

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Wesley Gardens Corporation		STREET ADDRESS, CITY, STATE, ZIP CODE 3 Upton Park Rochester, NY 14607	

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)
<p>F 0577</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Allow residents to easily view the nursing home's survey results and communicate with advocate agencies.</p> <p>49368</p> <p>Based on observations and interviews and record review conducted during the Recertification Survey, it was determined the facility did not ensure the results of the most recent New York State Department of Health inspection survey conducted by Federal or State surveyors was available for residents, family members, and legal representatives and was posted in a place that was readily accessible to all residents and visitors. Specifically, the most recent survey results, including the plan of correction, was not available without individuals having to ask for them, the sign stating that they were available if requested was not easily readable for wheelchair bound residents or visitors and when asked the Receptionist was unable to provide the prior three years of Recertification and Abbreviated (complaint investigations) surveys. This is evidenced by the following:</p> <p>During a Resident Council Meeting held on 5/30/24 at 10:31 AM, five of five alert and oriented residents (Residents #28, #59, #97, #99, and #108) stated they were not aware of the location of the facility's New York State Department of Health posted survey results.</p> <p>During an observation on 5/30/24 at 2:50 PM, an 8 inch by 10-inch laminated sign was located on the receptionist desk in the main lobby and was not visible at wheelchair level. The sign included New York State Department of Health Survey Report is Available. The survey results were not available without having to ask for them, and when the previous three years' survey results were requested, the facility was unable to provide them.</p> <p>During an interview on 6/4/24 at 10:24 AM, the Receptionist Supervisor stated that the sign on the desk was not in a place that a resident, family, or others could readily access if they were in a wheelchair and stated they would need to ask if they wanted to examine survey results. The Receptionist Supervisor looked through the binder and acknowledged that only the 2/8/23 recertification survey was available and not the results from the previous three years. When asked regarding the previous three years results the Receptionist Supervisor stated the surveys (in the binder) were all they had available.</p> <p>During an interview on 6/6/24 at 9:51 AM, the Administrator stated they did not realize it (the sign) was not at eye level and that the receptionist should assist with getting the results if asked.</p> <p>10NYCRR415.3(d)(1)(vi)</p>

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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Wesley Gardens Corporation		STREET ADDRESS, CITY, STATE, ZIP CODE 3 Upton Park Rochester, NY 14607	
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)		
<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46526</p> <p>Based on interviews, and record reviews conducted during the Recertification Survey and Complaint Investigation (NY00318393) completed on [DATE], for four of five residents reviewed for advanced directives, the facility did not ensure that there was an organized system to ensure that resident wishes regarding Cardiopulmonary Resuscitation (CPR) and Do Not Resuscitate (DNR - do not initiate Cardiopulmonary Resuscitation in the event of acute cardiac or respiratory event) were followed. Specifically, Residents #22, #29, and #59 had discrepancies in their code status as identified on facility forms. Additionally, Resident #115 gave verbal consent on their Medical Orders for Life Sustaining Treatment (known as a MOLST) for Full Code (initiate Cardiopulmonary Resuscitation for acute cardiac and/or respiratory event) that was not signed by two witnesses. This is evidenced by, but not limited to the following:</p> <p>The facility policy Advanced Directives, revised [DATE], documented the resident's wishes are communicated to direct care staff and the physician by placing the advance directive documents in a prominent, accessible location in the medical record and discussing the resident's wishes in care planning meetings. The plan of care for each resident is consistent with his or her documented treatment preferences and/or advance directive. The interdisciplinary team will review annually with the resident, his or her advance directives to ensure that such directives are still the wishes of the resident. Such reviews will be made during the annual assessment process and recorded in the medical record.</p> <p>1. Resident #59 had diagnosis including heart failure, wound infection, and diabetes. The Minimum Data Set Resident assessment dated [DATE] noted Resident #59 was cognitively intact.</p> <p>Current Physician orders for Resident #59 did not include any orders for the resident's wishes for advanced directives.</p> <p>Review of Resident #59's Medical Orders for Life Sustaining Treatment form dated [DATE] and signed by Nurse Practitioner #2 revealed the resident's wishes as Do Not Resuscitate (allow natural death).</p> <p>Review of Nurse Practitioner #2's notes on [DATE], [DATE], and [DATE] revealed Resident #59's code status was documented as Full Code.</p> <p>During an interview on [DATE] at 10:45 AM Nurse Practitioner #2 stated they were now aware that Resident #59 wishes were for Do Not Resuscitate and that their notes indicated the resident's wishes for Full Code. Nurse Practitioner #2 stated that because there were no medical orders for advanced directives it was presumed the resident was a Full Code. Nurse Practitioner #2 stated they had notified the previous Social Worker of the discrepancy and Resident #59 would be medically documented as a Full Code until the Medical Orders for Life Sustaining Treatment form was completed. Nurse Practitioner #2 stated they were not aware of the Medical Orders for Life Sustaining Treatment form from [DATE].</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Wesley Gardens Corporation		STREET ADDRESS, CITY, STATE, ZIP CODE 3 Upton Park Rochester, NY 14607	

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)
