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	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rochester Community Nursing and Rehabilitation Ctr	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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 49368 Based on observations, interviews and record reviews conducted during the Recertification Survey 09/25/2024 to 10/01/2024, for one (Resident #29) of four residents reviewed, the facility did not ensure that all alleged violations involving potential abuse, neglect, exploitation, or mistreatment were reported to the New York State Department of Health in accordance with state law. Specifically, the facility did not report an incident to the state agency regarding a care plan violation where Resident #29 fell out of bed while getting care by a staff member sustaining a major injury. This is evidenced by the following: The facility policy Abuse, Neglect, Exploitation and Misappropriation-Reporting and Investigating, reviewed January 2024, documented all reports of resident abuse and neglect are reported to local, state, and federal agencies and thoroughly investigated by facility management. Resident #29 had diagnoses including Parkinson's disease, respiratory failure, and asthma. The Minimum Data Set Resident Assessment, dated 08/14/2024, included the resident was cognitively intact, has upper (shoulder, elbow, wrist, hand) and lower extremity (hip, knee, ankle, foot) impairment on both sides, was dependent for toileting hygiene and transfers, and required maximal assistance for rolling left and right. Review of the Comprehensive Care Plan and Kardex (used by the Certified Nursing Assistant to direct care) revealed Resident #29 required assistance with self-care and mobility and was at risk for falls related to immobility, fatigue, and impaired balance, a history of falls, and a neurologic disorder. Interventions included, but were not limited to, to provide the resident with two persons assist for rolling left and right (bed mobility), transfers, and toileting hygiene. Review of the document titled '#245 Fall' (identified by the facility as an Incident and Accident form), dated 09/11/2024 and signed by Registered Nurse Manager #1, revealed Resident #29 had a witnessed fall in their room. Injuries observed at the time of incident were bruising to the face and a skin tear on the left elbow. Resident #29's mental status was oriented to place, time, person, and situation, and Resident #29 was sent to the hospital and returned with a fracture of the left wrist. The form included that Certified Nursing Assistant #4 was educated on proper positioning when checking for incontinence and the resident's care plan was updated to ensure proper positioning in bed when checking for incontinence. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of statements/description, dated 09/11/2024, obtained by the facility included the following: 1. In a statement, dated 09/11/2024, Licensed Practical Nurse #2 stated they were notified by Certified Nursing Assistant #4 that Resident #29 was on the floor. Licensed Practical Nurse #2 entered room and observed the resident on the floor next to the bed face down, was assisted back into the bed, first aid was administered to open areas, and the resident was sent to the emergency department. Licensed Practical Nurse #2's statement was a written progress note taken from the electronic health record. 2. In a statement, dated 09/11/2024, obtained from Certified Nursing Assistant #4 by the Director of Nursing in an in-person interview, Certified Nursing Assistant #4 stated they went into the room, Resident #29 was lying on their side, Certified Nursing Assistant #4 was checking for incontinence when the resident made a sudden move and fell off the opposite side of the bed. Certified Nursing Assistant #4 stated they tried to stop the resident from falling but were unable to. 3. Under resident description, the form included that the resident stated they fell off the bed. During observations on 09/25/2024 at 1:25 PM, Resident #29 had facial bruising on the corner of their right eye, left side of the neck, and left cheek, and their left wrist was in a cast. Resident #29 stated the bruises were from the fall and their left wrist was broken in the fall. When asked about the fall at this time, Resident #29 said they were in bed with their face towards the right side of the bed and Certified Nursing Assistant #4 was trying to change their sheets by themselves. As Certified Nursing Assistant #4 was tucking the sheet up under them, they fell off the bed. During an interview on 09/30/2024 at 1:08 PM, the Director of Nursing stated a fall with major injury and a break in care plan would be considered a state reportable incident to the New York State Department of Health. The Director of Nursing stated abuse and