STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335473	A. Building B. Wing	03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blossom Health Care Center Inc.	989 Blossom Road Rochester, NY 14610

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review, the facility did not ensure allegations of abuse were responded to timely and in response to allegations of abuse, residents were protected from further potential abuse for one (1) of three (3) residents reviewed (Resident #1). Specifically, on 03/12/2026, Physical Therapy Assistant #1 witnessed an alleged incident involving Resident #1 and Certified Nursing Assistant #1; however, the allegation was not immediately escalated to administration, Certified Nursing Assistant #1 continued to provide resident care across multiple shifts, and the facility did not ensure immediate protective measures were implemented upon initial staff awareness of the allegation.The findings include:The facility policy Prevention, Investigation and Reporting Resident Abuse and Mistreatment dated July 2024 documented all employees were responsible for monitoring residents. Any employee who witnessed abuse must immediately intervene to stop the abuse to protect the resident and must report the incident immediately to their supervisor or House Charge Nurse who would investigate the matter and, if warranted, immediately report to the Administrator, Director of Nursing, and/or Social Worker. The person responsible for completing the investigation should proceed to the incident scene promptly, ensure the resident was protected from the alleged abuser, and remove any accused staff from resident care pending the outcome of the investigation.Resident #1 had diagnoses including muscle weakness, cerebral infarction (loss of blood supply to part(s) of the brain), and diabetes. The Minimum Data Set (a resident assessment tool) dated 02/09/2026 documented the resident had moderately impaired cognition and required staff assistance for bed mobility and transfers.The facility investigation dated 03/16/2026 documented there was no evidence to support any alleged resident abuse had occurred. The investigation included a written statement from Physical Therapy Assistant #1 describing the alleged interaction, a statement from Certified Nursing Assistant #1, documentation Resident #1 could not recall the incident, and a statement from Resident #4 (roommate) indicating the interaction appeared abrupt. The facility investigation did not include documented statements from Licensed Practical Nurse #1 or the Human Resources Director, despite both being identified as having knowledge of the allegation.Review of the facility staff punches report revealed on 03/12/2026 Certified Nursing Assistant #1 punched in at 6:52 AM and punched out at 11:02 PM. On 03/13/2026 Certified Nursing Assistant #1 punched in at 6:48 AM and punched out at 11:00 AM.Review of the facility staff assignment sheets dated 03/12/2026 for the day and evening shifts and 03/13/2026 for the day shift revealed Certified Nursing Assistant #1 was assigned to Resident #1.In a progress note dated 03/13/2026, Registered Nurse #1 documented Resident #1 denied concerns with care and had no adverse findings on a full skin assessment.In a progress note dated 03/17/2026, the Regional Social Worker documented they spoke with Resident #1 regarding a possible incident, and the resident did not recall any issues.During an interview on 03/23/2026 at 11:48 AM, Resident #4 stated they recalled an interaction between Certified Nursing Assistant #1 and Resident #1 and stated Certified Nursing Assistant #1 seemed abrupt and rough but could not provide additional details.During an interview on 03/23/2026 at 12:23 PM, Resident #1 stated they did not believe they were ever abused by staff and did not know if staff yelled or swore due to their poor memory.During an interview on 03/23/2026 at 12:37 PM, Physical Therapy Assistant #1 stated on 03/12/2026 at approximately 11:15 (continued on next page)

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

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	AM they entered Resident #1's room to provide therapy. Physical Therapy Assistant #1 stated Resident #1 could sit up with cues and no additional assistance was required. Physical Therapy Assistant #1 stated while speaking with Resident #1, Certified Nursing Assistant #1 entered the room, stated who the hell told you to get back in bed, you need to be in the wheelchair for lunch, removed the blanket with force, threw it on the dresser, pulled Resident #1's leg, and yanked the resident up by the wrist, then stood the resident and placed them into the wheelchair before leaving the room. Physical Therapy Assistant #1 stated they did not intervene as the incident occurred quickly, and they froze. Physical Therapy Assistant #1 stated Resident #1 appeared fearful. Physical Therapy Assistant #1 stated Resident #1 indicated Certified Nursing Assistant #1 did that all the time. Physical Therapy Assistant #1 stated they reported the concern to Licensed Practical Nurse #1 sometime after lunch.During an interview on 03/23/2026 at 1:15 PM, Licensed Practical Nurse #1 stated on 03/12/2026 in the afternoon Physical Therapy Assistant #1 reported concerns regarding Certified Nursing Assistant #1 and Resident #1. Licensed Practical Nurse #1 stated immediately after the conversation they reported the concern to the Human Resources Director.During an interview on 03/23/2026 at 1:38 PM, the Human Resources Director stated when staff report abuse concerns, they bring the concern to the Director of Nursing immediately. The Human Resources Director stated they were aware of the incident involving Resident #1 and reported it to the Director of Nursing and Social Worker the same day but could not recall the exact date.During a telephone interview on 03/23/2026 at 2:05 PM, Certified Nursing Assistant #1 stated they provided care to Resident #1 and denied any inappropriate conduct. Certified Nursing Assistant #1 stated they did not use profanity toward Resident #1 and did not pull the resident by the wrist. Certified Nursing Assistant #1 stated they asked Resident #1 why they were in bed and told the resident they should be up for meals. Certified Nursing Assistant #1 stated they assisted the resident to a sitting position using their arm and indicated Physical Therapy Assistant #1 was present and assisted with positioning the wheelchair. Certified Nursing Assistant #1 stated Physical Therapy Assistant #1's account was not accurate and denied the allegations.During an interview on 03/23/2026 at 3:42 PM, the Regional Social Worker stated they became aware of the allegation on 03/13/2026, the day after the incident occurred.During an interview on 03/24/2026 at 11:44 AM, the Director of Nursing stated staff should report abuse concerns to their supervisor and then to the Assistant Director of Nursing or Director of Nursing. The Director of Nursing stated they were not aware of the incident until 03/13/2026 when informed by the Director of Therapy. The Director of Nursing stated Certified Nursing Assistant #1 should have been removed from resident care immediately and the investigation should have started on 03/12/2026.During an interview on 03/24/2026 at 11:59 AM, the Administrator stated staff should report abuse concerns to the Assistant Director of Nursing, Director of Nursing, or Administrator. The Administrator stated Physical Therapy Assistant #1 should have reported the concern the day of the incident and Certified Nursing Assistant #1 should not have continued providing care. The Administrator stated the investigation should have been initiated on 03/12/2026.During an interview on 03/24/2026 at 12:13 PM, the Director of Nursing stated if notified timely they would have obtained statements from Human Resources Director and Licensed Practical Nurse #1 and interviewed additional residents. The Director of Nursing stated there was a breakdown in communication related to this incident.10 New York Code of Rules and Regulations 415.4(b)(1)(i), (2), (3)