift, a low bed height, ensure the call light is within reach and encourage resident to use it for assistance as needed, follow facility fall protocol, and to review and record information on past falls and attempt to determine the root causes. During observations on 10/07/2024 at 10:22 AM, 11:12 AM, and 11:55 AM, Resident #38 was lying in bed leaning toward the right side of the bed with their head hanging off the mattress. The call bell was hung behind the headboard and not within the resident's reach. During an observation on 10/08/2024 at 10:04 AM, Resident #38 was lying in bed. The bed was not in a low position at approximately 24 inches from the ground. During an observation on 10/08/2024 at 3:29 PM, Resident #38 was lying in bed leaning toward the right side of the bed. The bed was not in a low position at approximately 35 inches from the ground. During observations on 10/09/2024 at 8:45 AM and 9:36 AM, Resident #38 was lying in bed. The bed was not in a low position at approximately 24 inches from the ground. During an interview on 10/10/2024 at 11:52 AM, Certified Nursing Assistant #5 stated resident Kardexes should be checked daily for the safety of the resident and staff. Resident #38's bed should have been in the low position, but it was not. Certified Nursing Assistant #5 stated it was the responsibility of the Certified Nursing Assistant and Licensed Practical Nurse assigned to the resident to make sure the bed is in the low position for the resident's safety. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #19 had diagnoses of dementia, epilepsy, and osteoporosis. The Minimum Data Set Resident Assessment, dated 07/01/2024, included the resident had severely impaired cognition, was dependent on staff for assistance with bed mobility and transfers, and had a fall with no injury. Review of the current Comprehensive Care Plan and Kardex revealed Resident #19 had a functional mobility deficit related to dementia (last revised on 11/09/2023) and was a high risk for falls (last revised 11/01/2023). Interventions included, but were not limited to, extensive assistance of one staff with bed mobility, total assistance of two staff for transfers using a mechanical lift, a fall mat on side of bed facing door, to follow facility fall protocol, a low bed height/in low position at night, and to review and record information on past falls and attempt to determine the root causes. During observations on 10/07/2024 at 10:16 AM and 11:44 AM, Resident #19 was lying in bed with the fall mat folded on the floor, not placed next to their bed. During an observation on 10/08/2024 at 10:05 AM, Resident #19 was lying in bed with their fall mat folded on the floor, not placed next to their bed. The bed was not in a low position and was approximately 18 inches from the ground. During an observation on 10/10/2024 at 5:05 PM, Resident #19 was lying in bed with their fall mat folded on the floor, not placed next to their bed. During an observation on 10/10/2024 at 5:15 PM, Resident #19 was lying in bed and the fall mat remained folded on the floor, not placed next to their bed. During an interview at this time, Certified Nursing Assistant #10 stated it was important for a fall mat to be in place for the resident's safety. Resident #19 should have a fall mat down next to her bed. Certified Nursing Assistant #10 stated they had last checked on the resident at the start of their shift and did not know why the fall mat was not in place. During an interview on 10/10/2024 at 5:18 PM, Licensed Practical Nurse Manager #2 stated Certified Nursing Assistants should check resident care plans daily. The need for a low bed or fall mat would be on the Kardex and should be in place when a resident was in bed and/or not eating a meal. Residents #19 and #38 were at risk for falls and their care plans should be followed. During an interview on 10/11/2024 at 9:30 AM, the Director of Therapy stated the need for a low bed or a fall mat was determined by the interdisciplinary team and should be in place when a resident is in bed. 10 NYCRR 415.11(c)(1)

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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. 49447 Based on observations, interviews, and record review conducted during the Recertification Survey and complaint investigations (NY00354611 and NY00349191), for two (Residents #25, and #53) of seven residents reviewed for activities of daily living, the facility did not ensure that residents who were unable to carry out activities of daily living received the necessary services to maintain good grooming and personal hygiene. Specifically, residents' fingernails were observed unclean and uncut over multiple days. Additionally, Resident #53 was observed eating with their hands while their fingernails remained dirty. This is evidenced by the following. The undated facility policy Care of Fingernails/Toenails included that the purpose was to clean the nail bed, to keep nails trimmed, and to prevent infections. The policy included that nail care included daily cleaning and regular trimming and that the treatment should be documented in the resident ' s medical record. Additionally, the policy included that the supervisor should be notified if the resident refuses the care. 1. Resident #53 had diagnoses that included a stroke with left sided hemiplegia (muscle weakness or partial paralysis on one side of the body), diabetes, and anxiety. The Minimum Data Set Resident Assessment, dated 08/11/2024, documented the resident was moderately impaired cognitively, did not reject care, had an impairment on the left side of the body, and was dependent on staff for assistance with all activities of daily living. Review of the Comprehensive Care Plan, revised on 05/29/2024, and the undated Kardex (a care plan used by the Certified Nursing Assistants to provide daily care) revealed the resident preferred showers, often refused their showers, and if they refused to wait 30 minutes to reapproach, and if refused again offer a bed bath. The Comprehensive Care Plan included that the resident's nails should be observed for debris, appropriate length, and jagged edges weekly on their shower day (scheduled on Monday evenings). Review of Resident #53's electronic medical record revealed no documented evidence of Resident #52 had refused nail care. During an observation on 10/07/2024 at 10:08 AM, Resident #53's fingernails were long and unclean with a dark substance underneath them. During observations on 10/08/2024 at 9:03 AM, 10/09/2024 at 8:49 AM and on 10/10/2024 at 1:20 PM Resident #53 was eating both breakfast and lunch food with their hands. The nails remained unclean with a dark substance underneath them. During an interview on 10/10/2024 at 9:10 AM, Resident #53 stated they had received a shower this week but did not get their fingernails cleaned and would like them cleaned. During an interview on 10/10/2024 at 11:25 AM, Licensed Practical Nurse #4 stated if a resident refused a shower or nail care, staff should reapproach, and that all refusals should be documented. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/10/2024 at 1:43 PM, Certified Nursing Assistant #6 (assigned to Resident #53) stated nail care is completed as needed and on shower day and includes trimming and cleaning. If residents refuse nail care, they should tell the nurses and reapproach the resident to attempt care again later. Nail care that is refused should be documented in the electronic medical record. During an interview on 10/10/2024 at 5:18 PM, Licensed Practical Nurse Manager #2 stated that nail care should be completed during every shower and as needed if there is debris under the nails. Licensed Practical Nurse Manager #2 stated that nail care is important for infection control. 2. Resident #25 had diagnoses that included diabetes, high blood pressure, and end stage kidney disease requiring dialysis. The Minimum Data Set Resident Assessment, dated 07/25/2024, documented the resident was cognitively intact and required assistance with hygiene. Review of the Unit 2 Assignment Sheet included Resident #25's shower day was on Tuesdays during the day shift. Review of the current Comprehensive Care Plan and the Certified Nursing Assistant Kardex included Resident #25 required extensive assistance with grooming. During an observation on 10/07/2024 at 3:05 PM, Resident #25 had long fingernails with dark brown debris under all nails on both hands. During an interview at this time, Resident #25 stated no one has helped them cut or clean their fingernails and their fingernails needed to be trimmed and cleaned. During observations on 10/09/2024 (one day after their shower day) at 11:23 AM and on 10/10/2024 at 9:01 AM, Resident #25's fingernails remained long with dark debris underneath. During an interview on 10/10/2024 at 10:26 AM, Certified Nursing Assistant #7 stated nail care should be done on shower day and as needed. During an interview on 10/10/2024 at 11:13 AM, Licensed Practical Nurse #1 stated they did a skin check for Resident #25 on Tuesday after their shower but did not look at their fingernails or do nail care. During an observations and interview on 10/10/2024 at 11:17 AM, Licensed Practical Nurse Manager #1 stated nail care including trimming and cleaning of any debris under the nails should be completed on shower days and as needed. During an observation at this time, Licensed Practical Nurse Manager #1 stated Resident #25's nails were long and dirty and should have been trimmed and cleaned on their shower day. During an interview on 10/11/2024 at 2:43 PM, the Director of Nursing stated nail care should be done on shower days, when requested, and as needed, and should not be overly long or dirty. 10 NYCRR 415.12(a)(3)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 40803 Based on observations, interviews, and record review conducted during the Recertification Survey from 10/07/2024 to 10/15/2024, for two (Resident #13 and #59) of two 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 #13 did not have documented evidence of a bowel movement for more than three days, that bowel medications were ordered and/or administered per the facility's protocol, or that a medical provider was notified. For Resident #59, who had nephrostomy tubes (thin, flexible tubes that drain urine from the kidney into a bag outside the body), there was frequently missed documentation to indicate medical orders were completed, the resident was hospitalized and treated for pyelonephritis (a kidney infection/bacterial infection that causes inflammation of the kidneys), and facility staff had not received special training to care for a nephrostomy tube. This resulted in actual harm to Resident #59 that was not Immediate Jeopardy and is evidenced by the following: The facility policy Charting and Documentation, dated April 2008, included all services provided to the resident, or any changes in the resident's condition would be documented in the resident's medical record. All observations, medications administered, services performed must be documented in the resident ' s medical records. All incidents, accidents, or changes in the resident's condition must be recorded. Documentation of procedures and treatments would include care-specific details at minimum: the date and time the procedure/treatment was provided, name and title of the individual who provided care, the assessment data and/or any unusual findings obtained during the procedure/treatment, how the resident tolerated the procedure/treatment, if the resident refused procedure/treatment, and notification of family, medical or other staff if indicated. The undated facility policy Care of a Nephrostomy Tube included instructions for the irrigation and dressing change of a nephrostomy tube and noted the procedure was a Registered Nurse only procedure secondary to needing an assessment. The facility was unable to provide documented evidence that nursing staff had received training and were competent to provide care for nephrostomy tubes. 1. Resident #59 had diagnoses including obstructive and reflux uropathy (urinary tract conditions that can cause urine to flow abnormally), chronic obstructive pyelonephritis (a kidney condition that results from repeated kidney infections and scarring), and presence of urogenital implants (a synthetic material that can be placed in the urinary organs or genitals). The Minimum Data Set Resident Assessment, dated 08/05/2024, included the resident had moderately impaired cognition, did not reject care, required assistance with toileting hygiene, and had an indwelling catheter (including nephrostomy tube). (continued on next page)

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the current comprehensive care plan included Resident #59 had renal failure related to kidney disease with bilateral nephrostomy tubes (last revised 10/11/2023), was incontinent of urine (last revised 01/21/2022), and had the potential for impairment to their skin integrity (last revised 08/14/2024). Interventions included, but were not limited to, monitor for signs/symptoms of infection, required extensive assistance with toileting, check and change resident every three to four hours, check placement of nephrostomy tubes and red areas as needed, and Registered Nurse to flush nephrostomy tubes daily. Physician orders initiated on 04/29/2024 included Registered Nurse to flush nephrostomy under sterile technique every shift as needed if urine output less than 100 milliliters, empty nephrostomy tube every shift for monitoring output, nephrostomy tube dressing change under sterile technique/measure length of tubing from insertion site to hub and document/check suture placement every three days for nephrostomy maintenance - Licensed Practical Nurse may change the dressing. Review of the June 2024 Treatment Administration Record revealed for 90 opportunities, the order to empty the nephrostomy tube every shift had 11 dates with blanks (no documented evidence of completion) and two dates documented as not applicable (N/A). On 06/04/2024 evening shift, urine output was documented as zero milliliters and there was no documented evidence that a Registered Nurse flushed the nephrostomy tubes. Review of the July 2024 Treatment Administration Record revealed for 93 opportunities, the order to empty the nephrostomy tube every shift had seven dates with blanks and eight dates documented as not applicable. On 07/08/2024, there was no documented evidence the nephrostomy dressing was changed, the length of tubing was measured, and suture placement was checked. Review of a progress note, dated 07/18/2024, Licensed Practical Nurse #1 documented during Resident #59's nephrostomy dressing change the right tube was leaking an excessive amount of urine, the nephrostomy may need to be replaced and the nurse manager was notified. The concern was placed in the 24-hour report book (filled out daily by a nurse at the end of each shift to communicate resident information) and acute medical book (used to communicate changes in resident condition to the medical provider). The facility was unable to provide documented evidence Resident #59 was assessed by a Registered Nurse or that a medical provider was notified. Review of the August 2024 Treatment Administration Record revealed for 77 opportunities, the order to empty the nephrostomy tube every shift had eight dates with blanks and one date documented as not applicable. On 08/09/2024 day shift was signed with code 9 (see progress note). Review of the electronic medical record revealed there was no progress note documented on this date. Urine output was documented as less than 100 milliliters on 08/09/2024 evening shift (85 milliliters), 08/22/2024 day shift (75 millimeters) and evening (zero millimeters) shifts, and there was no documented evidence that a Registered Nurse had flushed the nephrostomy tubes. Review of a progress note, dated 08/14/2024, Registered Nurse Supervisor #2 documented Resident #59's left nephrostomy dressing was soiled and there was a drainage stain on their t-shirt. Redness and irritation was observed when the old dressing was removed. Less than 100 milliliters of urine remained in the bag and the nephrostomy tube was flushed per the medical order. The medical provider was notified via the acute book. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A physician order, dated 08/15/2024, included Resident #59 was sent to the hospital for further evaluation related to the left nephrostomy tube not producing any urine. Review of a Hospital Discharge Summary, dated 08/19/2024, included Resident #59 was admitted following decreased urine output for the last week, dislodgment of their nephrostomy tube that was replaced on 08/15/2024, and was found to have pyelonephritis that was treated with antibiotics for five days. The resident would be discharged to the skilled nursing facility on oral antibiotics for two additional days. Review of a provider visit note, dated 08/20/2024, Physician #1 documented Resident #59 was hospitalized for displacement of nephrostomy tube and possible pyelonephritis. The resident was treated with antibiotics, the nephrostomy tube was replaced, and returned to the facility for long term care. Current medications included, but were not limited to, two days of amoxicillin (an antibiotic) three times daily for a bladder infection and levofloxacin (broad spectrum antibiotic) once daily for infection. Review of the September 2024 Treatment Administration Record revealed for 93 opportunities, the order to empty the nephrostomy tube every shift had six blanks and there was no documented evidence the nephrostomy dressing was changed, the length of tubing was measured, and suture placement was checked on 09/15/2024 and 09/18/2024. On 09/07/2024 evening shift and 09/12/2024 evening shift, urine output was documented as zero milliliters and there was no documented evidence that a Registered Nurse flushed the nephrostomy tubes. During an interview on 10/10/2024 at 1:30 PM, Licensed Practical Nurse #1 stated they had worked at the facility since March 2024 and floated to both units. There was one resident at the facility that had nephrostomy tubes and they had not received any education or competencies on nephrostomy tube care while employed at the facility. Licensed Practical Nurse #1 stated if they found the nephrostomy tubes to be dislodged or the resident had low urine output, they would document the concerns and notify the nursing supervisor. They stated it was important to provide care and treatments per the medical orders to prevent infections. During an interview on 10/10/2024 at 2:57 PM, Licensed Practical Nurse #14 stated they worked per diem and would cover the facility as the supervisor. There was one resident in the facility that had nephrostomy tubes. If the nephrostomy tubes needed to be flushed per the medical orders, they would call the Registered Nurse who was on-call and document the concern in the acute (medical) book and in a progress note. Licensed Practical Nurse #14 stated when in their role as supervisor, they could not recall a time that a Registered Nurse came in to flush the resident's nephrostomy tubes. During an interview on 10/11/2024 at 8:57 AM, Licensed Practical Nurse Manager #2 stated Resident #59 had nephrostomy tubes and had gone out to the hospital in August 2024. A Registered Nurse needed to flush the tubes per the medical order and a Licensed Practical Nurse could not do that. If the resident's tubes needed to be flushed and a Registered Nurse was not in the building, the Licensed Practical Nurse Supervisor would contact the Registered Nurse on-call who would come in to flush the nephrostomy tubes. Licensed Practical Nurse Manager #2 stated they had worked at the facility since July 2024 and had not received any training or competencies on nephrostomy tube care. They stated it was important to complete the medical orders to prevent infections and staff should document the resident ' s urine output each shift. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 10/11/2024 at 9:25 AM, Licensed Practical Nurse #10 stated they had worked at the facility for two years and Resident #59 was on their assignment. They also stated the resident did have nephrostomy tubes and if the urine output was less than 100 milliliters, they would contact the nursing supervisor and document their findings. Licensed Practical Nurse #10 stated they had not received any training regarding nephrostomy tube care. During an interview on 10/11/2024 at 1:53 PM, the Nurse Educator/Infection Preventionist stated they had been working at the facility since March 2024 and nephrostomy tube care was simple. They stated they could not find any documented education, trainings, or competencies for nephrostomy tube care for nursing staff at that time. During an interview on 10/11/2024 at 3:34 PM, the Medical Director stated it was rare to see a resident with nephrostomy tubes in a long-term care setting. It was important for staff to follow medical orders for nephrostomy tubes, especially flushing, as there could be issues with proper drainage due to sediment. The Medical Director stated Resident #59 was recently hospitalized for an infection and could not say for certain what would happen if staff did not flush the resident's nephrostomy tubes as ordered. During an interview on 10/15/2024 at 8:51 AM, the Director of Nursing stated staff should always follow the medical orders and document once treatments were completed. If there was missing documentation, there was no way to prove the treatment was completed. They stated if treatments were not completed as ordered, Resident #59 could be at risk for an infection. The Director of Nursing stated there were no documented competencies or trainings for the nursing staff on nephrostomy tube care. 2. Resident #13 had diagnoses including dementia, diverticulosis (small, bulging pouches in the digestive tract), and adult failure to thrive with protein-calorie malnutrition. The Minimum Data Set Resident Assessment, dated 06/29/2024, included the resident had moderately impaired cognition, required moderate assistance with toilet transfers, maximal assistance with toileting hygiene, and was always incontinent of bowel. The facility policy Bowel Habits, dated 12/19/2022, included that each resident admitted to the facility would have their bowel pattern assessed, with the objective being to develop regular bowel habits and prevent fecal incontinence, impaction, and irregularity. The certified nursing assistant would mark the bowel movement in the electronic medical record every shift, and the licensed nurse would check the electronic Medication Administration Record at the start of each shift to determine if a laxative, suppository, or enema was necessary. A laxative ordered by the physician for the resident should be given on the third day that the resident had no bowel movement. Review of the Comprehensive Care Plan, revised 04/16/2024, revealed Resident #13 required extensive assistance of two (staff) with toileting. During an interview on 10/07/2024 at 1:44 PM, Resident #13's visitor stated facility staff had previously been notified that Resident #13 was bloated and it went on for three to four weeks. Review of the Bowel and Bladder Elimination report from 08/01/2024 to 10/11/2024 revealed no documented bowel movements during the following timeframes: 08/04/2024 through 08/13/2024, 08/15/2024 through 08/19/2024, 08/26/2024 through 08/31/2024, 09/14/2024 through 09/19/2024, 09/25/2024 through 09/29/2024, and 10/04/2024 through 10/07/2024. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of active physician orders initiated on 04/15/2024 included the following medications to treat constipation: senna (a laxative) at bedtime and polyethylene glycol (a laxative) daily in the morning. There were no bowel medications ordered as needed to treat constipation. Review of the Medication Administration Records for August, September and October 2024 revealed Resident #13 was administered senna and polyethylene glycol as ordered. There was no documented evidence that as needed medications to treat constipation were ordered or administered. Review of a progress note, dated 08/24/2024, Licensed Practical Nurse #5 documented Resident #13's family member reported the resident was constipated. Licensed Practical Nurse #5 verbalized to the family member that Resident #13 had received bowel medications and they would also provide prune juice and milk of magnesium (a laxative). Review of active physician's orders for that timeframe did not include milk of magnesium. Review of interdisciplinary progress notes from 08/01/2024 to 10/11/2024 did not include documented evidence that a medical provider was notified of no bowel movement after three days or that as needed medications were administered to treat constipation. In a progress note, dated 10/06/2024, Licensed Practical Nurse #8 documented Resident #13 had complained of diarrhea with a foul smell and their daily dose of senna was subsequently held. During an interview on 10/11/2024 at 12:37 PM, Certified Nursing Assistant #1 stated they would chart residents' bowel movements in the electronic medical record and constipation would be considered if a resident went three to four days without a bowel movement. At times they would ask a resident when their last bowel movement was and would let the nurse know if a resident was constipated or had requested bowel medications. Certified Nursing Assistant #1 stated Resident #13 may have had problems with constipation due to having bowel movements that were liquid. They thought Resident #13's last bowel movement was on 10/07/2024, but they forgot to document it because the unit was short staffed. During an interview on 10/11/2024 at 12:56 PM, Licensed Practical Nurse #1 said for monitoring residents' bowel movements, they check the electronic health record or ask the residents and certified nursing assistants when the resident's last bowel movement was. A bowel movement report (no documented bowel movement in three days) was run daily by either the unit nurse manager or the nurse and the nurses' received notifications in the electronic health record if the resident did not have a bowel movement. Licensed Practical Nurse #1 stated if a resident did not have a bowel movement within 48 to 72 hours, they would verify with the resident and administer as needed medication per the facility bowel protocol. Licensed Practical Nurse #1 stated Resident #13 had normal bowel movements every day or two and did not have to administer any as needed medications for constipation. During an interview on 10/11/2024 at 2:13 PM, Licensed Practical Nurse Manager #2 stated Certified Nursing Assistants are supposed to document in the electronic medical record if the resident had a bowel movement or not. Licensed Practical Nurse Manager #2 stated they reviewed the bowel movement report daily and would notify the floor nurse of any resident that needed bowel medications. On weekends, it was the floor nurse's responsibility to review the report. Licensed Practical Nurse Manager #2 stated if a resident had no bowel movement for three days, the nurse would give bowel medications per the facility protocol and notify a medical provider if the protocol was ineffective. They stated as needed bowel medications were standard orders for all residents, but thought Resident #13 did not have them ordered because they were receiving routine laxatives daily. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 10/15/2024 at 8:51 AM, the Director of Nursing stated the nurses were supposed to run a bowel report daily and follow the facility's bowel protocol. The nurse completing the resident's admission was responsible for entering medical orders for as needed bowel medications per the protocol. The Director of Nursing stated if a resident did not have a bowel movement for three days, they would expect the nurses to follow the bowel protocol and notify a medical provider. They were not aware of any issues related to the monitoring of resident bowel movements. 10 NYCRR 415.12