neglect were ruled out after gathering Certified Nursing Assistant #4's statement. The Director of Nursing said that Certified Nursing Assistant #4 was not actually providing care at the time of Resident #29's fall and that abuse, neglect, or mistreatment did not occur. The Director of Nursing said checking for incontinence was not providing care as they were only moving the brief not the person, and that was why they did not report it to the Department of Health. The Director of Nursing stated if Certified Nursing Assistant #4 had been making the bed, then they would consider that providing care to the resident. During an interview on 09/30/2024 at 1:36 PM, Certified Nursing Assistant #5 (Resident #29's primary Certified Nursing Assistant for this day) stated Resident #29 was a two assist and they wait for another staff member before going into the room even if it was to check the resident for incontinence care. Certified Nursing Assistant #5 stated Resident #29 stays in bed during linen changes and required two staff assistance while checking for incontinence. Additionally, Certified Nursing Assistant #5 stated Resident #29 was factual in their stories and they would believe them. During an interview on 09/30/2024 at 3:07 PM, the Administrator stated to their understanding Certified Nursing Assistant #4 was not providing care to Resident #29 because they do not consider checking for incontinence as providing care. The Administrator said they were not aware that Resident #29 had a different recollection of the fall in which Resident #29 stated their linen was being changed on their bed or that the resident required two staff assistance (with bed mobility). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Certified Nursing Assistant #4 was not available for interview. The facility was unable to provide any additional information such as Resident #29's detailed statement or if abuse, neglect, and mistreatment had been ruled out related to Resident #29's fall with major injury. 10 NYCRR 415.4

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 49368 Based on observations, interviews, and record reviews conducted during the Recertification Survey from 09/25/2024 to 10/01/2024, the facility did not ensure all alleged violations involving abuse, neglect, or mistreatment were thoroughly investigated for one (Resident #29) of four residents reviewed. Specifically, the facility did not thoroughly investigate the resident's witnessed fall that resulted in a major injury and a care plan violation. This is evidenced by the following: The facility policy Investigating Resident Injuries, reviewed January 2024, included that all resident injuries are investigated, the director of nursing services or a designee will assess all resident injuries and document findings in the medical record, and descriptions in the medical record must be objective and sufficiently detailed. The facility policy Abuse-Prohibition Protocol, Types of Abuse, Response/Reporting, reviewed January 2024, documented all reports of alleged mistreatment, neglect, or abuse will be responded to immediately and an intervention shall be initiated. Events to be investigated may include, but not limited to, allegation of mistreatment, abuse, or neglect. Resident interviews are conducted to identify issues relating to mistreatment, neglect, or abuse. Investigations shall include, but not limited to re-enactments and written statements from the applicable staff members and residents. Statements must be dated and signed clearly indicating the name of the person giving the statement, their title, must be specific to the investigation, and must be a complete and accurate account of the incident. Resident #29 had diagnoses including Parkinson's disease, respiratory failure, and asthma. The Minimum Data Set Resident Assessment, dated 08/14/2024, included the resident was cognitively intact, has upper (shoulder, elbow, wrist, hand) and lower extremity (hip, knee, ankle, foot) impairment on both sides, was dependent for toileting hygiene and transfers, and requires maximum assistance for rolling left and right. Review of the Comprehensive Care Plan and Kardex (used by the Certified Nursing Assistant to direct care) revealed Resident #29 required assistance with self-care and mobility and was at risk for falls related to immobility, fatigue, impaired balance, history of falls, and neurologic disorder. Interventions included, but were not limited to, to provide the resident with two persons assist for transfers, rolling left and right (bed mobility), and toileting hygiene. Review of the document titled '#245 Fall' (identified by the facility as an Incident and Accident form in the electronic medical record), dated 09/11/2024, revealed Resident #29 had a witnessed fall in their room. Injuries observed at the time of incident were bruising to the