<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Resident #22 had diagnoses that included heart failure, hypertension, and chronic obstructive pulmonary disease. The Minimum Data Set Resident assessment dated [DATE], documented the resident was cognitively intact.</p> <p>Review of Resident #22's Comprehensive Care Plan dated [DATE], documented the resident's wishes were Do Not Resuscitate.</p> <p>Resident #22's Medical Orders for Life-Sustaining Treatment dated [DATE] and signed by the resident and witnessed by a Registered Nurse and a family member documented Resident #22's wishes were for Cardiopulmonary Resuscitation.</p> <p>Review of interdisciplinary progress notes since admission revealed in multiple medical and nursing notes that Resident #22 was alert and oriented and able to make their needs known.</p> <p>During an interview on [DATE] at 1:33 PM, Licensed Practical Nurse Manager #1 stated they were made aware that day that Resident #22's care plan did not match their Medical Orders for Life-Sustaining Treatment form. Licensed Practical Nurse Manager #1 stated they were unaware that advanced directives were also in the Comprehensive Care Plan.</p> <p>In an interview on [DATE] at 2:31 PM, the Director of Nursing stated the Social Worker and nursing were responsible for advanced directives. The Director of Nursing stated that nursing should get the physician's orders and input it in the electronic health record and that the Social Worker should take care of the paperwork portion. The Director of Nursing stated that if a Medical Orders for Life-Sustaining Treatment form was changed then the order should be updated the same day.</p> <p>3. Resident #29 had diagnoses that included depression, schizophrenia, and hypertension. The Minimum Data Set Resident assessment dated [DATE], included that Resident #29 was severely impaired cognitively and advanced directive wishes included Do Not Resuscitate.</p> <p>Review of Resident #29's Medical Orders for Life-Sustaining Treatment form dated [DATE] and signed by the resident revealed their wishes as Do Not Resuscitate. Additionally, Section F, which noted that a physician must review the form from time to time, did not include documentation that Resident #29's Medical Orders for Life-Sustaining Treatment had been reviewed by a medical provider since [DATE].</p> <p>Current Physician orders included Do Not Resuscitate.</p> <p>In medical progress notes dated [DATE], [DATE] and [DATE] Nurse Practitioner #2 documented that Resident #29's code status as Full Code.</p> <p>Review of medical progress notes for approximately the previous three months revealed no documentation that the medical team had reviewed the resident's code status with the resident or their representative.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Wesley Gardens Corporation		STREET ADDRESS, CITY, STATE, ZIP CODE 3 Upton Park Rochester, NY 14607	
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)		
<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 10:23 AM, Nurse Practitioner #2 said when a resident is admitted to the facility, the Social Worker reviews the resident's code status with them (or their representative) and completes a Medical Orders for Life-Sustaining Treatment form. The form is then placed in a book for the medical provider to review. Nurse Practitioner #2 said a resident's code status is reviewed during care planning meeting or if it is requested and if there is a concern such as the resident's health is declining. Nurse Practitioner #2 stated they (medical team) are not involved in care plan meetings unless specifically asked. Nurse Practitioner #2 said residents' code status (Medical Orders for Life-Sustaining Treatment forms) are not reviewed by a medical provider with the resident or representative at regular intervals. Nurse Practitioner #2 said they would document a resident's code status in their visit note and did not know if Section F of the Medical Orders for Life-Sustaining Treatment forms are signed when reviewed or who was responsible for documenting that a resident's code status was reviewed. Nurse Practitioner #2 said Resident #29 was their patient and that the resident's code status was Do Not Resuscitate. When reviewed at this time and the code status discrepancies, Nurse Practitioner #2 said they use a program to dictate their visit notes and unless they specifically say a resident's code status, it automatically defaults to Full Code.</p> <p>10 NYCRR 415.3(f)(1)(ii)</p> <p>46880</p> <p>47641</p> <p>49368</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Wesley Gardens Corporation		STREET ADDRESS, CITY, STATE, ZIP CODE 3 Upton Park Rochester, NY 14607	
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)		
<p>F 0582</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>49368</p> <p>Based on interview and record review conducted during the Recertification Survey for two (Residents #12 and #534) of three residents reviewed, the facility did not ensure that the appropriate appeal notices were provided to Medicare beneficiaries prior to the termination of their Medicare benefits. Specifically, the residents/resident representatives were not provided with a Notice of Medicare Noncoverage letter informing them of their appeal rights following the termination of their Medicare benefits. This is evidenced by the following:</p> <p>Resident #12 was admitted to the facility under Medicare Part A services and was termed from Medicare A benefits effective 12/28/23. The resident remained in the facility for long term care with services not covered under Medicare. There was no documented evidence that a Notice of Medicare Noncoverage letter was provided to the resident or their representative informing them of their appeal rights following termination of their Medicare A benefits.</p> <p>Resident #534 was admitted to the facility under Medicare Part A services and discharged to the community on 4/30/24. There was no evidence that a Notice of Medicare Noncoverage letter was given to the resident or their representative informing them at least two days before the end of their Medicare covered Part A stay to notify them of their appeal rights prior to discharge.</p> <p>During an interview on 6/4/24 at 3:54 PM, the Corporate Director of Resident Services stated that the Social Worker was responsible for providing the residents or representatives with a Notice of Medicare Noncoverage letter at the termination of their benefits. If the Social Worker was not in the facility, the Minimum Data Set Resident Assessment department staff or the Business Office would then issue the letter. The Corporate Director of Resident Services stated they were unable to provide any evidence that the letters of noncoverage were given to Resident #12 and #534 or their representatives.</p> <p>During an interview on 6/6/24 at 9:51 AM the Administrator stated they were not aware of any concerns regarding Liability Notices.</p> <p>10 NYCRR 415.3</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Wesley Gardens Corporation		STREET ADDRESS, CITY, STATE, ZIP CODE 3 Upton Park Rochester, NY 14607	
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)		