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 49447 Based on observations, interviews, and record review conducted during the Recertification Survey from 10/07/2024 to 10/15/2024, for one (Resident #25) of two residents reviewed, the facility did not ensure the resident received the necessary care, treatment, and services, consistent with professional standards of practice to promote healing, prevent new pressure ulcers from developing, and/or prevent existing pressure ulcers from worsening. Specifically, the facility did not ensure that recommendations from the Wound Care Nurse Practitioner were accurately transcribed and implemented and treatments provided. This is evidenced by the following: The facility policy Pressure Ulcer (Injury) Prevention Program, dated 12/19/2022, included risk factors that impact the development, treatment, and/or healing of a pressure ulcer include residents with end stage renal disease and diabetes. A system will be in place that assures observations are timely and appropriate, interventions are implemented, monitored, and revised as appropriate, and changes in condition are recognized, evaluated, reported to the resident's attending practitioner and other healthcare professional (e.g. , wound nurse). At least weekly, the pressure ulcer should be assessed and documented. The facility policy Verbal Orders, dated December 2008, included if a treatment, test, or another intervention is included in a protocol that has been reviewed and approved by the Medical Director, a nurse may write a verbal order for the situation that is covered by the protocol. 1. Resident #25 had diagnoses that included diabetes, high blood pressure, and end stage kidney disease requiring hemodialysis. The Minimum Data Set Resident Assessment, dated 07/25/2024, documented the resident was cognitively intact and had a stage 3 (a deep wound that occurs when tissue loss extends through the skin's full thickness and into the subcutaneous fat layer) pressure ulcer. Review of the Resident #25's Comprehensive Care Plan revealed they had a stage 3 pressure ulcer and to perform wound care treatments per physician's orders. Review of the physician's orders revealed a treatment order for sacral pressure ulcer wound care was discontinued on 09/26/2024 with no new orders for wound care until 10/09/2024. In a Wound Assessment Report, dated 09/26/2024, Wound Care Nurse Practitioner #3 documented to change Resident #25's wound care treatment to cleanse with normal saline and apply Triad cream (a sterile, zinc-oxide based wound dressing) every shift. Review of Resident #25's electronic Treatment Administration Record from 09/27/2024 through 10/09/2024 revealed no documented evidence that Resident #25 received the recommended treatment for the stage 3 sacral pressure ulcer. A copy of an unsigned Skin Observation Tool (a form that documented skin observations in the electronic record) provided by the facility, dated 09/17/2024, did not include any information related to Resident #25's sacral pressure ulcer. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Skin Observation Tool, dated 10/08/2024 (not signed by anyone in the provided copy), included barrier cream (a topical product that protects the skin from irritants, contaminants, and other harmful substances) was applied to the sacrum. During an interview on 10/11/2024 at 09:18 AM, Licensed Practical Nurse #2 stated wound care treatments are completed per physician's orders and Wound Care Provider's recommendations. During an interview on 10/11/2024 at 09:46 AM, Licensed Practical Nurse Manager #1 stated wound rounds were completed weekly with the Wound Care Nurse Practitioner and the Director of Nursing. After the provider sees the resident, they will write a note, make any recommendations for changes in treatment, then the recommendations will be entered as an order into the electronic medical record. Licensed Practical Nurse Manager #1 stated there should always be an order in the electronic medical record to address active wounds. During a record review, Licensed Practical Nurse Manager #1 stated Resident #25 had no active wound care treatment order for the stage 3 pressure ulcer from 09/27/2024 until 10/09/2024. During an interview on 10/11/2024 at 02:43 PM, the Director of Nursing stated wound care treatments should be ordered and documented in the electronic medical record for nurses to be able to sign that they provided the treatment, and there should never be a time where there is not an order for treating active wounds. Wound care recommendations should be reviewed by the Nurse Manager and the recommendations transcribed as a new order. Resident #25 did not have an active order for their pressure ulcer and should have. Without an order the nurses would not know what to do for the wound or that there was a wound to be observed. During an interview on 10/15/2024 at 12:34 PM, Wound Care Nurse Practitioner #3 stated they completed wound rounds with the Director of Nursing and Nurse Manager. Wounds are assessed and recommendations are discussed and made. Recommendations are documented in a wound note and recommendations should be followed by the facility and if there is a concern with a recommendation the facility should notify the Wound Care Nurse Practitioner to discuss concerns. The facility is responsible for entering recommendations/orders into the electronic medical record. All residents with active wounds should have active treatment orders. If a treatment is not provided wounds can get worse quickly. 10 NYCRR 415.12 (c)(1)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 40803 Based on observations, record review, and interviews conducted during the Recertification Survey from 10/07/2024 to 10/15/2024, for one (Resident #19) of five residents reviewed, the facility did not ensure each resident received adequate supervision and the environment remained as free of accident hazards as possible. Specifically, Resident #19's care planned fall mat was not in place and there was no documented evidence the resident had been assessed by a Registered Nurse following an unwitnessed fall to their fall mat. The facility's undated policy Fall and Fall Risk documented staff with the help of the attending physician, would identify appropriate interventions to reduce the risk of falls. The facility's undated policy Falls Clinical Protocol documented: a. Staff and physician would document in the medical record a history of one or more falls. b. The nurse would assess and document vital signs, recent injuries, range of motion, change in condition, neurological status, pain, and details on how the fall occurred. c. Staff would evaluate and document falls that occurred while the resident was at the facility, when and where the fall happened, and observations of the event, and other circumstances such as sliding out of a chair or rolling from a low bed to the floor. Resident #19 had diagnoses that included dementia, epilepsy (a seizure disorder), and weakness. The Minimum Data Set Resident Assessment, dated 07/01/2024, documented the resident had severely impaired cognition, did not reject care, had impairments to both lower extremities, required substantial/maximal assistance (helper does more than half the activity to roll left and right), and was dependent on staff to move from sitting on the side of the bed to lying flat and to transfer to and from a bed to a chair. The resident had one fall without injury in the past three months. Active physician's orders documented the resident was to wear Geri sleeves (arm skin protector sleeves) daily for protection and remove daily for skin check and hygiene (start date 06/13/2022). The Comprehensive Care Plan, last reviewed on 07/08/2024, documented Resident #19 was at high risk for falls related to gait and balance problems. Interventions included fall mat on the floor on side facing the door (left side of bed) and bed in a low position at night. The undated Kardex (care plan used by the Certified Nursing Assistants for daily care) documented Resident #19 required a fall mat on the side of the bed facing the door and a low bed. The resident was non-ambulatory, required extensive assistance of one staff for bed mobility, a low bed height, and was dependent on two staff for transfers with a mechanical lift. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an unwitnessed fall incident report, dated 08/04/2024, Licensed Practical Nurse #12 documented Resident #19 was found sitting up on the floor mat leaning on the bed facing the door. The resident was unable to provide a description of what occurred and was checked for any red or open areas, vital signs were obtained, and no injuries were observed at the time of the incident. The resident had no pain, was alert, and ambulatory with assistance. There were no documented predisposing environmental, physiological, or situation factors. A note was placed in the medical book. The report did not include if a Registered Nurse had assessed the resident after the unwitnessed fall or if the resident's bed had been in low position. In an electronic statement, dated 08/04/2024, Licensed Practical Nurse #12 stated they found Resident #19 sitting on the floor facing the door. The statement did not document if the resident's bed was in a low position. On 08/05/2024 at 2:05 PM, the Director of Therapy completed a Fall Consult 1 form that included that Resident #19 fell out of bed on 08/03/2024. The resident had no changes in bed mobility or transfer status and remained non-ambulatory. They documented the resident was found in their room next to their bed. The resident was unable to describe what happened. No functional changes were noted, and staff would continue with current recommendations. The medical record did not include any nursing or medical information regarding the 08/03/2024 fall. On 08/13/2024, Physician #1 documented the resident had dementia, had no recent falls, or no new neurological deficits. On 08/13/2024, Wound Care Nurse Practitioner documented the resident had a left forearm skin tear/laceration. On 08/16/2024 at 11:18 AM, Licensed Practical Nurse #8 documented while they completed the resident's treatment to their left arm, they noticed another laceration that appeared to be healing on the resident's right arm. The 08/16/2024, nursing schedule documented Licensed Practical Nurse #9 was the supervisor on the 3 PM - 11 PM shift and there was no documented supervisor scheduled on the 11 PM - 7 AM shift. The 08/17/2024, nursing schedule documented Licensed Practical Nurse #9 was the supervisor on the 7 AM - 3 PM and on the 3 PM - 11 PM shift. In a #2258 Injury-other Report dated 08/17/2024 at 10:30 AM, Licensed Practical Nurse #9 (acting supervisor) documented they were alerted to Resident #19's room for a report of new skin impairments. The resident presented with a 5-centimeter by 7.5-centimeter hematoma (an area of blood that collects outside of the larger blood vessels) on their left hip, a 4-centimeter x 7.5-centimeter hematoma on their right knee, multiple scattered hematomas on the left hand and arm, and a 0.6-centimeter x 0.3-centimeter skin tear on the left wrist. The resident's head of bed was elevated, call light was in reach, and floor mat was in place. The Director of Nursing and medical were notified. In an undated witness statement, Licensed Practical Nurse #8 documented the resident had bruises on their arms when they worked on 08/16/2024. (continued on next page)

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	335467	A. Building B. Wing	10/15/2024

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an undated witness statement, Certified Nursing Assistant #8 documented bruises were already present on Resident #19 on 08/16/2024 in the morning. In an undated witness statement, Licensed Practical Nurse #12 documented Resident #19 was found on the floor mat on the night shift on 08/16/2024. Licensed Practical Nurse #12 stated they were informed by the unit manager that the resident was care planned for this and that the incident did not need an accident or incident report completed. The statement included that the Director of Nursing had explained to them that a nursing note was still needed. There was no documented evidence in Resident #19's electronic medical record that the resident had been assessed by a Registered Nurse. In a Summary of Investigation, dated 08/17/2024, The Director of Nursing documented the resident was found to have several bruises during morning care, was alert with significant confusion, and unable to explain the bruises. The resident had fragile skin, bruised easily, and was on a medication for a seizure disorder, which could contribute to the bruising. The Director of Nursing wrote after statements were obtained, it was found that the resident was found on their bedside floor mat, which they were care planned for, and this coupled with their medications and diagnosis, would most probably explain their bruises. During observations on 10/07/2024 at 10:16 AM and 11:44 AM and on 10/10/2024 at 5:05 PM, Resident #19 was in bed. Their bedside mat was folded up the left side of their bed on the floor. During an interview on 10/10/2024 at 5:11 PM, Certified Nursing Assistant #10 stated Resident #19's care plan included information such as the need for a low bed and fall mats. If they observed a resident's fall mat was missing or not in place, they would tell the nurse. Certified Nursing Assistant #10 also stated was important to follow the care plan to ensure the safety of the residents. At 5:14 PM, Certified Nursing Assistant #10 entered the resident's room and stated their fall mat was not in place and it should have been. During an interview on 10/10/2024 at 5:18 PM, Licensed Practical Nurse Manager #2 stated certified nurse aides should be checking the care plans daily. The care plans included information regarding low bed and fall mats. They stated Resident #19 was at risk for falls and should have a fall mat down when they were in bed. During an interview on 10/15/2024 at 8:51 AM, the Director of Nursing stated investigations should be started when a resident had an unwitnessed fall or a fall with injuries, and that it was important for the investigation to be completed to rule out what happened. The investigation should include reviewing nursing notes, getting staff statements, resident statements, and the resident should be assessed for injuries. The facility was unable to provide documented evidence that the resident's fall out of bed had been investigated or that medical had been notified. 10 NYCRR 415.12(h)(2)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 40803 Based on observations, record review, and interviews during the Recertification Survey conducted from 10/7/2024 through 10/15/2024, the facility failed to ensure acceptable parameters of nutritional status for two (Residents #38 and #11) of three residents reviewed. Specifically, Resident #38 did not receive assistance at meals per their care plan, did not have their nutritional needs reassessed timely, and had poor meal intakes resulting in significant weight loss. Additionally, Resident #38 developed a stage three pressure ulcer (full thickness tissue loss) following the weight loss. Resident #11 was care planned to receive extensive assistance with meals and was observed on multiple occasions eating independently without staff assistance, did not consistently receive their Mighty Shake (nutritional supplement) as ordered with no substitutes offered or provided, and had significant weight loss. This resulted in actual harm to Resident #38 that was not Immediate Jeopardy and is evidenced by the following: Findings include: The facility's undated policy Weight documented nursing staff would weigh all residents upon admission or readmission, three days after admission, weekly for four weeks, then monthly thereafter. If there was a fluctuation of five pounds for any residents who weighed 100 pounds or more or a fluctuation of three pounds for a resident who weighed 100 pounds or less, the resident would be re-weighed for verification on the same scale and at that time. The dietitian would review weights for five percent gain or loss in one month or 10 percent gain or loss in six months. A list of significant weight changes would be distributed monthly to each nurse manager and discussed if any further interventions were necessary. Residents would be assessed on an individual basis which supplements (if needed) were to be implemented. Residents could also be placed on a fluid and solid intake sheet to better assess by mouth intake as needed. 1. Resident #38 had diagnoses including Alzheimer's dementia, moderate protein-calorie malnutrition, and depression. The Minimum Data Set Resident Assessment, dated 07/23/2024, documented the resident had impaired cognition, did not reject care, and required supervision or touching (helper provides verbal cues and/or touching assistance as resident completes the activity) assistance with meals. The resident was 72 inches tall, weighed 113 pounds, received a therapeutic and mechanically altered diet, and had no significant weight changes in the past six months. The resident had no pressure ulcers. Current physician's orders, initialed 01/15/2024, documented the resident received a heart healthy, mechanical soft (ground meat) and thin liquid consistency diet. Review of medical orders for life sustaining treatments (MOLST), dated 01/16/2024, documented the resident had an order for cardiopulmonary resuscitation (full code) and there were no limitations on medical interventions with a trial period of feeding tube and intravenous fluids if the resident could no longer eat or drink. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The Comprehensive Care Plan, dated 01/30/2024, documented Resident #38 was at risk for potential sub-optimal nutrition and dehydration related to their past medical history of Alzheimer disease, depression, varied intakes, low body weight, and decreased skin integrity. Interventions included, but were not limited to, meal set up with assist and supervision as needed and accepted by the resident, encourage meal consumption, honor food preferences, and to monitor weights, intakes, skin integrity, signs and symptoms of malnutrition, significant weight loss, and intakes not meeting the resident's needs. The undated Kardex (care plan used by the Certified Nursing Assistant for daily care) documented the resident required extensive assistance of one person with meals. In a progress note, dated 07/22/2024, Occupational Therapist #1 documented that Resident #38 required substantial/maximum assistance at meals. Review of a progress note, dated 08/01/2024, Registered Dietitian #1 documented Resident #38's July 2024 weight was 112.5 pounds. Weights since admission ranged from 106 - 116 pounds and their body mass index was 15.5, which was chronically low. The resident remained on a heart healthy diet and mechanical soft consistency with most meal intakes greater than 50 percent. The resident received Liquacel (high protein nutritional supplement) twice daily for skin integrity, disliked Ensure and Boost (nutritional supplements), and received ice cream at lunch and dinner for additional calories and protein. Review of monthly weights from January 2024 through August 2024 revealed Resident #38's weights fluctuated from 106 pounds to 117 pounds. On 9/16/2024, the resident's weight was 99.8 pounds which indicated a 14.3 percent (16.7 pound) weight loss in one month, 11.3 percent (12.7 pound) loss in three months, and a 10.9 percent (12.2 pound) loss in six months. Their body mass index was down to 13.5. On 09/17/2024, Nurse Practitioner #2 documented the resident was seen for a 60-day review and had a significant weight loss for September 2024 down to 99.8 pounds and a re-weight was pending. On 09/20/2024, Registered Dietician #1 documented the resident's weight at 99.8 pounds which was down 16 pounds this month, a re-weight was requested, the resident received ice cream at lunch and dinner, and Mighty Shakes (nutritional supplement) was added to all meals and they would follow weight trend and adjust meal plan as resident accepts. The facility was unable to provide evidence that a re-weight was obtained. On 09/20/2024, Nurse Practitioner #1 documented they were asked to see Resident #38 for a new, stage two pressure ulcer (partial thickness loss of skin) measuring 1.5-centimeters by 1-centimeter to the left buttock. The resident received Liquacel twice daily for wound healing and weighed 99.8 pounds. The resident remained a full code. During an observation on 10/07/2024 at 10:22 AM, Resident #38 was in bed with their breakfast tray on the overbed table. Their meal included ground sausage, pureed toast, scrambled eggs, orange juice, a hot beverage, and a four-ounce milkshake. The resident had consumed zero to 25 percent of their meal and beverages. Review of the resident's electronic health record did not include documented meal or fluid intakes for 10/07/2024. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	During continuous observations on 10/09/2024, at 8:45 AM, Resident #38 was in bed. Their meal tray was on the table well out of the resident's reach and contained eight ounces of Ensure, eight ounces of milk, two ounces of scrambled eggs, pureed toast, one ounce ground sausage, and six ounces of hot cereal. At 8:46 AM, an unidentified Certified Nursing Assistant moved the meal tray closer to the resident and left the room without offering any assistance. At 9:53 AM, Licensed Practical Nurse Manager #2 entered the resident's room and removed their meal tray. Review of the resident's electronic health record revealed the breakfast intake was documented as zero to 25 percent. During an observation on 10/09/2024 at 12:55 PM, Certified Nursing Assistant #1 provided Resident #38 their meal tray and left the resident's room. The meal included ground chicken, ice cream, pudding, eight ounces of Ensure, a hot beverage, pureed vegetables, pureed sweet potatoes, and four ounces of orange juice. No assistance was provided. At 1:47 PM, the resident had consumed zero to 25 percent of solids. Review of the resident's electronic health record revealed the meal intake was documented by Certified Nursing Assistant #5 as 76 to100 percent. During continuous observations on 10/10/2024, at 8:38 AM, Certified Nursing Assistant #6 provided Resident #38 their meal tray and left the resident's room. The meal included pureed toast, a four-ounce milkshake, a hot beverage, eggs, hot cereal, and four ounces of orange juice. At 9:03 AM, Licensed Practical Nurse Manager #2 entered the resident's room and asked how they were doing, but did not provide assistance and left the room. At 9:34 AM, the resident's meal tray was observed on the food cart to be returned to the kitchen. The resident had consumed zero to 25 percent of the meal. Review of a progress note, dated 10/10/2024, the Wound Care Nurse Practitioner documented Resident #38 had an in-house acquired stage three pressure ulcer on their right ischium (lower, back part of the hip bone) that measured 1.5-centimeters by 2-centimeters and 1/10-centimeter deep. The resident also had a stage three pressure ulcer acquired outside the facility on their right buttock that measured 3/10-centimeter by 6/10-centimeter and 1/10-centimeter deep. During an interview on 10/10/2024 at 11:52 AM, Certified Nursing Assistant #5 stated prior to assisting a resident they checked the resident's Kardex which included the level of assistance the resident required for eating. They stated extensive assistance meant the resident needed more help, but was not totally dependent on staff for the task. If a resident required extensive assistance at meals, staff needed to watch the resident eat and provide them with assistance. If the resident refused assistance, they would let the nurse know. Certified Nursing Assistant #5 stated the nurse manager let them know who needed to be weighed and they entered the weights into the electronic medical record. If a re-weight was needed, the nurse manager would let them know. Certified Nursing Assistant #5 stated Resident #38 was independent for meals and fed themselves after set-up. Resident #38 did not allow staff to help them with their meals, but staff should check on them during the meal. Certified Nursing Assistant #5 stated Resident #38 was on their assignment 10/08/2024 and 10/09/2024, but the resident did not allow them to assist with their meal. They had not informed the nurse of this. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	During an interview on 10/10/2024 at 5:58 PM, Licensed Practical Nurse Manager #2 stated nursing staff should review the care plans daily and if staff had a question about the care plan they should ask the nurse. Licensed Practical Nurse Manager #2 stated nursing staff was hung up on what extensive assistance at meals meant as it is different than total assistance. They said if a resident did not receive the amount of assistance they were care planned for, it could impact their intakes at meals. Licensed Practical Nurse Manager #2 stated the therapy department determined the resident's level of assistance needed at meals, and the Registered Dietitian informed them if any re-weights were needed. Licensed Practical Nurse Manager #2 stated Resident #38 appeared to have lost weight. During an interview on 10/11/2024 at 8:57 AM, Licensed Practical Nurse Manager #2 stated it was the nurse manager's responsibility to discuss weight loss with the medical team which could be done verbally or written in the acute (medical communication) book on the unit. They could not find any documented evidence Resident #38's weight loss had been discussed with medical. During an interview on 10/11/2024 at 9:30 AM, the Director of Therapy stated Resident #38 required extensive assistance with meals, and extensive assistance meant staff were to provide hands on assistance and cueing during meals. The Director of Therapy stated therapy staff had not been notified of any changes regarding Resident #38's eating abilities. During an interview on 10/11/2024 at 10:23 AM, Registered Dietitian #1 stated they were at the facility once per week and provided coverage remotely as needed. Weights were obtained by nursing staff by the 10th of each month, after that they notified nurse managers of any missing weights and requested re-weights as needed. They asked for re-weights if a resident triggered for a significant change of five percent at one month, seven and one-half percent at three months, and 10 percent at six months. Registered Dietician #1 stated once a resident triggered for a significant weight loss, they reviewed their intakes and progress notes to get the whole picture and determined if any nutrition supplements needed to be added to their meals. They had reminded nursing staff of the importance of accurate meal intake documentation. Registered Dietitian #1 stated Resident #38 had sporadic intakes and had triggered for a significant weight loss in September 2024. They added milkshakes to all three meals and requested a re-weight, but it had not been obtained. Registered Dietitian #1 stated if a resident did not receive assistance per their care plan, it could impact their intake at meals. They were not aware the resident had developed pressure ulcers. During an interview on 10/11/24 at 3:35 PM, the Medical Director stated they expected medical staff to be made aware of significant weight changes. Typically, the Registered Dietitian informed medical of significant weight changes and medical could also review weights in the electronic health record. The Medical Director stated Resident #38 had advanced dementia and was a full code, and while the family was not leaning towards starting tube feedings or intravenous fluids, this was not documented anywhere. Resident #38 should receive the assistance with meals per their care plan. After reviewing the electronic health record at this time, the Medical Director stated they did not see any medical interventions regarding the resident's weight loss. 2. Resident #11 had diagnoses that included dementia, dysphagia (difficulty swallowing), and heart failure. The Minimum Data Set Resident Assessment, dated 08/30/2024, revealed Resident #11 had severely impaired cognition and required moderate assistance (helper assists with less than half the effort) with eating. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The Comprehensive Care Plan, dated 09/18/2024, and Kardex, dated 10/11/2024, included Resident #11 required extensive assistance with meals and received a mechanically soft, pureed diet. Review of current Physician's orders included a regular pureed consistency diet and a Mighty Shake three times a day. During an observation on 10/09/2024 at 1:24 PM, Resident #11 was in bed, eating lunch independently. No facility staff entered the resident's room during the meal and there was no Mighty Shake on the resident's lunch tray as listed on the meal ticket. During an observation on 10/10/24 at 12:52 PM, Resident #11 was in bed, eating lunch independently. No facility staff entered the resident's room during the meal. During an observation at 1:08 PM, Certified Nursing Assistant #1 picked up Resident #11's lunch tray and stated based on the items left on the tray, Resident #11 had consumed less than 25 percent of the meal. Review of weights from April 2024 through August 2024 revealed Resident #11's weight fluctuated from 100 pounds in April 2024 to 96 pounds in August 2024 and to 88 pounds in September 2024 and October 2024. Review of a progress note dated 09/20/2024, Registered Dietician #1 documented Resident #11's meal intakes were between 25 to 50 percent, and weights reviewed from August 2024 to September 2024 revealed the resident was down approximately nine pounds. Registered Dietician #1 noted there was a new scale on the unit which may have affected some difference in numbers. Review of the electronic health record did not include documented evidence that a reweight had been obtained. Review of documented of meal intakes from 08/16/2024 to 10/10/2024 revealed for 168 meal opportunities, staff had documented no documentation for 72 meals, zero to 25 percent for 20 meals, and 26 to 50 percent for 25 meals. During an interview on 10/10/2024 at 1:13 PM, Certified Nursing Assistant #1 said the Kardex in the resident's room included the level of assistance a resident needed. They reviewed Resident #11's Kardex at that time, and stated extensive assist of one (staff member) was listed which meant the resident needed help with opening items but was capable of lifting and eating. During a follow-up interview at 1:34 PM, Certified Nursing Assistant #1 said they had not sat with or assisted Resident #11 with their meals. During an interview on 10/10/2024 at 1:38 PM, Licensed Practical Nurse Manager #2 said the Kardex on the back of the resident's room door indicated what level of assistance they needed. They said staff should also know based on the morning huddle (meeting) and the assignment sheets, which residents required assistance with meals. Licensed Practical Nurse Manager #2 said an extensive assist of one with meals meant the staff should open all food items (on the tray), feed the residents by cueing them to eat but did have to sit with the residents. Instead, staff should go back and forth to check on the resident. Licensed Practical Nurse Manager #2 said Resident #11 would not eat food, only took fluids, and did not receive assistance with meals other than opening items and cueing. During an interview on 10/11/2024 at 12:56 PM, Licensed Practical Nurse #1 said if listed as extensive assistance, staff should be with the resident for the entire meal. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	During an interview on 10/15/2024 at 8:51 AM, the Director of Nursing stated extensive assistance at meals meant staff should physically assist the resident for the entire meal. The Director of Nursing said there was an issue with staff not assisting residents with meals but thought it had been resolved a few months prior. 