face and a skin tear on the left elbow. Resident #29's mental status was oriented to place, time, person, and situation. Resident #29 was sent to the hospital and returned with a fracture to the left wrist. The form included that Certified Nursing Assistant #4 was educated on proper positioning when checking for incontinence and the resident's care plan was updated to ensure proper positioning in bed when checking for incontinence. Review of statements/description of the incident, dated 09/11/2024, obtained by the facility and documented in the electronic medical record included the following: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. In a statement, dated 09/11/2024 obtained from Certified Nursing Assistant #4 by the Director of Nursing during an in-person interview, Certified Nursing Assistant #4 stated they went into the room, Resident #29 was lying on their side, and that they were checking for incontinence when the resident made a sudden move and fell off the opposite side of the bed. Certified Nursing Assistant #4 stated they tried to stop the resident from falling but were unable to. 2. In a statement, dated 09/11/2024, and written in a progress note in Resident #29's electronic medical record, Licensed Practical Nurse #2 stated they were notified by Certified Nursing Assistant #4 that Resident #29 was on the floor. Licensed Practical Nurse #2 entered room and observed the resident on the floor next to the bed face down, they were assisted back into the bed, first aid was administered, and the resident was sent to the emergency department. 3. Under 'resident description' on the electronic form, it included that the resident stated they fell off the bed. There was no further information regarding Resident #29's account of the fall. The Incident/Accident form did not include any information related to any potential care plan violation related to one staff assist for bed mobility. During observations on 09/25/2024 at 1:25 PM, Resident #29 had facial bruising on the corner of their right eye, left side of the neck, and left cheek, and their left wrist was in a cast. During an interview at this time, Resident #29 stated the bruises were from the fall and their left wrist was broken in the fall. When asked about the fall, Resident #29 said they were in bed with their face towards the right side of the bed and Certified Nursing Assistant #4 was trying to change their sheets by themselves. As Certified Nursing Assistant #4 was tucking the sheet up under them, they fell off the bed. During an interview on 09/30/2024 at approximately 12:20 PM, Registered Nurse Manager stated they opened the Accident and Incident report in the electronic health records risk management module and instructed the nurse they needed to document the fall. The Director of Nursing conducted the investigation and spoke to Certified Nursing Assistant #4 and Resident #29. During an interview on 09/30/2024 at 1:08 PM, the Director of Nursing stated the facility recently switched to using the electronic health record module for completing Incident and Accident reports and that there were different questions to answer than the previous forms such as abuse, neglect, or mistreatment, and additional questions to prompt the investigation. The Director of Nursing said that they ruled out abuse during morning report while gathering the Certified Nurse Assistant's statement and did not believe there was a break in the care plan as the Certified Nursing Assistant was not actually providing care while checking the brief. The Director of Nursing stated that if the Certified Nurse Assistant had been making the bed they would consider that providing care. During an interview on 09/30/2024 at 3:07 PM, the Administrator stated they felt the incident was thoroughly investigated since the report contained a resident statement, a nurses' statement, a Certified Nursing Assistant statement, and the provider had been made aware and the Resident #29 had been sent out for further evaluation. The Administrator stated the person who conducted the investigation should have been more specific when asking Certified Nursing Assistant #4 questions regarding checking the resident for incontinence, specifically how they performed that task. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility was unable to provide any additional information such as the resident's detailed statement, a thorough statement from Certified Nursing Assistant #4 regarding following the care plan, or any conclusion including if abuse, neglect, and/or mistreatment had been ruled out related to Resident #29's fall with major injury. 10 NYCRR 415.4(b)(3)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. 