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20765</p> <p>Based on observations, interviews, and record review conducted during the Recertification Survey and Complaint Investigations (NY00327022, NY00323935, NY00343607) it was determined that for five (1st, 2nd, 3rd, 4th, and 5th floors) of five occupied resident-use floors and one of one basement, the facility did not provide housekeeping or maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Specifically, hot water was not maintained above 90 degrees Fahrenheit (F), floors, walls, and ceilings were dirty and/or in disrepair, bathrooms and shower rooms were dirty and in disrepair, ventilation exhaust units in bathrooms, showers, and soiled utility rooms were not functioning resulting in foul odors, ice machines were dirty, ready stand lifts were dirty, plumbing fixtures were not maintained and/or working properly, there were ceiling plumbing leaks, overhead lights were not functional or functioning properly, light lenses and covers were missing, there were damaged electrical fixtures with exposed wiring, there was a dirty fan, and there was standing water on floors. The findings are:</p> <p>Observations on 5/28/24 at 9:24 AM included a faucet leak in the kitchen two bay sink where the handles were attached and up through the back flow preventer.</p> <p>Observations on 5/28/24 from 9:52 AM to 2:30 PM included the following:</p> <ol style="list-style-type: none"> 1. There was a black, slimy residue underneath the handwash sink next to the ice machine on the 5th floor near the nurse station. The residue appeared to be coming from a leaking drainpipe under the sink. 2. The lights over the beds in resident rooms [ROOM NUMBERS] were inoperable and the cover was missing from the light fixture in room [ROOM NUMBER]. Additionally, there was a hole in the wall from the doorknob in room [ROOM NUMBER]. 3. There was a strong urine and fecal odor in the 3rd, 4th and 5th floor soiled utility rooms across from the nurse stations. The exhaust ventilation grates in the ceilings of these rooms were observed not drawing air out of the room. Additionally, there was urine, body odor, and a sewage odor throughout the fifth floor and on the elevator. 4. The floor in the shower room near room [ROOM NUMBER] was dirty with hair and dark debris. 5. The bathroom in room [ROOM NUMBER] had a significant fecal odor, the toilet was clogged, and the exhaust ventilation was not functional. 6. There was a Packaged Terminal Air Conditioner (PTAC) unit disassembled on the floor of room [ROOM NUMBER] with the plug missing and exposed wire ends coming from a partially open electrical outlet box. 7. There was a strong urine and fecal odor in room [ROOM NUMBER] (unoccupied) and the bathroom toilet was clogged with yellow and brown material. The exhaust ventilation grate in the bathroom ceiling was observed not drawing air out of the room. <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Wesley Gardens Corporation		STREET ADDRESS, CITY, STATE, ZIP CODE 3 Upton Park Rochester, NY 14607	
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)		
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>8. The garbage storage room on the 4th floor contained a sink with brown debris in the base and no handles to turn it on. There was also a section of drywall missing in this room that was approximately three feet long by 1.5 feet wide.</p> <p>9. The sinks in the 3rd and 5th floor garbage storage rooms, near rooms [ROOM NUMBERS], lacked handles and were not functional.</p> <p>10. The staff bathroom door by the 4th floor dining room was locked with a sign that read: Out of order temporarily.</p> <p>11. The ice machine dispenser on the counter next to the 4th floor nurse station had a slimy brown, pink, and black residue in the area where the ice ejects.</p> <p>12. There was a toilet seat in the 4th floor dining room bathroom on the floor next to the toilet.</p> <p>13. The footrests on ready stand lifts located in the hallway near room [ROOM NUMBER], the 2nd floor therapy room, and in the 2nd floor shower room were dirty with an accumulation of crumbs and other debris.</p> <p>14. The light lens above the bed in room [ROOM NUMBER] was cracked and damaged, and the exhaust ventilation grate in the ceiling of the bathroom room was observed to not be drawing air out of the room.</p> <p>15. There was a flower vase in room [ROOM NUMBER] that was filled with a cloudy yellow liquid with dead moldy flowers floating.</p> <p>16. A Wind Machine brand portable fan located in the hall on an overbed table near the 3rd floor nurse station had a build-up of dust on the cover and fan blades.</p> <p>17. There was a strong urine and fecal odor in rooms 309, 318, and throughout the corridor from rooms 301 to 308 (3rd floor).</p> <p>18. The temperature of the water from the shower fixture in the 2nd floor shower room (across from room [ROOM NUMBER]) did not get higher than 74 F, after being run for several minutes.</p> <p>19. The main fire alarm annunciator panel behind the reception desk in the 1st floor lobby displayed several supervisory trouble signals related to the penthouse exhaust fans for toilets and lounges.</p> <p>20. The urinal in the 1st floor men's bathroom across from the reception desk would not completely flush. When activated the device would briefly flush and did not push the urine down the drain.</p> <p>21. One of the three toilets in the basement women's locker room was not functional and one of the two sinks in the room was inoperable. Additionally, one of the two sinks was not functional in the 1st floor women's bathroom near the lobby and the other sink would only dispense cool water.</p> <p>22. There was approximately four inches of standing water on the floor in the basement boiler room. A sump pump was observed in a pit outside the basement boiler room with an accumulation of water, leaves, and garbage, and the drains in this pit appeared to be clogged.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Wesley Gardens Corporation		STREET ADDRESS, CITY, STATE, ZIP CODE 3 Upton Park Rochester, NY 14607	
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)		