10 NYCRR 415.12(i)(1)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 46526 Based on observations, interviews, and record review conducted during the Recertification Survey and complaint investigation (NY00354611), for one (Resident #2) of one resident reviewed, the facility did ensure the resident's pain was managed to the extent possible in accordance with the comprehensive assessment and plan of care, current professional standards of practice, and the residents goals and preferences. Specifically, Resident #2 did not receive their pain medication as ordered by the physician on multiple occasions. In addition, there was no evidence that the medical team was notified. This is evidenced by the following: The facility policy Pain Assessment and Management, dated revised October 2010, included to assess the resident's pain and consequences of pain at least every shift for acute pain or significant changes in levels of chronic pain, and at least weekly in stable chronic pain. Ask the resident if they are experiencing pain and be aware that the resident may avoid the term pain and use other descriptors such as throbbing, aching, hurting, cramping, numbness, or tingling. The policy included to review the Medication Administration Record to determine how often the individual requested and received pain medication and to what extent the administered medications relived the resident's pain. The undated facility policy Administration of Oral Medications included the administration of medications would be performed following the six rights of medication administration. The right medication would be administered to the right resident in the right dose, at the right time, via the right route, followed by right documentation. Resident #2 had diagnoses that included chronic pain, osteoporosis (disorder in which bones become weak and brittle), and polymyalgia rheumatica (a form of inflammatory arthritis causing muscle and joint pain). The Minimum Data Set Resident Assessment, dated 08/24/2024, revealed Resident #2 was cognitively intact. The Comprehensive Care Plan included that Resident #2 had chronic pain related to arthritis. Interventions included to administer analgesics (medications to relieve pain) as ordered, monitor and report resident complaints of pain to the nurse, and respond immediately to any complaint of pain. Active physician's orders included tramadol 50 milligrams four times a day for pain (start date 09/26/2024). Review of the Medication Administration Record for October 2024 revealed tramadol doses were not documented as administered on the following dates and scheduled times. - 10/07/2024 at 8:00 AM and 12:00 PM - 10/08/2024 at 8:00 AM and 12:00 PM - 10/09/2024 at 8:00 AM - 10/10/2024 at 4:00 PM and 8:00 PM (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Pharmacy Controlled Substance audit list (resident-specific list of medications removed from the Pyxis [automated medication dispensing system that stored medications] which included the names of nurses who removed the medications) revealed no tramadol doses were removed from the Pyxis with corresponding dates and times to the missing doses observed on the October 2024 Medication Administration Record. During an interview on 10/07/2024 at 11:45 AM, Resident #2 stated they had nerve pain in their legs and feet, which they rated at an eight on a scale of zero to ten. Resident #2 stated they were given pain medications that do not help. In Order-Administration notes, dated 10/07/2024 at 9:05 AM and at 1:30 PM, Licensed Practical Nurse #3 documented that Resident #2's tramadol medication had not been delivered, and they were awaiting arrival from pharmacy. Licensed Practical Nurse #3 documented that the pharmacy was contacted, and the nursing supervisor was made aware. There was no documented evidence that the medical provider had been notified that the medication was unavailable. In Order-Administration notes, dated 10/08/2024 at 1:13 PM and 1:15 PM, Licensed Practical Nurse #3 documented that Resident #2's tramadol had been ordered, were awaiting from pharmacy, and the nurse manager was notified. There was no documented evidence that the medical provider had been notified that the medication was unavailable. In a nursing progress note, dated 10/08/2024 at 2:45 PM, Licensed Practical Nurse Manager #2 documented that they called the pharmacy due to the tramadol not being delivered. Licensed Practical Nurse Manager #2 documented that they spoke with pharmacy's Regional Director of Client Services, and a script (order) was sent to the pharmacy. There was no documented evidence that the medical provider had been notified that the medication remained unavailable. During an interview on 10/09/2024 at 10:29 AM, Resident #2 was in bed and stated they had pain in their legs, which they rated between eight and nine out of ten. Resident #2 stated they asked staff to get them out of bed, so they could put their feet down (which would help their pain). In an Order-Administration note, dated 10/09/2024 at 2:42 PM, Licensed Practical Nurse #3 documented that the pharmacy had not delivered the tramadol and they were unable to get into the emergency medication box in order to administer the medication. Licensed Practical Nurse #3 documented that the nurse manager and the pharmacy had been notified. There remained no documented evidence that the medical provider had been contacted or notified that the medication remained unavailable. During an observation and interview on 10/10/2024 at 10:42 AM, Resident #2 was in bed and stated that staff had brought in the APEX (equipment used to assist residents with transfers out of bed) to get them out of bed, but then someone else came and took it and they remained in bed. Resident #2 stated they were having pain. During an interview on 10/11/2024 at 12:25 PM, Resident #2 was out of bed and stated when they get out of bed and put their feet down, their pain is better. During an interview on 10/11/2024 at 12:37 PM, Certified Nursing Assistant #1 stated Resident #2 had complained of pain and asked staff to place pillows under their legs but that no one seems to help the resident with their pain. (continued on next page)

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	335467	A. Building B. Wing	10/15/2024

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

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 10/11/2024 at 12:56 PM, a blister pack of tramadol tablets with Resident #2's name was in a medication cart on the third-floor residential unit. The blister pack label listed a date of 10/09/2024, and review of the corresponding narcotic count sheet revealed that the blister pack was received on 10/09/2024 at 11:35 PM (well before the missed doses on 10/10/2024). During an interview at the time, Licensed Practical Nurse #1 stated they will ask residents if they are having pain every shift and document it in the Medication Administration Record. Licensed Practical Nurse #1 stated if a medication was due to be given and was not available, they check the Pyxis, and if not there, they would tell the nurse manager, call the pharmacy, inform the oncoming nurse, and document it on the 24-hour report. Licensed Practical Nurse #1 stated Resident #2 had more pain when in bed, and when they saw Resident #2 earlier in the morning, the resident did not express that they were in pain. Additionally, Licensed Practical Nurse #1 stated Resident #2 was scheduled to receive tramadol three to four times a day. During an interview on 10/11/2024 at 2:13 PM, Licensed Practical Nurse Manager #2 stated it is on the resident's Medication Administration Record to ask residents about their pain level daily. Licensed Practical Nurse Manager #2 stated Resident #2 complained of pain all day, every day, and received tramadol four times a day. Licensed Practical Nurse Manager #2 stated the physician said there was not much else they can do since the resident's body is in pain from aging. During a review of Resident #2's October 2024 Medication Administration Record at this time, Licensed Practical Nurse Manager #2 stated they went to the Pyxis and got tramadol doses on 10/07/2024 for Resident #2's scheduled 8:00 AM and 12:00 PM administration (review of the Pharmacy Controlled Substance audit list could not confirm any tramadol doses were removed from the Pyxis by Licensed Practical Nurse Manager #2). Licensed Practical Nurse Manager #2 stated the nurses should document in a progress note if a medication was taken from the Pyxis and given to a resident. During an interview on 10/15/2024 at 8:51 AM, the Director of Nursing stated if a medication was due to be given and was unavailable, they should check the Pyxis, and if it was still unavailable, go to their supervisor. The Director of Nursing stated the supervisor should them notify them if they need the medication immediately. The Director of Nursing stated the steps for nurses to take if a medication was unavailable were posted on each medication cart. The Director of Nursing stated if a nurse gave a medication after it was unavailable, it should be documented in a progress note. The Director of Nursing stated sometimes there are issues with getting narcotic medications (from the pharmacy) because the order must have a doctor's signature before it is sent. The Director of Nursing stated resident's pain levels must be documented every shift, and it is important for residents to receive pain medication, so they are kept out of pain. The Director of Nursing stated it was hard to answer why there are issues with getting medications from the pharmacy since the process should be automatic. 10 NYCRR 415.12

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 46526 Based on observations, interviews, and record review conducted during the Recertification Survey and complaint investigations (NY00354611 and NY00349191), for two (Second Floor and Third Floor) of two resident units, the facility did not ensure sufficient staffing to provide nursing services to attain or maintain the highest practical physical, mental, and psychosocial well-being for residents in the facility. Specifically, there were several observations of residents who were in bed and wearing hospital gowns during the late morning hours, residents with dirty, unkept fingernails, and residents that were not provided assistance with meals as care planned. The findings include, but not limited to, the following: For additional information see the Centers for Medicare/Medicaid Services Form 2567: F677 Activities of Daily Care Provided for Dependent Residents, F565 Resident/Family Group and Response, and F692 Nutrition/Hydration Status and Maintenance. Review of the Facility Assessment, dated October 2024, revealed the facility was licensed for 80 beds with an average daily census of 70 to 75 residents. Resident care and services included, but were not limited to, assistance with activities of daily living. The facility's staffing plan listed eight Certified Nursing Assistants from 7:00 AM to 3:00 PM (day shift), eight from 3:00 PM to 11:00 PM (evening shift), and four from 11:00 PM to 7:00 AM (night shift). The direct care staff (Certified Nursing Assistant) to resident ratio listed one Certified Nursing Assistant to eight residents for day shift, one Certified Nursing Assistant to 10 residents for evening shift, and one Certified Nursing Assistant to 20 residents for night shift. During the entrance conference on 10/07/2024 at 8:58 AM with the Administrator and Director of Nursing, it was reported that the facility census was 73 residents. Observations and interviews on the Third-floor unit (unit census was 39 residents) included: a. During observations on 10/07/2024 at 7:54 AM, Licensed Practical Nurse Manager #2 was passing medications to residents and the Medical Records Coordinator was assisting on the unit. b. During observations on 10/07/2024 at 8:23 AM, Licensed Practical Nurse Manager #2 and the Medical Records Coordinator were passing breakfast trays to residents. c. During an interview on 10/07/2024 at 9:00 AM, Resident #38 stated staff sometimes do not get them up until 12:00 PM, when the resident would prefer to get up between 10:00 AM to 10:30 AM. d. On 10/07/2024 at 9:35 AM, two Certified Nursing Assistants and two nurses were observed on the unit. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	e. During observations on 10/07/2024 between 9:50 AM to 1:17 PM, 14 residents were still in bed wearing hospital gowns/night shirts. At 11:46 AM, Resident #2 was still in a hospital gown. During an interview at this time, Resident #2 stated they wanted the hospital gown off and had been asking to get out of bed since 10:00 AM. They were supposed to be up and dressed for lunch in the dining room. Resident #2 stated since they had not been assisted out of bed, they would not be able to go to lunch in the dining room. f. During observations on 10/07/2024 at 12:17 PM, a white board behind the nurses' station read All residents up by 11:00 AM. g. During an interview on 10/07/2024 at 3:30 PM, Licensed Practical Nurse Manager #2 stated the unit had 22 residents that required a mechanical lift and 17 residents that required a standing lift for transfers. The unit would frequently have only two Certified Nursing Assistants and the residents' needs were too heavy to have only two aides. h. During observations on 10/9/2024 at 8:45 AM and 12:55 PM, and on 10/10/2024 at 8:38 AM, Resident #38 who was care planned to receive extensive assistance during meals, was eating independently and without the assistance of staff. i. During observations on 10/09/2024 at 10:20 AM, 10/10/2024 at 11:58 AM, and 10/11/2024 at 12:31 PM, Resident #11 had debris underneath their fingernails. On 10/09/2024 at 1:24 PM and 10/10/2024 at 12:52 PM, Resident #11 who was care planned to receive extensive assistance during meals, was eating independently and without the assistance of staff. Observations and interviews on the Second-floor unit (unit census was 34 residents) included: a. During an observation and interview on 10/07/2024 at 10:07 AM, Resident #10 was in bed wearing a hospital gown. They stated they preferred to be up by 9:00 AM and almost never got up that early because there was no staff. Resident #10 stated they were told there was only one Certified Nursing Assistant, and it would be 11:00 AM or 12:00 PM before someone could assist them. At 11:29 AM, Resident #10 was wearing a shirt and stated they were half dressed and waiting for assistance with lower body dressing. b. During an interview on 10/07/2024 at 10:08 AM, Licensed Practical Nurse Manager #1 stated staffing on the second-floor unit for that day was two Licensed Practical Nurses, two Certified Nursing Assistants, and a unit manager to care for 34 residents. They stated a staff member had called off, and normally day shift staffing was two Licensed Practical Nurses and four Certified Nursing Assistants. Licensed Practical Nurse Manager #1 stated the nurses should be helping with residents who required the assistance of two staff and answering call bells. c. During an interview on 10/07/2024 at 10:51 AM, Resident #47 stated there was only one Certified Nursing Assistant on night shifts, had to wait forever to get assistance with care, and would end up soiling themselves (episode of incontinence). (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a special Resident Council meeting on 10/09/2024 at 11:00 AM, residents voiced the facility was often short staff on the evening shifts, which staff often expressed to the residents. Residents stated on Monday, 