41591 Based on observations, interviews, and record review conducted during a Recertification Survey and complaint investigation (ACTS Reference number: NY00337359), for one (Resident #53) of two resident's reviewed for pressure ulcers, the facility did not ensure that the resident received the necessary treatment and services consistent with professional standards of practice to promote healing, prevent infection, and prevent new ulcers from developing. Specifically, Resident #53 did not receive treatment for multiple wounds as prescribed by the Physician. This was evidenced by the following: Resident #53 had diagnoses including multiple stage three (full thickness tissue loss involving damage of the subcutaneous tissue) pressure ulcers (left buttock, right buttock, and sacrum), diabetes, and congestive heart failure. The Minimum Data Set Resident Assessment, dated 06/21/2024, documented that the resident was severely impaired cognitively, was at risk for developing pressure ulcers, and had no pressure ulcers at that time. Physician's orders, dated 09/19/2024, included for sacral wound care, staff were to cleanse the open sites on the buttocks with normal saline, pat dry, and apply Critic-Aid clear cream to all aspects of sacrum and buttocks thoroughly. The orders also included to apply Triad Hydrophilic cream once daily to the open wound sites only and to leave the wound sites open to air to prevent further moisture damage. The September 2024 Treatment Administration Record, dated 09/20/2024, documented that nursing staff signed off the wound care as not completed as ordered on 09/20/2024 to 09/27/2024 due to other-see nurses note and on 09/28/2024-09/30/2024 as on hold by the Physician. Review of interdisciplinary team progress notes, dated 09/20/2024 to 09/30/2024, did not include any information related to why the Triad Hydrophilic cream had not been administered or was on hold. In a wound progress note, dated 09/23/2024, Physician #1 documented to change the orders for the right buttock, left buttock, and sacral area wounds to cleanse the wounds with sterile water, apply xeroform gauze to wound bed, and cover with a border gauze (a wound dressing) once daily and as needed. The facility was unable to provide documentation that this order had ever been placed in their electronic health record or administered to the resident from 09/23/2024 to 09/30/2024. During an observation and interview on 09/27/2024 at 1:08 PM, Registered Nurse #2 stated the facility did not have the ordered Triad Hydrophilic cream and they would need to call the Physician to obtain a one-time order for the wound care. Registered Nurse #2 applied the new one-time order to the wounds using zinc oxide. Registered Nurse #2 stated that they were unable to find any Triad Hydrophilic cream for Resident #53 and was unsure as to why the cream was not available. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/30/2024 at 9:00 AM, Registered Nurse Manager #1 stated that when a resident returns from the hospital, the Physician should be notified, the medications reviewed, and entered in the electronic health system, and the orders sent to pharmacy to be filled. They stated that if there were any issues with the pharmacy not being able to fill prescriptions, then the pharmacy will notify the facility via phone. Registered Nurse Manager #1 stated they were not aware that the Triad Hydrophilic cream had never been filled or that Resident #53 had not been receiving the treatments as ordered. During an interview on 09/30/2024 at 9:44 AM, Pharmacist #1 stated that they do not provide Triad Hydrophilic cream and they have it noted that the facility has it as a stock cream. Pharmacist #1 stated that insurance is not an issue since the resident is all inclusive. They stated that they have not sent any of the Triad Hydrophilic cream to the facility except for the one time courtesy last Friday (09/272024 following the observation of wound care by the surveyor). During an interview on 09/30/2024 at 1:07 PM, Physician #1 revealed that their expectation was that when there are changes in orders or new orders are given that they are carried out in a timely manner. Physician #1 stated that they examined Resident #53's wounds on 09/23/2024 and gave new orders for the wounds. Physician #1 stated that they were just notified that Resident #53 had not been receiving the treatments ordered on 09/23/2024 due an error that the new orders had not been entered into the electronic medical record. During an interview on 09/30/2024 at 12:55 PM, Registered Nurse #3 stated they perform weekly wound rounds with the wound care Physician on all residents that have wounds and they accompany the wound care Physician when they assess the wounds. Registered Nurse #3 stated that they did perform wound care on Resident #53 recently but was unable to recall if Triad Hydrophilic cream was available. They stated that if the resident did not have the ordered wound supplies, then staff should contact the medical