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>23. The ceiling lighting in the basement fire pump room, generator room, and boiler room were continuously blinking and flashing brightly.</p> <p>24. There was standing water on the floor in the basement air handler room with water dripping down from the unit.</p> <p>During an interview on 5/28/24 at 10:22 AM Resident #97 stated that they have not had a shower since early December 2023 and that they receive bed baths with cold water, and were told that the facility does not have hot water. During another interview at 12:41 PM Resident #512 stated that they had not had a shower in a month as staff told them that they were having trouble with the water and that it is cold.</p> <p>Observations on 5/30/24 at 12:08 PM included a floor tile in the 4th floor dining room that was loose, partially broken, and not adhered to the floor.</p> <p>During an interview on 5/31/24 at 4:35 PM Certified Nursing Assistant #1 stated we can usually give resident showers when the water is warm but usually the water is freezing, and that the water has been cold consistently since June of last year. Certified Nursing Assistant #1 also stated that the high side hall on every unit does not have hot water or a full strong stream, and sometimes the water looks green or yellow.</p> <p>Observations on 5/31/24 at 5:11 PM included the hot water temperature in the shower on the 5th floor next to room [ROOM NUMBER] was 73.8 F after running for several minutes, and the water came out at a very low pressure like drips.</p> <p>Observations on 5/31/24 at 10:04 AM included an approximately one foot by four-foot ceiling tile in the 2nd floor corridor outside room [ROOM NUMBER] was brown, stained, and wet from a leak above.</p> <p>During an interview on 5/31/24 at 10:45 AM, the regional maintenance director stated that for maintenance it is just themselves, because one of the maintenance staff is out on medical leave and the other one left about two weeks ago. Further record review at 2:52 PM revealed another maintenance technician was hired 5/2/24 and was terminated from employment 5/21/24.</p> <p>Observations on 5/31/24 at 11:12 AM included an electrical connection behind and above the dryers in the first-floor laundry room had green and red wires exposed including the copper wiring ends and wire nuts.</p> <p>During an interview on 5/31/24 at 12:34 PM a resident family member stated that the floors in the room are sticky, dirty, and the facility smells of urine and feces, and that it is not right or humane.</p> <p>During an interview on 5/31/24 at 1:31 PM Resident #97 stated that they denied a bed bath last night because the water was too cold, and they would have taken a shower if the water was warm and if they were offered.</p> <p>Record review of a facility grievance for resident #73 and dated 1/15/24 documented that this resident does not have hot water for when they wash up and that staff wash them with cold water.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Wesley Gardens Corporation		STREET ADDRESS, CITY, STATE, ZIP CODE 3 Upton Park Rochester, NY 14607	
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)		
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observations on 6/2/24 at 5:47 PM included the hot water temperature in the 5th floor shower room near room [ROOM NUMBER] was 75.3 F after running for several minutes, and the water pressure was observed to be just a trickle. Further observations included the toilet in this shower room was filled with paper and stool and the shower room smelled of stool.</p> <p>Review of a nursing progress note dated 6/4/24 at 6:31 AM revealed that Resident #75 had a bed bath and that there had been no hot water on the unit (4th floor).</p> <p>During an interview on 6/4/24 at 10:26 AM Licensed Practical Nurse #1 stated that they knew a couple of times the water went out and that they do not think the water is hot.</p> <p>During an interview on 6/4/24 at 11:23 AM the Regional Director of Maintenance stated that maintenance takes daily water temperatures and records them in a log. Record review of hot water temperature logs revealed multiple temperatures of hot water at points of use in resident rooms were less than 90 F beginning on 5/14/24.</p> <p>During an interview on 6/4/24 at 12:22 PM Certified Nursing Assistant #2 stated that they do not use the showers on the 5th floor because the water is cold and it is very difficult to give residents showers. Certified Nursing Assistant #2 also stated that only the shower on unit two (second floor) had hot water, and they have to get people up and get them downstairs. Certified Nursing Assistant #2 stated that there was a shower list, but they had to go down and check to see if the shower was occupied.</p> <p>On 6/4/24 at 12:41 PM the surveyor thermometer was calibrated using the ice-point method and read 32.1 F.</p> <p>In an interview on 6/5/24 at 2:31 PM The Director of Nursing stated many residents refuse showers as they do not want to go to another floor. The Director of Nursing stated the water pumps are in house and that they are working on someone to get them installed so that the 5th floor can have better water pressure.</p> <p>During an interview on 6/6/24 at 8:51 AM Certified Nursing Assistant #3 stated the water temperatures have been inconsistent for 6 months and the water pressure in the shower room at the end of the hall has been bad for about a month or two.</p> <p>10NYCRR: 415.29, 415.29(c), 415.29(d), 415.29(g), 415.29(h)(1), 415.29(i)(1,2), 415.29(j)(1)</p> <p>47641</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Wesley Gardens Corporation		STREET ADDRESS, CITY, STATE, ZIP CODE 3 Upton Park Rochester, NY 14607	
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)		
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46880</p> <p>Based on interviews and record reviews conducted during the Recertification Survey and Complaint Investigation (NY00326620), the facility did not ensure each resident was free from misappropriation of resident property and exploitation for two (Residents #28, #57) of four residents reviewed for missing property and for three (Residents #59, #99, and #108) residents interviewed during Resident Council. Specifically, the residents reported missing money, clothing, and personal items and the facility was unable to provide documentation that the missing property complaints had been investigated and/or any resolutions offered for the missing property. This is evidenced by the following:</p> <p>The facility policy Personal Property with a revised date of August 2022, documented the facility promptly investigates any complaints of misappropriation or mistreatment of resident property.</p> <p>The facility policy Lost and Found, dated of January 2008, documented the facility shall assist all personnel and residents in safeguarding their personal property. Resident or family complaints of missing items must be reported to the Director of Nursing, lost and found records will be maintained for one year, then destroyed and reports of misappropriation or mistreatment of resident property are immediately investigated.