STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335476	A. Building B. Wing	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Friendly Home	3156 East Avenue Rochester, NY 14618

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review conducted during recertification and complaint (#2619460) surveys from 12/11/2025 to 12/19/2025, for three (3) (Resident's #85, #125, and #126) of ten (10) residents reviewed, the facility did not ensure the resident's environment remained as free of accident hazards as is possible and each resident received adequate supervision and assistive devices to prevent accidents. Specifically, Resident #85 was observed over several days to have unopened wine bottles unsecured at their bedside, Resident #85 was not care planned for personal alcohol possession or consumption and there were other residents with wandering tendencies residing on that unit. In addition, Resident #125 had a right-sided transfer bar attached to their bed and a gap of approximately four (4) inches was observed between the transfer bar and mattress, concerning of a potential area of entrapment (where an individual can be caught between components of a bed). The facility could not provide documented evidence that transfer bar and bed safety checks were performed every shift by Nursing staff. Lastly, Resident #126 was known to have wandering and exit seeking behaviors, and eloped (resident leaves the premises or safe area without the facility's knowledge and supervision) from the facility. Prior to Resident #126's elopement, the door was known to not be functioning properly, and the facility was unable to provide documentation that interventions were put in place to keep the resident safe on the unit. This is evidenced by the following:The facility policy Wander Monitor System Alarm, with an unknown date documented the reception desk monitors the main entrance for departures by residents with a wander guard bracelet. The facility policy Missing Member/Elopement dated September 2024, documented alarms do not replace necessary supervision and require maintenance and testing to ensure proper functioning. The Nurse Manager assigns a staff member to observe the resident at times when wandering behavior intensifies and initiates more frequent checks as needed. The facility policy Alcohol in Life Enrichment Programs with an unknown date, included consumption shall be monitored at programs where alcohol was served, the staff were to use a standard measurement of 1 (one) ounce of alcohol per drink, and a maximum drink limit of two (2) per resident. Additionally, the policy included for staff to serve alcohol to residents in designated areas only. The facility policy Transfer Bar with an unknown date, included a transfer bar being defined as a one-piece device attached to the bed frame on one of both sides of the bed that is grasped to aid in bed entry and exit, and bed mobility. The policy included that all staff were responsible to monitor residents with transfer bars to ensure they are in good working order and do not pose an immediate risk of entrapment or injury. Additionally, daily checks of the transfer bar were to be completed to ensure it is placed appropriately and does not pose a risk for entrapment. 1.Resident #126 had diagnoses including dementia, major depressive disorder and muscle weakness. The Minimum Data Set (a resident assessment tool) dated 10/16/2025 revealed the resident had moderate impaired cognitive function and had history of delusions and wandering. The Comprehensive Care Plan initiated on 01/07/2025 documented Resident #126 wore a wander guard bracelet (wearable device for elopement prevention) and had exit seeking behaviors, and interventions included to distract the resident from wandering by offering pleasant diversions. In several progress notes, License Practical Nurse #10 documented the following:- On 08/06/2025, Resident #126 was exit seeking and trying to put the code in for the [NAME] Unit door to open, was stating that they wanted to leave and was trying to get other residents to help them get through the door. - On 08/22/2025, Resident #126 was exit seeking and was stating staff were keeping them at the facility against their will. - On 08/23/2025 and 09/11/2025, Resident #126 was going into other resident's rooms and was exit seeking. In a progress note dated 09/15/2025 at 3:29 PM, Licensed Practical Nurse #7 documented Resident #126 was pacing the hallways and interrupted them several times while trying to complete the medication pass. In a progress dated 09/15/2025 at 6:07 PM, Licensed Practical Nurse #11 documented Resident #126 was not on the unit, they initiated the appropriate policy in response, and Resident #126 returned to the unit around 6:30 PM. Review of the facility's investigation documented Concierge #1 reported hearing the alarm on the main door activate around 5:57 PM. They thought a resident at a party (occurring in the front room) had triggered the alarm, so they deactivated the alarm using a device at the front desk, and Resident #126 walked out of the building. The resident was returned to the facility by the police at 6:40 PM. Review of facility Maintenance Work Orders dated 08/15/2025, 08/21,2025, 09/03/2025, 09/04/2025, 9/14/2025, and 09/15/2025 revealed maintenance requests were made by five (5) different staff documenting the [NAME] unit door was not latching properly and was not secured. The work