provider and get a different order. During an interview on 09/20/2024 at 2:37 PM, the Director of Nursing stated the nurse should contact the provider and inform them that the ordered wound care supplies were not available and request a new order. The Director of Nursing stated that the Triad Hydrophilic cream has not been ordered on a regular basis, is not a stock cream, and must come from the pharmacy. The Director of Nursing stated that when the wound care Physician does their weekly rounds with the nurse, any changes or new orders should be checked with pharmacy and if it is not something that they provide then someone in Administration should be notified. They stated that they were not aware Resident #53 did not have the Triad Hydrophilic cream to complete the ordered wound care. 10 NYCRR 415.12(c)(2)

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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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 49368 Based on observations, interviews, and record reviews conducted during the Recertification Survey from 09/25/2024 to 10/01/2024, for one (Resident #3) of one resident reviewed, the facility did not ensure that residents with limited mobility received the appropriate services, equipment, and assistance to maintain mobility and prevent complications. Specifically, Resident #3 did not consistently receive a hand device (rolled washcloth or gauze pad) for a hand contracture (a shortening of muscles, tendons, and skin) to prevent complications per Occupational Therapy's recommendations and as ordered by the physician. This is evidenced by the following: Resident #3 had diagnoses including cerebral infarction (stroke) with hemiplegia (paralysis on one side of the body) and aphasia (absence or difficulty with speech). The Minimum Data Set Resident Assessment, dated 07/18/2024, included the resident was severely impaired of cognitive function, had rejected care on one to three days in the previous seven days, and required substantial/maximal assistance for upper body dressing and personal hygiene. Review of Resident #3's Comprehensive Care Plan and Kardex (used by the Certified Nursing Assistant to direct care) revealed Resident #3 required a rolled washcloth or gauze pad to be applied to their right hand in the morning and removed at bedtime, to monitor the skin daily during care, and to notify the Registered Nurse for any redness or open areas to the hand. Physician's orders, dated 02/26/2024, included to place a rolled washcloth or gauze pad in the right hand in the morning, remove it at bedtime, and to notify the Registered Nurse for any redness or open areas to hand. In an Occupational Therapy Discharge Summary, dated 02/23/2024, Occupational Therapist #1 documented that Resident #3 received Occupational Therapy skilled interventions for a right-hand contracture to manually stretch (right hand) and increase palm guard tolerance. Discharge recommendations included to continue wearing a palm guard or rolled washcloth in their right hand to increase tolerance and reduce tone. During observations on 09/27/2024 at 11:21 AM, Resident #3 did not have a rolled washcloth or gauze pad in their right hand and the inside palm was reddened with dry and scaly skin that was peeling. During observations on 9/30/2024 at 9:43 AM and on 10/01/2024 at 10:11 AM and 12:32 PM, Resident #3 did not have a rolled washcloth or gauze pad in their right hand. Resident #3's skin integrity was unable to be observed due to the tightness of the contracture. During an interview on 10/01/2024 at 12:56 PM, Registered Nurse Manager #1 stated that at one time Resident #3 had a palm guard and sometimes they have a rolled washcloth in their palm. During an interview on 10/01/2024 at 1:00 PM, Certified Nursing Assistant #6 stated Resident #3's Kardex included to put a rolled washcloth or gauze pad in their right hand in the morning and off at bedtime. Certified Nursing Assistant #6 stated they did not know Resident #3 required a rolled washcloth only lotion (to the right hand). (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/01/2024 at 1:07 PM, Physical Therapist #1 stated that Resident #3 needed the rolled washcloth or gauze pad for their right-hand contracture and if Resident #3 did not have the rolled washcloth or gauze pad in place, the resident could get skin breakdown. Physical Therapist #1 said the hand device would help to maintain their current range of motion and skin integrity of their hand. During an interview on 10/01/2024 at 2:51 PM, the Director of Nursing stated the Certified Nursing Assistants should follow and provide care to the residents using their care cards (Kardex). 