</p> <p>During Resident Council meeting on 5/30/24 at 10:30 AM several residents reported that they were missing personal items and that the facility had not provided any resolutions. Resident #59 stated they were missing an electric razor, and their cell phone was stolen approximately 6 months ago. Resident #99 stated they have had several items missing and have been asking staff about them for a long time. Resident #108 stated they were missing a cell phone charger and has had no follow-up.</p> <p>When requested the facility was unable to provide documentation regarding any resident's missing property and/or any resolutions for the past year.</p> <p>1. Resident #28 had diagnosis including dementia, diabetes, and heart failure. The Minimum Data Set Resident assessment dated [DATE] included that Resident #28 was cognitively intact.</p> <p>During an interview on 5/31/24 at 12:34 PM Resident #28's Representative stated they label the resident's clothes, but they still get lost, and that the resident was missing three new tops, four pairs of shorts, and twenty bras within the last year. The Representative stated that they have told staff at the facility, filled out missing item reports, and gone to the laundry room themselves to look.</p> <p>2. Resident #57 had diagnoses including, chronic kidney disease dependence on dialysis and diabetes. The Minimum Data Set Resident assessment dated [DATE] included that the resident was moderately cognitively impaired.</p> <p>In an interview on 6/4/24 at 10:54 AM Resident #57 stated that they were missing two sweaters, three dress shirts, the padding for their wheelchair, and a blanket. Resident #57 stated that they were also missing \$60 a few months ago and the facility did not do anything about it. Resident #57 stated that they reported the missing items to several staff, but no paperwork had been filled out.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Wesley Gardens Corporation		STREET ADDRESS, CITY, STATE, ZIP CODE 3 Upton Park Rochester, NY 14607	
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)		
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/31/24 at 9:44 AM Laundry Aide #1 stated unlabeled clothing should be put in a cart and sent downstairs. If a resident reported missing something they would go to the basement to look for the specific item and if unable to locate it, they would notify the supervisor.</p> <p>During an interview on 6/5/24 at 1:33 PM Licensed Practical Nurse Manager #1 stated that they were informed that day that Resident #57 was missing their wheelchair pillow but were not aware of the other items. Licensed Practical Nurse Manager #1 stated that they email everyone when there is a missing item reported and let staff and other nurse managers know to keep an eye out and to follow up on it. Licensed Practical Nurse Manager #1 stated that the Social Worker should get notified by email and start the paperwork and take care of the issue from there.</p> <p>In an interview on 6/5/24 at 2:31 PM the Director of Nursing stated they would expect staff to look for and report off any missing item and report it to the Social Worker and themselves. If the item was not found, then the item would be replaced. The Director of Nursing stated that they are usually involved with grievance forms and was not aware of Resident #57 missing any items.</p> <p>The facility Social Worker was not available for interview.</p> <p>10 NYCRR 415.4(b)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Wesley Gardens Corporation		STREET ADDRESS, CITY, STATE, ZIP CODE 3 Upton Park Rochester, NY 14607	
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)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20765</p> <p>Based on observations, interviews, and record review conducted during a Recertification Survey and Complaint Investigations (NY00337587, NY00324938, NY00321613, NY00323935, NY00317625, NY00328756) for six of six residents reviewed, the facility could not provide evidence that allegations of resident abuse and injuries of unknown origin were thoroughly investigated. Specifically for Resident #22 there was no evidence that an allegation of staff abuse had been investigated. For Residents #44, #68 and #100 there was no evidence that allegations of resident-to-resident abuse had been investigated. For Residents #87 and #371 there was no evidence that the facility investigated injuries of unknown origin. This is evidenced by but not limited to the following:</p> <p>1. Resident #371 had diagnoses that included a history of falls, adult failure to thrive, and visual hallucinations. The Minimum Data Set Resident assessment dated [DATE] documented the resident was cognitively intact.</p> <p>Review of the Comprehensive Care Plan dated [DATE], revealed Resident #371 had a self-care performance deficit with activities of daily living and was totally dependent on staff for bed mobility, transfers, and toileting.</p> <p>Review of Resident #371's electronic medical record revealed the following:</p> <p>a. On [DATE] Nurse Practitioner #2 documented that the resident had a swallow evaluation due to bilateral neck swelling and demonstrated pharyngeal dysphagia (difficulty swallowing) likely caused by swelling.</p> <p>b. On [DATE] a Nurse Manager documented that the resident was seen by the Physician who said the neck swelling had gotten bigger and that the resident was still complaining of difficulty swallowing with fluids getting stuck. The resident was sent to the emergency department.</p> <p>c. On [DATE], in a hospital progress note, the hospital Physician documented that they evaluated Resident #371 and determined that resident had a laryngeal (voice box) fracture. The Physician documented that laryngeal fractures were most often caused by trauma, but that the patient (Resident #371) had no clear history to account for this. However, fracture during a fall or from non-accidental trauma could not be excluded.</p> <p>d. On [DATE] a Medical Examiner request included that a subpoena had been sent to the facility informing them that Resident #371 had died on [DATE]. The Medical Examiner requested an incident report from the facility that would explain why the resident was transported to the hospital on [DATE].</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Wesley Gardens Corporation		STREET ADDRESS, CITY, STATE, ZIP CODE 3 Upton Park Rochester, NY 14607	