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, review conducted during recertification and complaint (#2691821) surveys from 12/11/2025 to 12/19/2025, the facility failed to ensure residents were free of significant medication errors for three (3) of six (6) residents reviewed (Residents #33, #88, #154). Specifically, Resident #33 received insulin outside of administration parameters included in the medical order. Resident #88 received insulin outside of administration parameters included in the medical order and received insulin without documented evidence a blood glucose measurement was obtained prior to administration. Resident #154 did not receive medications and treatments in accordance with physician orders for multiple days after returning to the facility following a hospitalization. The findings include:The facility policy Medication Administration, Documentation, and Premedication revised August 2024 included, but was not limited to, licensed nursing staff were to check for hold parameters for medications, check laboratory values prior to administering any medications with ordered hold parameters and documents results prior to administration. 1. Resident #154 had diagnoses including Parkinson's disease with dyskinesia (a movement disorder of the nervous system with involuntary uncontrollable movements), localized edema (tissue swelling), and difficulty walking. The Minimum Data Assessment (a resident assessment tool) dated 09/19/2025 revealed the resident was cognitively intact. Review of Resident #154's electronic medical record from 12/04/2025 to 12/10/2025 revealed the following:- In a nursing progress note dated 12/05/2025 at 4:28 PM, Registered Nurse Supervisor #1 documented Resident #154 was transferred to the hospital for evaluation following a fall.- In a nursing progress note dated 12/06/2025 at 10:34 AM, Licensed Practical Nurse #3 documented Resident #154 returned from the hospital.- A hospital after-visit summary dated 12/06/2025 at 7:47 AM, indicated no new medications were prescribed during the emergency department visit and instructed the facility to follow up with Resident #154's primary care provider regarding continuation of medications.- In a nursing progress note dated 12/10/2025 at 3:52 PM, Registered Nurse Supervisor #1 documented Resident #154 had not received any prescribed medications since returning from the hospital. Review of the Medication and Treatment Administration Records from 12/06/2025 through 12/10/2025 revealed Resident #154's previously prescribed medications and treatments were placed on hold and not administered on these consecutive days following the resident's return from the hospital, including:- Carbidopa-levodopa 20-100 milligrams, 1.5 tablets once in the morning at 6:00 AM and one (1) tablet in the afternoon at 1:00 PM daily for Parkinson's disease (ordered on 10/01/2024).- Hydrochlorothiazide 12.5 milligrams, once daily at 6:00 AM for localized edema (ordered on 10/01/2024).- Apply below the knee TED stockings (compression stockings used to help control leg swelling), applied to both legs in the morning at 6:00 AM and taken off both legs in the evening. There was no documented evidence the medications were discontinued by a medical provider, or if the primary care provider was contacted to clarify continuation of orders. During an interview on 12/19/2025 at 10:35 AM, Licensed Practical Nurse Clinical Coordinator #1 stated when a resident returns from the hospital, medications and treatments are expected to be resumed unless there is documentation in the hospital discharge paperwork indicating otherwise. During an interview on 12/19/2025 at 11:14 AM, Registered Nurse Manager #1 stated Resident #154 had returned from the hospital and was on the unit from 12/06/2025 to 12/10/2025, medications were not given during this time, and missing medications used to treat Parkinson's disease could place the resident at increased risk for falls with injuries. 2. Resident #88 had diagnoses including diabetes, dementia, and high blood pressure. The Minimum Data Set, dated [DATE] revealed the resident had severe cognitive impairment. Review of current physician orders revealed Resident #88 was prescribed the following:- Humalog insulin (a fast-acting insulin given with meals), six (6) units two (2) times daily at lunch and dinner for hyperglycemia, hold for blood glucose less than 105 milligrams/deciliter (ordered on 12/05/2025).- Finger-stick blood glucose before meals. For blood glucose less than 80 milligrams/deciliter or greater than 300 milligrams/deciliter, place in medical book. For blood glucose greater than 400 milligrams/deciliter or under 70 milligrams/deciliter, call medical (ordered on 03/26/2025). Review of Resident #88's Medication Administration Records, Treatment Administration Records, blood glucose monitoring records, progress notes, and medication administration audit reports from 10/01/2025 to 12/18/2025 revealed the following: - On 10/07/2025, the resident's blood glucose was 73 milligrams/deciliter at 11:03 AM; six (6) units of Humalog were administered at 12:18 PM with no documented evidence of a repeat blood glucose measurement or interventions for low blood glucose