10 NYCRR 415.12(e)(2)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 49368 Based on observations, interviews, and record reviews conducted during the Recertification Survey 09/25/2024 to 10/01/2024, for one (Resident #29) of three residents reviewed, the facility did not provide specialized care needs for the provision of respiratory care in accordance with professional standard of practice, and the resident's care plan, goals, and preferences. Specifically, Resident #29 was observed wearing oxygen via nasal cannula (a device that delivers oxygen through a person's nose). There was not a physician's order in place for oxygen use or documentation in the Medication Administration and Treatment Administration Records that reflected the use and care of the oxygen. Additionally, the facility did not develop a comprehensive person-centered care plan related to Resident #29's respiratory needs. This is evidenced by the following: The facility policy Oxygen Administration, reviewed January 2024, documented for staff to verify that there is a physician's order for this procedure and review the residents' care plan to assess for any special needs for the resident. Resident #29 had diagnoses that included respiratory failure, asthma, and obstructive sleep apnea (disorder in which breathing stops and starts repeatedly during sleep). The Minimum Data Set Resident Assessment, dated 08/14/2024, included the resident was cognitively intact, had shortness of breath when lying flat, and was not receiving oxygen therapy. Review of the Resident #29's Comprehensive Care Plan did not include that the resident had a compromised respiratory diagnosis requiring continuous oxygen via nasal cannula, person-centered interventions, or desired outcomes. Review of the current physician's orders did not include the use of oxygen. Review of the Medication Administration and Treatment Administration Records from 08/01/2024 to 08/31/2024 and 09/01/2024 to 09/30/2024 did not include documentation reflecting Resident #29's continuous use of oxygen via nasal cannula. During several observations on 09/25/2024 at 1:37 PM, 09/27/2024 at 11:36 AM, and 09/30/2024 at 12:14 PM, Resident #29 was in their room, wearing a nasal cannula with oxygen set at 2.5 liters per minute administered through an oxygen concentrator. During an interview on 09/30/204 at 12:17 PM, Licensed Practical Nurse #2 stated Resident #29 was on continuous oxygen and last they knew it was at 3 liters. Licensed Practical Nurse #2 reviewed Resident #29's current orders for oxygen administration at this time and stated they could not see any. During an interview on 09/30/2024 at approximately 12:20 PM, the Registered Nurse Manager #1 stated Resident #29 used oxygen continuously via nasal cannula at a rate fluctuating between 2-3 liters, but usually kept at 2 liters, through an oxygen concentrator. Registered Nurse Manager #1 reviewed Resident #29's current orders for oxygen at this time and stated there was no order and there should be. Registered Nurse Manager #1 stated there was nothing in the resident's care plan for oxygen use and there should be along with a supporting diagnosis for the need for the oxygen. (continued on next page)

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	335473	A. Building B. Wing	10/01/2024

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Rochester Community Nursing and Rehabilitation Ctr	989 Blossom Road Rochester, NY 14610

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/01/2024 at 2:51 PM, when asked if oxygen should be administered without a physician's order, the Director of Nursing stated it should not and that there should be a person-centered comprehensive care plan for the oxygen, including the respiratory diagnoses (associated with the need for oxygen). 10 NYCRR 415.12(k)(6)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 47641 Based on observations and interviews conducted during a Recertification Survey from 09/25/2024 to 10/01/2024, the facility did not ensure that all drugs and biologicals were properly stored in accordance with State and Federal Laws for two of four narcotic (controlled medications) cabinets reviewed. Specifically, numerous controlled medications (drugs that are regulated by law due to their potential for abuse or addiction), including narcotics and opioids (pain relievers), were secured with one lock rather than double-locked per the regulations. This is evidenced by the following: The facility policy Storage of Medications, dated January 2024, included that controlled medications are stored in separately locked, permanently affixed compartments. Access to controlled medication is separate from access to non-controlled medications. The policy did not include that controlled substances were required to be double-locked behind two separate doors with two separate locks per the regulation. During observations on 09/25/2024 at 1:08 PM, the first door of the controlled medication cabinet (Third Floor Medication Room) labeled even was