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)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on [DATE] at 11:51 AM, the Director of Nursing stated that if a resident had an injury with unknown origin, a Registered Nurse should assess the resident, determine if the resident could state what happened, notify the medical team, the resident's family, and then they would initiate an investigation. The Director of Nursing said they had spoken with the hospital Social Worker who felt Resident #371's injuries were consistent with someone who had been assaulted. The Director of Nursing said they did not attribute the resident's neck swelling to anything that needed to be investigated but that looking back, the Registered Nurse who discovered the swelling to the resident's neck should have initiated an investigation, but they did not think of it at the time.</p> <p>During an interview on [DATE] at 9:53 AM, Nurse Practitioner #2 stated they evaluated Resident #371 and felt it was urgent to send the resident to the hospital because the resident's neck was large, and they were having trouble swallowing. Nurse Practitioner #2 said when an injury of unknown origin occurs, the facility should complete an Incident/Accident report, investigate, and determine a root cause. Nurse Practitioner #2 said that given the hospital provider's notes that trauma could not be excluded, the facility should have started an investigation.</p> <p>During a phone interview on [DATE] at 2:26 PM, a family member said they saw Resident #371 a few days before they were sent to the hospital and that they had had a red mark on the left side of their throat and the following week their neck was swollen. The family member stated that no one from the facility had called them regarding the resident's neck being red and swollen.</p> <p>2. Resident #22 had diagnoses that included heart failure, hypertension, and chronic obstructive pulmonary disease. The Minimum Data Set Resident assessment dated [DATE] documented the resident was cognitively, able to make themselves understood and able to understand with clear comprehension.</p> <p>An Incident/Accident Report provided by the facility included that a progress note dated [DATE] and written by a nurse documented that physical aggression took place in Resident #22's room. Resident #22 had reported that two Certified Nursing Assistants were rough when providing care, held their arm down and pushed their fingernails into their back. Resident #22 reported that one of the Certified Nursing Assistants pinched their skin and stuck their middle finger out at the resident on their way out of their room. The Incident/Accident Report included that both Certified Nursing Assistants were told to not go back into Resident #22's room for any reason, that the resident was alert and oriented, did not have any injuries and that the investigation was ongoing.</p> <p>The facility was unable to provide any further documentation that the alleged incident had been investigated.</p> <p>During an interview on [DATE] at 2:31 PM, the Director of Nursing stated that they did recall the alleged incident with Resident #22 on [DATE]. The Director of Nursing stated that Resident #22 can be a storyteller but that a lot of the things they say can have some merit. The Director of Nursing stated one of the Certified Nursing Assistants was terminated due to the alleged incident and that they believe a full investigation was completed but the facility could not locate it.</p> <p>3. Resident # 68 had diagnoses that included weakness, repeated falls, and dementia. The Minimum Data Set Resident assessment dated [DATE], included the resident was severely impaired cognitively.</p> <p>Resident #100 had diagnoses that included dementia, diabetes, and heart disease. The Minimum Data Set Resident assessment dated [DATE], documented the resident was severely impaired cognitively.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Wesley Gardens Corporation		STREET ADDRESS, CITY, STATE, ZIP CODE 3 Upton Park Rochester, NY 14607	
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)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #68's current Comprehensive Care Plan revealed the resident could display aggression and had impaired cognitive thought process due to their dementia.</p> <p>Review of Resident #100's Comprehensive Care Plan dated [DATE], revealed the resident was aggressive towards others and had impaired cognitive thought processes related to their dementia.</p> <p>Review of an Incident/Accident Report dated [DATE] revealed that Resident #100 sustained a lump on top of their head with a small cut, after being hit in the head with a reaching device by another resident. The Incident and Accident report did not include witness statements, or any additional notes related to the event.</p> <p>Review of the compliant form reported to the Department of Health by the previous Administrator revealed that a resident-to-resident incident involving Resident #100 and Resident #68 had occurred on [DATE]. Upon request, the facility could not provide any evidence that a thorough investigation of the incident had been completed. Additionally, several subsequent incidences were reported to the Department of Health by the facility, and the facility could not provide evidence that any of these incidences had been investigated.</p> <p>During an interview on [DATE] at 10:05 AM, the Corporate Infection Preventionist stated the incident was identified in either February or [DATE] and that the investigations were missing, likely due to changes in facility leadership.</p> <p>In an emailed correspondence dated [DATE] at 11:04 AM, the Corporate Infection Preventionist stated that they could not locate any facility investigations related to these events.</p> <p>10 NYCRR 415.4(b)(1)</p> <p>46526</p> <p>46880</p> <p>47641</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Wesley Gardens Corporation		STREET ADDRESS, CITY, STATE, ZIP CODE 3 Upton Park Rochester, NY 14607	
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)		
<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39181</p> <p>Based on record review and interviews conducted during the Recertification Survey and Complaint Investigation (NY00327022), for three (Residents #90, #116, #371) of four residents reviewed the facility did not ensure that notification of a discharge/transfer was provided to the resident and/or the resident's representative in writing, and in a language and manner they understood, as soon as possible when an immediate discharge/transfer was required by the resident's urgent medical needs. Additionally, the facility did not ensure a copy of the notice was sent to a representative of the Office of the State Long-Term Care Ombudsman. This is evidenced by the following:</p> <p>Review of the facility policy, Transfer or Discharge Notice, dated March 2021 revealed that residents and/or representatives would be notified in writing, and in a language and format they understood as soon as possible but before the transfer or discharge, when an immediate transfer or discharge was required by the resident's urgent medical needs. The policy included that a copy of the notice would be sent to the Office of the State Long-Term Care Ombudsman at the same time the notice of transfer or discharge was provided to the resident and representative.