10/07/2024, the third-floor unit started with one aide. On a Sunday day shift, about one month and a half prior, there were only two Certified Nursing Assistants working on the third floor, residents were unable to get out of bed and were told to stay in bed because staff did not have time. Residents stated they were told by staff (scheduled to leave at 7:00 PM), if they did not go to bed before 7:00 PM, they would have to wait for the next shift (11:00 PM) to receive assistance. Resident #26 stated at times they have had to wait a long time, between two to ten hours (after pressing their call button) for assistance and some days they gave up and went to their activity soaked (incontinent). Review of actual nursing staffing sheets from 08/01/2024 to 10/10/2024, for the two 40-bed units, revealed the following: - On 08/10/2024, there were two Certified Nursing Assistants on the Third floor from 3:00 PM to 11:00 PM. - On 08/18/2024, there were two Certified Nursing Assistants on the Third floor from 7:00 AM to 3:00 PM. - On 08/19/2024, there were two Certified Nursing Assistants on each unit (Second and Third floors) from 3:00 PM to 11:00 PM. - On 08/23/2024, there was one Certified Nursing Assistant on the Second floor from 11:00 PM to 7:00 AM. - On 08/25/2024, there were two Certified Nursing Assistants on the Second floor from 7:00 AM to 3:00 PM, with documentation that both arrived late. - On 08/26/2024, there was one Certified Nursing Assistant on each floor from 11:00 PM to 7:00 AM. - On 08/25/2024, there were two Certified Nursing Assistants on the Second floor from 7:00 AM to 3:00 PM, with documentation that both arrived late. - On 09/04/2024, there was one Certified Nursing Assistant on each floor from 11:00 PM to 7:00 AM. - On 09/05/2024, there were two Certified Nursing Assistants on the Second floor from 7:00 PM to 11:00 PM. - On 09/06/2024, there was one Certified Nursing Assistant on each floor from 11:00 PM to 7:00 AM. - On 09/07/2024, there was one Certified Nursing Assistant on the Third floor from 11:00 PM to 7:00 AM. - On 09/08/2024, there was one Certified Nursing Assistant on the Third floor from 7:00 PM to 11:00 PM, and one Certified Nursing Assistant on the Second floor from 8:00 PM to 11:00 PM. - On 09/10/2024, there was one Certified Nursing Assistant on each unit from 11:00 PM to 7:00 AM. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- On 09/11/2024, there was one Certified Nursing Assistant on each unit from 11:00 PM to 7:00 AM. - On 09/17/2024, there were two Certified Nursing Assistants on the Third floor from 8:00 PM to 11:00 PM. - On 09/19/2024, there were two Certified Nursing Assistants on the Third floor from 1:00 PM to 4:30 PM. - On 09/28/2024, there was one Certified Nursing Assistant on the Third floor from 11:00 PM to 7:00 AM. - On 10/07/2024, there were two Certified Nursing Assistants on the Second floor from 7:00 AM to 3:00 PM. On the Third floor, one Certified Nursing Assistant was scheduled to start at 7:00 AM, another scheduled to start at 8:00 AM, and a third scheduled to start at 12:00 PM. During an interview on 10/10/2024 at 5:18 PM, Licensed Practical Nurse Manager #2 stated on Monday morning (10/07/2024) at the start of the day shift (7:00 AM), the night shift staff had already left and there were no Certified Nursing Assistants assigned to the unit. They were the only nurse and the only other staff member on the unit was the Medical Records Coordinator. During an interview on 10/11/2024 at 12:37 PM, Certified Nursing Assistant #1 stated the unit was short-staffed on Monday (10/07/2024) day shift and they forgot to document a resident's bowel movement. During an interview on 10/11/2024 at 12:56 PM, Licensed Practical Nurse #1 said on Monday, 10/07/2024 day shift, there were only two Certified Nursing Assistants on the Second-floor unit, staffing was typically like that on weekends. Licensed Practical Nurse #1 stated depending on the resident census, with two Certified Nursing Assistants, they could potentially have an assignment of 20 residents each. During an interview on 10/15/24 at 8:51 AM, the Director of Nursing stated minimum nursing staffing in the facility consisted of two nurses, a unit manager and four Certified Nursing Assistants on each floor during the day shift; four Certified Nursing Assistants for each unit on the evening shift, and four Certified Nursing Assistants would be in the building for the night shift (two assigned to each unit). The Director of Nursing stated if minimum staffing levels were not met, everyone would assist, and attempts would be made to replace the (missing) staff. If minimum staffing levels were not met, the impact would include residents getting up late or scheduled showers postponed until the next day when the unit was fully staffed. During an interview on 10/15/2024 at 11:11 AM with the Administrator and Regional Administrator, the Regional Administrator stated the facility had met their staffing levels. 10 NYCRR 415.13 (a)(1)(i-iii)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 40803 Based on interviews and record review conducted during the Recertification Survey from 10/07/2024 to 10/15/2024, for one (Resident #59) of two residents reviewed, the facility did not ensure licensed nurses have the specific competencies and skill sets necessary to care for residents' needs as identified through resident assessments and described in the plan of care. Specifically, Resident #59 who had nephrostomy tubes (thin, flexible tubes that drain urine from the kidney into a bag outside the body), nursing staff reported not having received training related to the care and management of nephrostomy tubes and the facility was unable to provided documented evidence of any trainings or related competencies. This is evidenced by the following: Review of the Facility Assessment Tool, dated October 2024, revealed the facility was licensed to provide care for 80 residents and had an average daily census of 70 to 75 residents. The assessment did not address residents that had diagnoses/conditions related to obstructive and reflux uropathy (urinary tract conditions that can cause urine to flow abnormally), chronic obstructive pyelonephritis (a kidney condition that results from repeated kidney infections and scarring), and presence of urogenital implants (a synthetic material that can be placed in the urinary organs or genitals). Resident support and care needs included general care of the bladder with specific care/practices including, but not limited to, intermittent/indwelling/other urinary catheters. For the management of medical conditions, the facility would offer assessment, early identification of problems, and management of symptoms and conditions. Additionally, as part of the facility's staffing plan, the facility would provide staff training, and education and competencies that were necessary to provide the level and types of support and care needed for their resident population. The undated facility policy Care of a Nephrostomy Tube included instructions for the irrigation and dressing change of a nephrostomy tube and noted the procedure was a Registered Nurse only procedure secondary to needing an assessment. The facility was unable to provide documented evidence that nursing staff had received any training and were competent to provide care for nephrostomy tubes. Resident #59 had diagnoses including obstructive and reflux uropathy, chronic obstructive pyelonephritis, and presence of urogenital implants. The Minimum Data Set Resident Assessment, dated 08/05/2024, included the resident had moderately impaired cognition and had an indwelling catheter (nephrostomy tube). Review of the current Comprehensive Care Plan, last revised 10/11/2023, included Resident #59 had renal failure related to kidney disease with bilateral nephrostomy tubes. Interventions included, but were not limited to, monitor for signs/symptoms of infection, check placement of nephrostomy tubes and red areas as needed, and a Registered Nurse was to flush nephrostomy tubes daily. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Physician's orders, initiated on 04/29/2024, included Registered Nurse to flush nephrostomy under sterile technique every shift as needed if urine output less than 100 milliliters, empty nephrostomy tube every shift for monitoring output, nephrostomy tube dressing change under sterile technique/measure length of tubing from insertion site to hub, and document/check suture placement every three days for nephrostomy maintenance - Licensed Practical Nurse may change the dressing. During an interview on 10/10/2024 at 1:30 PM, Licensed Practical Nurse #1 stated they had worked at the facility since March 2024. There was one resident at the facility that had nephrostomy tubes and they had not received any education or competencies on nephrostomy tube care while employed at the facility. During an interview on 10/11/2024 at 8:57 AM, Licensed Practical Nurse Manager #2 stated they had worked at the facility since July 2024 and had not received any training or competencies on nephrostomy tube care. During an interview on 10/11/2024 at 9:25 AM, Licensed Practical Nurse #10 stated Resident #59 was on their assignment, they had worked at the facility for two years, and had not received any training regarding nephrostomy tube care. During an interview on 10/11/2024 at 1:53 PM, the Nurse Educator/Infection Preventionist stated they had been working at the facility since March 2024 and nephrostomy tube care was simple. They stated they could not find any documented education, trainings, or competencies related to nephrostomy tube care for nursing staff at that time. During an interview on 10/11/2024 at 3:34 PM, the Medical Director stated it was rare to see a resident with nephrostomy tubes in a long-term care setting. It was important for staff to follow medical orders for nephrostomy tubes, especially flushing, as there could be issues with proper drainage due to sediment and nephrostomy tubes were known for potential infection. The Medical Director did not know if the facility staff had received training or competencies related to nephrostomy care, but stated it should be treated like any insertion device. During an interview on 10/15/2024 at 8:51 AM, the Director of Nursing stated there were no documented competencies or trainings for the nursing staff related to nephrostomy tube care. During an interview on 10/15/2024 at 11:11 AM with the Administrator and Regional Administrator, the Regional Administrator stated the Quality Assurance committee was not aware of any concerns related to the care and management of nephrostomy tubes. 10 NYCRR 415.26(c)(2)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 39181 Based on observations, interviews, and record review conducted during the Recertification Survey from 10/07/2024 to 10/15/2024, for one (Resident #18) of five residents reviewed, the facility did not ensure a resident was not given psychotropic (medication used to treat mental processes and behaviors) drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record. Specifically, Resident #18 was prescribed an antipsychotic (medication used to treat symptoms of psychosis such as hallucinations, delusions, and agitation) medication and there was no documentation in the clinical record to show the resident was experiencing behavioral symptoms that presented a danger to the resident or others, symptoms of significant distress, monitoring for the effectiveness of the medication, and/or the resident's response to the treatment. The consultant pharmacist documented recommendations related to the antipsychotic in August 2024 and September 2024, and the facility was unable to provide documented evidence the recommendations were accepted or rejected by a medical provider and/or their rationale. Additionally, the resident was first prescribed the antipsychotic on 08/17/2024, and a comprehensive care plan, to include measurable goals and interventions for its use, was not developed until 10/14/2024. This is evidenced by the following: Review of the facility policy and procedure Antipsychotic Medication Use, dated April 2007, included residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective. The Attending Physician and other staff will gather and document information to clarify a resident's behaviors, mood, function, medical condition, symptoms, and risks. Nursing staff will document in detail an individual's target symptom(s). The Attending Physician will identify, evaluate, and document, with input from other disciplines and consultants as needed, symptoms that may warrant the use of antipsychotic medications. The staff will observe, document, and report to the Attending Physician information regarding the effectiveness of any interventions, including antipsychotic medications. Antipsychotic medications shall only be used for the following conditions/diagnoses as documented in the record including, but not limited to, mood disorders, depression with psychotic features, treatment of refractory major depression (a type of depression that does not respond to multiple types of antidepressant therapies), and dementing illnesses with associated behavioral symptoms. Antipsychotic medications will not be used if the only symptoms include, but are not limited to, poor self-care, impaired memory, mild anxiety, unsociability, inattention or indifference to surroundings, uncooperativeness, or behaviors that do not represent a danger to the resident or others. The Physician shall respond appropriately by changing or stopping problematic doses or medications, or clearly documenting (based on assessing the situation) why the benefits of the medication outweigh the risks of suspected or confirmed adverse consequences. Resident #18 had diagnoses including major depressive disorder, anxiety disorders, and polyneuropathy. The Minimum Data Set Resident Assessment, dated 10/06/2024, included the resident was cognitively intact, had no or minimal depression, did not exhibit behaviors, and was taking antidepressant and antipsychotic medications. The Minimum Data Set Resident Assessment, dated 07/06/2024, included the resident was cognitively intact, had no or minimal depression, did not exhibit behaviors, and was taking antidepressant medication. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a medical order, dated 08/17/2024, included Seroquel (an antipsychotic medication) 25 milligrams at bedtime. There was no associated diagnosis or indication for its use at that time. Review of Resident #18's medical order history included Remeron (an antidepressant) was discontinued on 06/13/2024 and Cymbalta (an antidepressant) was discontinued on 08/21/2024. Current medical orders did not include a prescribed antidepressant. Review of the Comprehensive Care Plan, initiated on 07/19/2023, included Resident #18 used antidepressant medication related to a diagnosis of depression. Interventions included, but were not limited to, administer medications as ordered by the physician and to monitor, document, and report side effects per provider order. The care plan did not address the use of an antipsychotic medication and did not include target behaviors for the use of an antipsychotic or individualized, non-pharmacological behavioral interventions. Review of progress notes from 06/10/2024 to 10/10/2024 revealed the resident had occasional refusals of care which included refusals to put on a hand guard/splint to treat a contracture related to increased pain with its use, complaints of pain, but later declining as-needed pain medication, and infrequent refusals of other medications. There were no documented behaviors that posed a danger to the resident or others and/or symptoms of significant mental distress. Review of a provider visit note (with an effective date of 06/12/2024 but signed by the Medical Director on 08/24/2024) documented the resident was reviewed for psychotropic drug regimen and the interdisciplinary team met to evaluate Resident #18's behaviors and consideration for a gradual dose reduction if appropriate. The resident had depression, was receiving Remeron (an antidepressant) for appetite, Cymbalta (an antidepressant) for neuropathy, and to consider tapering (gradually reducing a medication dose to avoid or lessen adverse symptoms) in the future. The list of active medications included Seroquel 25 millligrams at bedtime, but did not include Remeron or Cymbalta. The plan for major depressive disorder included to taper Remeron and monitor, and continue Cymbalta with a taper to be considered in the future. Review of provider visit notes from 06/10/2024 to 10/10/2024 did not include documentation that supported the use of Seroquel, to include significant behaviors or exacerbation of a chronic psychiatric condition. Additionally, there was no documentation from a medical provider during August 2024 that clearly and specifically identified Resident #18's symptoms/behaviors, non-pharmacological approaches that had been attempted, or therapeutic goals for initiating treatment with Seroquel. Review of Psychoactive Medication Use Recommendations, dated 08/26/2024, revealed the consultant pharmacist documented Resident #18 recently started on Seroquel with no clear diagnosis to support current use and to consider a psychosocial and medical workup to assess for underlying causes of behaviors. There was no documented evidence the recommendations were accepted or rejected by a medical provider and/or their rationale. Review of Psychoactive Medication Use Recommendations, dated 09/28/2024, the consultant pharmacist documented Resident #18 was receiving Seroquel 12.5 milligrams at bedtime for mental health. There were no recent behavior problems apparent on review of documentation in the clinical record and to consider discontinuing the medication or documenting the inability to do so. There was no documented evidence the recommendations were accepted or rejected by a medical provider and/or their rationale. (continued on next page)

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	335467	A. Building B. Wing	10/15/2024

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

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observations on 10/07/2024 at 8:53 AM, 10/08/2024 at 8:39 AM, and 10/09/2024 at 8:49 AM, Resident #18 was awake in bed and appeared comfortable with no obvious signs or symptoms of depression, anxiety, behaviors, or other indications of distress. During an interview on 10/11/2024 at 3:42 PM, the Medical Director stated that Seroquel to treat mental health would not be a medical indication, but may have been an option in the electronic health record for the nurses who input the medical orders. Resident #18 had a diagnosis of major depressive disorder, and it would be an appropriate diagnosis for the use of Seroquel. The Medical Director reviewed the clinical record at that time and stated the provider that prescribed the Seroquel had recently and unexpectedly passed away, and there was no note related to the order, but would suspect it was associated with Resident #18's major depressive disorder. The Medical Director stated psychotropic medication review meetings were held monthly with the interdisciplinary team to discuss residents who were on antipsychotics. They stated nursing documentation of behaviors could be better, which was why the team met routinely to review each resident. During an interview on 10/15/2024 at 9:20 AM, the Director of Nursing stated Resident #18's only behavior was refusing to get out of bed due to their preference to stay in bed. The Director of Nursing stated they would expect a resident with a diagnosis of major depressive disorder could be prescribed Seroquel even without documented behaviors and that nursing documentation was not good, but it was a work in progress. The Director of Nursing stated the facility monitored the need for gradual dose reductions closely, the Medical Director attended the gradual dose reduction meetings monthly and was very involved in the process. During an interview on 10/15/2024 at 11:11 AM with the Administrator and Regional Administrator, the Regional Administrator stated they had discussed Resident #18 with the medical provider who stated the Seroquel was prescribed to treat clinical depression and the medication was clinically indicated per the provider. The Regional Administrator stated some pharmacy recommendations were not in the facility at that time as they had been taken home by a provider who had recently and unexpectedly passed away. 10 NYCRR 415.18(c)(1)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 46526 Based on observations, interviews, and record review conducted during a Recertification Survey and complaint investigations (NY00354611 and NY00349191), for two (Residents #1 and #182) of six residents observed during medication administration, the facility did not ensure its medication error rate was less than five percent. There were three medication errors for 47 opportunities resulting in a medication error rate of 6. 38 percent. Specifically, three medications were omitted (resident did not receive a medication that was ordered) during the observation due to being unavailable in the facility. This is evidenced by the following: 1. Resident #1 had diagnoses including bipolar disorder, anxiety disorder, and major depressive disorder. The Minimum Data Set Resident Assessment, dated 09/07/2024, included the resident was cognitively intact. Current physician's orders included, but were not limited to, lamotrigine 100 milligram tablet, give 50 milligrams with 25 milligram tablet (total dose = 75 milligrams) daily at 8:00 AM for bipolar disorder. During a medication administration observation on 10/10/2024 at 8:16 AM with Licensed Practical Nurse #4, the dose of lamotrigine was unavailable in the facility for administration. During an interview on 10/10/2024 at 8:30 AM, Licensed Practical Nurse #4 stated they had checked the Pyxis (an automated medication dispensing system), but the lamotrigine dose was not available. 2. Resident #182 had diagnoses including neuropathy (weakness, numbness, and pain from nerve damage), vitamin B12 deficiency, and hypertension. The Minimum Data Set Resident Assessment, dated 10/01/2024, included the resident was cognitively intact. Current physician orders included, but were not limited to, gabapentin 400 milligram capsule, give four capsules (total dose = 1600 milligrams) daily for pain, and cyanocobalamin 500 micrograms daily for vitamin B12 deficiency. During a medication administration observation and interview on 10/10/2024 at 8:57 AM with Licensed Practical Nurse #2, the doses of cyanocobalamin and gabapentin were unavailable in the facility for administration. During an interview at that time, Licensed Practical Nurse #2 stated they had contacted the pharmacy the previous day to reorder the cyanocobalamin, but it had not been delivered yet. They stated the gabapentin dose was not available in the Pyxis and the pharmacy would need to be notified. Licensed Practical Nurse #2 stated the facility had issues with medications not being available due to the pharmacy not delivering them timely. During an interview on 10/11/2024 at 2:13 PM, Licensed Practical Nurse Manager #2 stated that omitting a medication would be considered a medication error. During an interview on 10/15/2024 at 8:51 AM, the Director of Nursing stated that omitting a medication would be considered a medication error. They were only aware of medications not being available to administer when they were directly involved with getting the medications sent from pharmacy. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/15/2024 at 11:11 AM with the Administrator and Regional Administrator, the Regional Administrator stated the facility was aware that there was an ongoing issue related to medications not being available at the time of administration, and the Director of Nursing had previously done weekly audits and reeducated the staff. 10 NYCRR 415.12(m)(1)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. 39181 Based on observations, interviews, and record review conducted during the Recertification Survey and complaint investigations (ACTS Reference Numbers: NY00354611 and NY00349191), for three (Residents #1, #2, and #53) of eight residents reviewed, the facility did not ensure residents were free from significant medication errors. Specifically, for Resident #1 who had diagnoses of a bipolar disorder and anxiety and was prescribed an antianxiety (lorazepam) medication and a mood stabilizer (lamotrigine), a medication administration observation and medical record review revealed the medications were frequently documented as unavailable in the facility for administration. For Resident #2 who had chronic pain and was prescribed a narcotic pain medication (tramadol), there was frequent documentation in the medical record that indicated the medication was unavailable in the facility to be administered. For Resident #53 who had diagnoses of major depressive disorder, hypertensive heart disease with heart failure, history of stroke, and diabetes and was prescribed an antihypertensive (metoprolol), an anticoagulant (clopidogrel), an antidepressant (trazodone), and insulin (Humalog), there was frequent documentation in the medical record that indicated the medications were unavailable in the facility to be administered. This is evidenced by the following: The facility policy and procedure Medication Error, dated 12/19/2022, included a type of medication error was omission (not administered before the next scheduled dose was due). When a medication error occurred, the physician should be notified and evaluate the resident, the notification of the physician should be recorded in the medical record with any resultant orders, and any actions or clinical interventions taken should be recorded. 1. Resident #1 had diagnoses including bipolar disorder, anxiety disorder, and major depressive disorder. The Minimum Data Set Resident Assessment, dated 09/07/2024, included the resident was cognitively intact and had moderate depression. Review of the current Comprehensive Care Plan included Resident #1 used an antidepressant medication to treat depression and an antianxiety medication to treat anxiety disorder. Interventions included, but were not limited to, administer medications as ordered by the physician. Review of current medical orders included, but were not limited to, lorazepam at bedtime for anxiety and lamotrigine twice daily for bipolar disorder. During a medication administration observation on 10/10/2024 at 8:16 AM with Licensed Practical Nurse #4, the dose of lamotrigine was unavailable in the facility for administration. During an interview on 10/10/2024 at 8:30 AM, Licensed Practical Nurse #4 stated they had checked the Pyxis (an automated medication dispensing system), but lamotrigine was not available. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the September 2024 Medication Administration Record revealed lamotrigine scheduled on 09/29/2024 at 7:00 PM was signed and coded 9 (see progress note). Lorazepam scheduled on 09/07/2024, 09/11/2024, 09/12/2024, 09/13/2024, 09/14/2024, and 09/25/2024 at 9:00 PM were signed and coded 9; on 09/24/2024 at 9:00 PM was signed and coded 5 (hold/see progress notes); and on 09/27/2024 at 9:00 PM was blank (no documentation to show the medication was administered). Review of corresponding progress notes revealed the medication was on order and awaiting arrival from pharmacy. Review of progress notes did not include relevant documentation about the missed lorazepam dose on 09/27/2024. Review of the June 2024 Medication Administration Record revealed lorazepam scheduled on 06/11/2024, 06/12/2024, 06/13/2024, and 06/14/2024 at 9:00 PM was signed and coded 9. Review of corresponding progress notes revealed the medication was on order awaiting arrival from pharmacy or awaiting a provider signature. 2. Resident #2 had diagnoses including chronic pain, hypertension, and anemia. The Minimum Data Set Resident Assessment, dated 08/24/2024, included the resident was cognitively intact. Review of the current Comprehensive Care Plan included Resident #2 had chronic pain related to arthritis and polymyalgia rheumatica (an inflammatory disorder that causes muscle pain and stiffness). Interventions included, but were not limited to, administer medication as per medical orders, anticipate the resident's need for pain relief, and respond immediately to any complaint of pain. Review of current medical orders included, but were not limited to, tramadol hydrochloride (a narcotic medication used to treat moderate to severe pain) 50 milligrams four times daily for pain. Review of the September 2024 Medication Administration Record revealed tramadol scheduled on 09/09/2024 at 8:00 PM; on 09/10/2024 at 8:00 AM, 12:00 PM, 4:00 PM and 8:00 PM; on 09/18/2024 at 12:00 PM, on 09/20/2024 at 4:00 PM; and on 09/22/2024 at 4:00 PM were signed with code 9. Review of corresponding progress notes revealed the medication was on order and awaiting arrival from pharmacy, order was pending a provider signature, or was unavailable. Review of the October 2024 Medication Administration Record revealed tramadol scheduled on 10/07/2024 at 8:00 AM and 12:00 PM; on 10/08/2024 at 8:00 AM and 12:00 PM; on 10/09/2024 at 8:00 AM; and on 10/10/2024 at 4:00 PM and 8:00 PM were signed with code 9. On 10/07/2024 at 4:00 PM and 8:00 PM were signed with code 5. Review of corresponding progress notes revealed the medication was on order and awaiting arrival from pharmacy. 3. Resident #53 had diagnoses including major depressive disorder, hypertensive heart disease with heart failure, history of stroke, and diabetes. The Minimum Data Set Resident Assessment, dated 08/11/2024, included the resident had moderately impaired cognition. Review of the current Comprehensive Care Plan included Resident #53 was prescribed antidepressant medications related to a diagnosis of depression, was on anticoagulant therapy related to history of stroke, and had diabetes. Interventions included, but were not limited to, administer medications as ordered by the physician. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of current medical orders included, but were not limited to, metoprolol twice daily for hypertension, clopidogrel once daily for cerebral vascular accident, trazadone at bedtime for anxious depression, and Humalog (a fast-acting insulin) twice daily for diabetes. Review of discontinued orders included an order dated 06/13/2024 for Diflucan (medication used to treat yeast infections) 150 milligram tablet give one tablet on 06/13/2024 and one on 06/16/2024 for peri-rectal area and folds. Review of the September 2024 Medication Administration Record revealed metoprolol scheduled on 09/17/2024 at 8:00 PM, 9/18/2024 and 09/19/2024 at 8:00 AM were signed with code 9. Clopidogrel scheduled on 09/18/2024 at 8:00 AM was signed with code 9. Trazodone scheduled on 09/27/2024 at 9:00 PM was blank (no documentation to show the medication was administered). Review of corresponding progress notes revealed the metoprolol and clopidogrel were on order and there was no relevant documentation about the missed dose of trazodone. Review of the August 2024 Medication Administration Record revealed trazodone scheduled on 08/03/2024 at 9:00 PM was blank (no documentation to show the medication was administered). Review of progress notes did not include relevant documentation about the missed medication. Review of the June 2024 Medication Administration Record revealed trazodone scheduled on 06/08/2024 at 9:00 PM was signed with code 9. Humalog insulin scheduled on 06/21/2024 at 4:00 PM was signed with code 9 and there was no blood glucose value documented. Diflucan 150 milligrams scheduled on 06/16/2024 at 9:00 AM was signed with code 9. Review of corresponding progress notes revealed the medications were unavailable. During an interview on 10/11/2024 at 3:34 PM, the Medical Director stated that all medications are significant with the exception of an as needed medication that is not being used. Medications to treat anxiety or depression would be significant for a resident with those diagnoses. The Medical Director stated there were a number of issues with medications not being available when they took over the position of Medical Director in March 2024. They felt there was a lack of communication where the pharmacy was concerned, including inconsistent follow-up with the nurses and/or providers when medications were not available, and poor management with how the pharmacy received and tracked orders. The Medical Director stated they were not aware of current issues with medications being unavailable for any prolonged period of time and was under the impression the process had improved. If a medication was unavailable, the Medical Director stated the nursing staff should contact pharmacy to get it delivered and important medications could be sent on a rush delivery. There were times that some medications were held up at the pharmacy because they required a physician's order. The Medical Director stated that some medications could wait to be given and others could not. There were alternative medications available in the facility that could be ordered if there was a concern with a medication not being available. The Medical Director stated nursing staff would typically notify a medical provider when a medication was unavailable or if a medication order needed to be signed. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/15/2024 at 8:51 AM, the Director of Nursing stated almost all medications would be considered significant because every medication was prescribed for a reason. Some significant medications would include cardiac, pain, and diabetic medications. The Director of Nursing stated that omitting a medication would be considered a medication error, and they were only aware of medications not being available to administer when they were directly involved with getting the medications sent from pharmacy. If a medication was unavailable, the Director of Nursing stated they would expect the nurse to first check the Pyxis (an automated medication dispensing system), and if still not available, to contact the nursing supervisor so the medication could be delivered from pharmacy right away. They would also expect the nurse to document in a progress note once the medication was received from pharmacy and administered. During an interview on 10/15/2024 at 11:11 AM with the Administrator and Regional Administrator, the Regional Administrator stated the facility was aware there was an ongoing issue related to medications not being available at the time of administration and the Director of Nursing had previously done weekly audits and reeducated the staff. 10 NYCRR 415.12(m)(2)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 46526 Based on observations, interviews, and record review conducted during the Recertification Survey from 10/07/2024 to 10/15/2024, for two (Second Floor and Third Floor) of two resident care units, the facility did not ensure they maintained all mechanical, electrical, and patient care equipment in safe operating condition. Specifically, for the Third Floor, a mechanical lift wheel was missing the rubber around the wheel, causing the mechanical lift to tilt. Additionally, both resident care units did not have enough assistive equipment, including mechanical lifts and sit-to-stand lifts, to adequately provide for the transfer needs of the residents. This is evidenced by the following: The facility policy Mechanical, Electrical, and Patient Care Equipment, dated 11/22/2017, documented all equipment, before being placed in the facility and used, must be checked that it is in safe operating condition. All existing equipment, including electrical patient care equipment, will be checked through a preventative maintenance check to ensure proper functioning. If the equipment is found to be in non-working condition, it is reported to the Maintenance Director who will work to replace or repair the equipment. Review of the monthly preventative maintenance logs and annual electrical inspection vendor logs for the electrical patient lifts revealed the units documented on the logs did not match the lifts currently in use on the resident care units. Review of a facility list of residents who required the use of assistive devices included, but was not limited to, the following: a. The second-floor unit had five residents that used the mechanical lift and six residents that used the sit-to-stand lift. b. The third-floor unit had 16 residents that used the mechanical lift and eight residents that used the sit-to-stand lift. c. The facility had a total of three mechanical lifts and three sit-to-stands lifts currently in use. During several observations on 10/07/2024 between 10:45AM and 11:55 PM, 10 residents on the third-floor unit were still in bed wearing hospital gowns. During an interview on 10/07/2024 at 1:26 PM, Resident #18 stated the mechanical lift and sit-to-stand lift were not working well. The lifts were dirty, and the mechanical lift was broken. During an interview on 10/09/2024 at 11:00 AM, participants of a special Resident Council meeting stated equipment at the facility was faulty. Specifically, a mechanical lift on the third floor had a missing wheel and was still being used. The facility staff were aware and told the residents they were waiting for parts. A sit-to-stand lift had loose bolts and was also still in use. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/09/2024 at 11:09 AM, Certified Nursing Assistant #3 stated there was only one sit-to-stand lift on the (second floor) unit. The second floor usually had two lifts on the unit, but the third-floor staff borrowed the other lift because they had a lot of residents who needed it. Certified Nursing Assistant #3 stated that often times, having two sit-to-stand lifts was not enough because of the number of residents who used them, and residents often had to wait for assistance with getting up for the day or with transfers to use bathroom because the equipment was not available. During an observation and interview on 10/10/2024 at 10:00 AM, a patient mechanical lift located on the third-floor unit and labeled #9959, had a broken right wheel; there was no rubber surrounding the wheel and it was resting flat on the ground. The lift was tested for movement and did not roll but instead dragged across the floor. During an interview at this time, the Maintenance Director stated the broken wheel had previously been identified, but was not sure how long ago. Staff were still using the lift in its current condition and although they wanted to replace the wheel, a new one could not be ordered without approval. During an observation on 10/10/2024 at 10:05 AM, the patient lift #9958 on the third floor had taped wrapped around the control board. During an interivew at this time, the Maintenance Director stated the bracket was broken and staff taped it on with medical and duct tapes. They also stated the control unit was expensive to replace, and a new one could not be ordered without approval. The Maintenance Director stated the control unit, including the panel screen, still functioned. During an interview on 10/11/2024 at 12:37 PM, Certified Nursing Assistant #1 stated multiple residents on the unit (third floor) used either the mechanical lift or sit-to-stand lift. The unit had one or two lifts, however, there were not enough available, and residents had to wait until one became available for assistance with their care needs. During an interview on 10/11/2024 at 12:56 PM, Licensed Practical Nurse #1 stated the unit (third floor) had multiple residents who used the mechanical lift and sit-to-stand lift. Staff often had to wait for equipment to become available and residents had to wait for assistance with getting up for the day or with transfers. During an interview on 10/15/2024 at 8:51 AM, the Director of Nursing stated nursing staff should report mechanical concerns for the residents' adaptive equipment (including mechanical and sit-to-stand lifts) to maintenance, and they were unaware of any issues with having enough equipment or equipment not being well-maintained. During an interview on 10/15/2024 at 1:30 PM, the Regional Administrator stated if there was a concern for not having enough equipment, therapy would let leadership know. The amount of equipment the facility had should be sufficient for the resident population. The Regional Administrator stated they were unsure of the nursing staff's timing and/or use of the equipment to assist the residents. 10 NYCRR 415.29(b)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34459 Based on observations, interview, and record review conducted during the Recertification Survey from 10/7/2024 to 10/15/2024, for one (second floor) of two resident sleeping floors, the facility did not properly maintain the nurse call system. Specifically, there was no central nurse call system panel and the audible component for the system was not functional. The findings are: The facility mechanical, electrical, and patient care equipment policy and procedure, dated November 22, 2017, listed the following: It is the policy of Crest Manor Living and Rehabilitation Center to ensure all mechanical, electrical, and patient care equipment is in safe operating condition. All existing equipment will be checked through a preventative maintenance check to ensure proper functioning. Essential equipment, electrical patient care equipment, and non-patient care electrical equipment - all existing essential equipment can be checked during preventative maintenance checks. If equipment is found to be not in safe operating condition, they are to report it immediately to the Maintenance Director who will work to either replace or repair equipment so that it is in safe operating condition. The facility call bell policy, dated 12/19/2022, included: resident call lights will be answered promptly. All members of the facility staff are expected to respond to call lights. If call bell appears to be non-functioning inform maintenance staff immediately. Record review of weekly nurse call system checks revealed the logs did not include functionality of the system panel on the second floor. The documentation did not list that there was no control station present on the second floor, or that the audible component of the system was not functioning. Record review of the manufacturer's technical manual for the Executone Care/Com nurse call system, dated 1985, revealed the system (including the second floor) was originally designed to have a telephone control station with both audible and visual components to indicate room location, and a speaker-microphone for two-way voice communication when activated. During an interview on 10/09/2024 at 3:15 PM, Licensed Practical Nurse #2 stated there has not been a central call bell panel on the second floor. Licensed Practical Nurse #2 also stated there was no audible sound when call bells were activated and they had to rely on looking up to see if an overhead corridor light was on outside a room. During observations on 10/09/2024 from 3:25 PM to 3:28 PM, there was no audible sound in the room or on the second-floor unit when the call bells were tested in resident rooms [ROOM NUMBERS]. Additionally, there was no control panel at the nurse station or elsewhere on the unit. During an interview on 10/10/2024 at 9:40 AM, the Maintenance Director stated the call bell system on the third floor was replaced last year, and this system was audible and addressable at the panel at the nurses' desk with overhead lights outside rooms. The Maintenance Director also stated that the older system on the second floor did not have a panel and did not have any audible function; they heard there used to be a panel at the nurses' station for the second-floor unit about five or six years ago which was removed as staff at that time did not like it and were unplugging it. The Maintenance Director stated they would have to rely on looking up and seeing a light on for the corridor, then seeing which light was on in that corridor to know where to respond to a call bell being activated. (continued on next page)

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	10/15/2024

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/10/2024 at 10:26 AM, Certified Nursing Assistant #7 stated the only way to know if a resident had used the call bell (on the second floor) was to see the light on outside the door. Certified Nursing Assistant #7 also stated there was no audible sound when a call bell was activated, and if they were in the shower room or in a resident room they would not know if a resident was calling until they were back in the hallway. Additionally, Certified Nursing Assistant #7 stated when a bathroom call bell is activated it turns on a red light, but it does not indicate which room's bathroom light was activated, so staff need to check every bathroom until they find the resident that called. During an interview on 10/10/2024 at 12:47 PM, the Regional Administrator stated they did not know about a central call station on the second floor. The Regional Administrator also stated that there was no phone or panel in place on the second floor when they started at the facility and thought the call bell system on second floor was audible. 10NYCRR: 415.29, 415.29(b); 415.29(j)(1) 10NYCRR: 713-1.3(b), 713-3.25(g)