unlocked and open. During an interview at this time, Registered Nurse #1 stated they were not sure why the door was unlocked. They knew there were problems with it in the past and it did not lock easily. Registered Nurse #1 was unable to lock the cabinet door with the key when requested. During observations on 09/27/2024 at 8:53 AM, the first door of the controlled medication cabinet (Second Floor Medication Room) was unlocked and open. The first door of the cabinet had a hole where the lock should have been. The cabinet contained several blister packs of controlled substances including pain medications, narcotics, opioids, anti-seizure, and anti-anxiety medications. During an interview at this time, Licensed Practical Nurse #1 stated the first door of the cabinet had been broken for a long time. During an interview on 10/01/2024 at 9:18 AM, Licensed Practical Nurse Manager #1 stated controlled substances should be double locked in a cabinet and should have two different keys to open it. They were not aware a controlled cabinet lock was broken. During observations at this time, the first door of the controlled cabinet (Second Floor Medication Room) was unlocked and open. Licensed Practical Nurse #1 verified there had not been a lock on the door the previous week and maintenance had fixed the lock, but they forgot to lock the door. Licensed Practical Nurse #1 had difficulty turning the lock with the key. Licensed Practical Nurse Manager #1 stated they were aware the cabinet door did not have a lock a few months ago, but thought maintenance had fixed it. Licensed Practical Nurse Manager #1 stated the cabinet needed a new door and lock. During an interview on 10/01/2024 at 9:47 AM, the Director of Maintenance stated they were notified late last week that the second-floor controlled medication cabinet needed a new lock, but they did not have the correct size barrel and it was too long for that lock. The Director of Maintenance was not aware the third-floor medication room also had a controlled medication cabinet that did not lock properly. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/01/2024 at 9:49 AM, the Director of Nursing stated they were not aware there were controlled medication cabinets that were not double-locked. They were made aware of concerns with the cabinet locks in the past but thought they had been repaired. The Director of Nursing stated all controlled medications should be stored in the double lock cabinets. 10 NYCRR 415.18(e)(1-4)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. 34459 Based on observations, interviews, and record review during the Recertification Survey from 09/25/2024 to 10/01/2024, the facility did not ensure there was a policy and procedure regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. Specifically, staff were not aware or educated on facility policies and procedures to label, date, and measure temperatures of resident food brought in from outside the facility, and items were not properly labeled and dated. The findings are: The facility policy Foods Brought by Families/Visitors, dated January 2024, documented that food brought by family/visitors that is left with the resident to be consumed later will be labeled and stored in a manner that is clearly distinguished from facility-prepared food. The nursing and/or food service staff will discard any foods prepared for the resident that show obvious signs of potential food borne danger (for example mold growth, foul odor, past due package expiration dates). During obseravations on 09/25/2024 at 10:34 AM, there was no policy and procedure for how to store, label, and reheat food for resident consumption within the 3rd floor kitchenette. Additionally, there were no thermometers present for staff use to measure reheated food temperatures for resident consumption. During observations on 09/25/2024 and 09/26/2024 between 11:00 AM and 4:00 PM, there were undated and improperly labeled resident food items within the refrigerator of the 2nd floor kitchenette. There were three plastic containers of resident food items, two of which were containers displaying a resident name and room number with no date, and one container with no labeling at all. In addition, there were two reusable shopping bags with unidentified food items in them with no dates on the foods or containers. There was no policy and procedure for how to store, label, and reheat food for resident consumption within the 2nd floor kitchenette. Additionally, there were no thermometers present for staff use to measure reheated food temperatures for resident consumption. During an interview on 09/26/2024 at 12:32 PM, the Food Service Director stated nursing staff was responsible for the labeling and dating resident of food in the kitchenettes. The Food Service Director also stated that they were not sure if nursing staff was trained