</p> <p>1. Resident #371 had diagnoses including adult failure to thrive, spinal stenosis, and chronic kidney disease. The Minimum Data Set Resident assessment dated [DATE] revealed the resident was cognitively intact.</p> <p>In a medical team note, dated 3/21/24 Nurse Practitioner #2 documented that Resident #371 had a change in symptoms, difficulty swallowing, and required transfer to the emergency department.</p> <p>Review of Resident #371's electronic health record did not include any documentation that a written notice of the transfer had been provided to the resident and/or their representative.</p> <p>2. Resident #90 had diagnoses including seizure disorder, dysphagia (difficulty swallowing), and dementia. The Minimum Data Set Resident assessment dated [DATE] revealed the resident had severe cognitive impairment.</p> <p>In a nursing progress note, dated 8/27/24 Licensed Practical Nurse #4 stated that Resident #90 was transferred to the hospital at approximately 4:40 PM to get their Percutaneous Endoscopic Gastrostomy (PEG) (a tube inserted directly into the stomach to provide nutrition for residents with swallowing difficulties) fixed.</p> <p>Review of Resident #90 electronic health record did not include any documentation that a written notice of transfer had been provided to the resident and/or their representative.</p> <p>3. Resident #116 had diagnoses including chronic obstructive pulmonary disease (lung disease that makes it difficult to breathe), congestive heart failure, diabetes. A mental status interview, dated 3/18/24, revealed the resident was cognitively intact.</p> <p>In a nursing progress note, dated 3/19/24 Licensed Practical Nurse #8 documented that Resident #116 was transferred to the hospital by Emergency Medical Services and the family was to be notified.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Wesley Gardens Corporation		STREET ADDRESS, CITY, STATE, ZIP CODE 3 Upton Park Rochester, NY 14607	
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)		
<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #116 electronic health record did not include any evidence that a written notice of transfer had been provided to the resident and/or their representative.</p> <p>The facility was unable to provide any documented evidence that a written notice of the transfers, to include the specific reason for the transfer, the date of the transfer, and the location of the transfer had been provided to any of the residents or their representatives. Additionally, the facility was unable to provide any documentation that the Office of the State Long Term Care Ombudsman office had been notified of the transfers per the regulations.</p> <p>During an interview on 6/5/24 at 11:39 AM, Registered Nurse Manager #3 stated when residents are transferred to the hospital nursing staff should complete an electronic alert that notifies all departments that a resident was being transferred and contact the family. Registered Nurse Manager #3 stated transfer notices were completed by the Receptionist or the Nursing Supervisor.</p> <p>During an interview on 6/5/24 at 11:58 AM, the Business Office Representative stated they did not have a role in the resident transfer or discharge process and did not provide any written notices to the resident, the resident representative, or the Ombudsman.</p> <p>During an interview on 6/5/24 at 12:12 PM, the Reception Supervisor stated nursing staff notified the Receptionist why a resident was being sent out and to where. Then the Receptionist would print the relevant medical documentation, complete an electronic alert that notified all departments that a resident was being transferred, and send an email to the Admission/Discharge team. When a resident was transferred during an off shift (i.e., night shift) the Nursing Supervisor was responsible for completing the process. The Reception Supervisor stated they were not involved in notifying the Ombudsman of any resident transfers or discharges and was not sure who was responsible.</p> <p>During an interview on 6/5/24 at 1:42 PM and again at 1:57 PM, the Director of Nursing stated the Business Office was responsible for completing notifications and providing the written notice to the resident and their representative when a resident was transferred to the hospital. The Director of Nursing later stated the Ombudsman's Office was notified of resident transfers and discharges once monthly via fax. Documentation for the notification of the Ombudsman was requested at this time.</p> <p>During an interview on 6/6/24 at 11:37 AM, Registered Nurse Manager #2 stated, on behalf of the Director of Nursing, the facility was unable to provide any documentation that notifications of transfers and discharges had been provided to the Ombudsman due to the inability to access the previous Social Worker's files.</p> <p>10 NYCRR 415.3(i)(1)(iv)(a-e)</p> <p>46880</p> <p>49368</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Wesley Gardens Corporation		STREET ADDRESS, CITY, STATE, ZIP CODE 3 Upton Park Rochester, NY 14607	
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)		
<p>F 0655</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39181</p> <p>Based on interviews, and record review conducted during the Recertification Survey, for four (Residents #57, #73, #105, and #519) of 13 residents reviewed the facility did not ensure a baseline care plan had been completed within 48 hours of a resident's admission and that a summary of the baseline care plan had been provided to the resident and/or their representative. Specifically, for Resident #57, the facility could not provide documented evidence that a baseline care plan had been completed within 48 hours of the resident's admission. For Residents #73, #105, and #519, the facility could not provide evidence that a summary of the baseline care plan had been provided to the resident and/or their representative. This included, but was not limited to, the following:</p> <p>Review of the facility policy, Care Plans - Baseline, dated January 2020, revealed that a baseline plan of care to meet the resident's immediate needs would be developed for each resident within forty-eight (48) hours of admission. The facility would provide the resident and the representative, if applicable, with a written summary of the baseline care plan by completion of the comprehensive care plan. Additionally, the facility would document and record receipt of the information by the family, whether in the form of a copy of signed acknowledgement or a note within resident's clinical record.