on how to reheat food for residents or if there was a procedure or thermometer available for nursing staff to use to reheat food. The Food Service Director further stated there was no microwave available on the nursing units so staff might have to come down to the first-floor breakroom to use the microwave. During an interview on 09/27/2024 at 11:35 AM, Licensed Practical Nurse #1 (3rd floor) stated nursing staff should be labeling food items for residents that are brought into the facility with name, room, and date. Licensed Practical Nurse #1 also stated that if food was not dated, they would discard it, and reheating of resident food would be the responsibility of nursing staff. Licensed Practical Nurse #1 further stated there was no training they received on how to reheat food for residents and they did not have microwaves or thermometers to reheat food. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/27/2024 at 11:50 AM, Certified Nursing Aide #5 (2nd floor) stated nursing staff was responsible for labelling and dating resident food from outside the facility with room number and name. Certified Nursing Aide #1 also stated they were not allowed to reheat food and had no way to do so as there was no microwave on the unit. Certified Nursing Aide #1 further stated they were not trained on how to reheat food and would take in ready to eat food, so they did not have to reheat anything. 10 NYCRR: 415.1(b)(1), 415.14(d), (h)

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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 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. 34459 Based on observations and interview during the Recertification Survey from 09/25/2024 to 10/01/2024, for three (first, second, and third floors) of three resident-use floors, the facility did not ensure compliance with all applicable State codes. Specifically, the facility was not in compliance with section 915 of the 2015 edition of the International Fire Code as adopted by New York State, which requires the use of carbon monoxide detection and testing in a building that has fuel-burning appliances. The findings are: During observations on 09/25/2024 between 9:00 AM and 4:00 PM, battery operated carbon monoxide detectors were affixed to the walls on the first, second, and third floors. A battery-operated carbon monoxide detector was observed within the generator room that contained a natural gas generator, and another battery-operated carbon monoxide detector was observed within the main mechanical room on the first floor that contained fuel burning furnaces and boilers. During an interview on 09/25/2024 at 11:45 AM, the Director of Maintenance stated they were not aware the carbon monoxide detectors needed to be tested and did not know how often they should be tested . The Director of Maintenance further stated there was no documentation as they had never tested the detectors throughout the building. The 2015 edition of the International Fire Code, requires carbon monoxide detection to be provided in an approved location between the fuel burning appliance and the dwelling unit, sleeping unit, or classroom; or on the ceiling of the room containing the fuel-burning appliance. Additionally, carbon monoxide alarms shall be maintained in accordance with National Fire Protection Agency (NFPA) 720. The 2012 Edition of NFPA 720, Standard for the Installation of Carbon Monoxide Detection and Warning Equipment, requires that single-station carbon monoxide alarms shall be inspected and tested in accordance with the manufacturer's published instructions at least monthly. 10 NYCRR: 415.29(a)(2), 711.2(a)(1); 42 CFR: 483.70(b), 2015 IFC: Section 915, 915.1, 915.1.4, 915.6, Section 1103.9, 2012 NFPA 720: 8.7.1

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 34459 Based on observations and interview during the Recertification Survey from 09/25/2024 to 10/01/2024, for two (second and third floors) of three resident-use floors, the facility did not ensure essential equipment was properly maintained in operating condition. Specifically, handwash sinks in soiled utility rooms did not function and were not operational when tested . The findings are: Durinb observations in the presence of the Director of Maintenance on 09/25/2024 at 10:40 AM, the handwashing sink in the 3rd floor soiled utility room was not functional and did not discharge water when the hot- and cold-water handles were turned. During an interview at this time, the Director of Maintenance stated the faucet had not been operational for some time, at least a year. During observations in the presence of the Director of Maintenance on 09/25/2024 at 10:57 AM, the handwashing sink in the 2nd floor soiled utility room was not functional and did not discharge water when the hot and cold-water handles were turned. 10NYCRR: 415.29, 415.29(b), 415.29(d)