</p> <p>1. Resident #57 had diagnoses including End Stage Renal Disease, diabetes, and chronic kidney disease. The Minimum Data Set Resident assessment dated [DATE] revealed the resident had moderately impaired cognition.</p> <p>Review of the electronic health record did not include documented evidence that a baseline care plan had been completed for Resident #57 following admission and prior to their comprehensive care plan meeting.</p> <p>When requested, the facility was unable to provide any documented evidence that the resident's baseline care plans had been completed.</p> <p>2. Resident #73 had diagnoses including diabetes, chronic kidney disease, and major depressive disorder. The Minimum Data Set Resident assessment dated [DATE] revealed the resident was cognitively intact.</p> <p>Resident #73's baseline care plan dated 12/6/23 did not include any evidence that a summary of the baseline care plan had been provided to the resident and/or their representative.</p> <p>Review of Resident #73's medical record revealed no evidence that a summary of the baseline care plan had been provided to the resident and/or their representative following admission.</p> <p>3. Resident #519 had diagnoses including myelodysplastic syndrome (a group of disorders caused when something disrupts the production of blood cells), congestive heart failure, and anemia. The Minimum Data Set Resident assessment dated [DATE] revealed the resident was cognitively intact.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Wesley Gardens Corporation		STREET ADDRESS, CITY, STATE, ZIP CODE 3 Upton Park Rochester, NY 14607	
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)		
<p>F 0655</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Resident #519's baseline care plan, dated 5/9/24, did not include any evidence that a summary of the baseline care plan had been reviewed with the resident and/or their representative.</p> <p>Review of Resident #519's medical record revealed no evidence that a summary of the baseline care plan had been provided to the resident and/or their representative following admission.</p> <p>During an interview on 6/6/24 at 8:28 AM, the Corporate Director of Resident Services (acting Social Worker) stated that each discipline completed their own section of the baseline care plan, but they were not sure who presented the summary to the resident or their representative. They stated the baseline care plan should be reviewed with the resident by social work or nursing but recognized that the facility did not have a good process in place for this.</p> <p>During an interview on 6/6/24 at 9:16 AM, Registered Nurse Manager #2 stated the baseline care plan was supposed to be completed within the first 48 hours of admission thought that the Social Work reviewed the baseline care plan with the resident and/or family during the care plan meeting.</p> <p>During an interview on 6/6/24 at 9:51 AM with the Administrator and the Director of Nursing both stated that they were not aware of any concerns related to the baseline care plans.</p> <p>During a follow-up interview on 6/6/24 at 10:48 AM, the Director of Nursing stated it was the Social Worker's responsibility to present the baseline care plan summary to the resident and/or their representative. The Director of Nursing stated they thought that all baseline care plans were current, however, if they were not signed by the resident or their representative, then the summary had not been presented.</p> <p>10 NYCRR 415.11(c)(1)</p> <p>47641</p> <p>47642</p> <p>49368</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Wesley Gardens Corporation		STREET ADDRESS, CITY, STATE, ZIP CODE 3 Upton Park Rochester, NY 14607	
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)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46526</p> <p>47641</p> <p>47642</p> <p>Based on observations, interviews, and record review conducted during a Recertification Survey and Complaint Investigations (NY318393, NY00323935, NY00328756, and NY00343607) for three (Residents #52, #76, #87) of nine residents reviewed 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, Resident #52 was not provided with the assistance to obtain a haircut, Resident #76 was observed with uncut nails and unshaven facial hair and Resident #87 had oily and unwashed hair. This is evidenced by the following:</p> <p>The facility policy Supporting Activities of Daily Living dated March 2018, documented that residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out Activities of Daily Living and the date and time of fingernail care, shaving and hair shampooing should be documented in the resident's medical record.</p> <p>1. Resident #87 had diagnoses including Lewy body dementia (a type of dementia characterized by changes in sleep, behavior, and movement), chronic obstructive pulmonary disease (a chronic inflammatory lung disease), and major depressive disorder (a mood disorder characterized by a persistent feeling of sadness). The Minimum Data Set Resident assessment dated [DATE] documented that Resident #87 was severely impaired cognitively and required assistance with personal hygiene.</p> <p>Review of the current Comprehensive Care Plan and Kardex (care plan used for Certified Nursing Assistants for daily care) revealed Resident #87 required extensive assistance of staff with showering and personal hygiene.</p> <p>During an interview on 5/28/24 at 1:30 PM Resident #87 and a visitor stated that the resident had only had a few showers since they had been admitted (approximately six months) and wished they could have their hair washed in the shower (versus a no water cap that staff had been using). Resident #87 stated staff wipe them down (with a cloth) for washing but that they would really like a shower.</p> <p>During an interview on 6/5/24 at 11:56 AM Certified Nursing Assistant #5 stated that residents received hair washing on their shower day (weekly) which they documented (in the computer) and if a resident refused care, they documented the refusal and informed the nurse.</p> <p>During an observation on 6/6/24 at 9:30 AM, Resident #87 was observed in the dining room and their hair appeared stringy, oily, and unwashed (despite the previous day being the resident's assigned shower day).</p> <p>Review of Resident #87's electronic health record revealed no documented evidence that the resident had received any showers for the previous thirty days and no documented evidence of refusals.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Wesley Gardens Corporation		STREET ADDRESS, CITY, STATE, ZIP CODE 3 Upton Park Rochester, NY 14607	
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)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/6/24 at 8:33 AM, Licensed Practical Nurse #3 stated that washing hair was usually done with residents' showers but sometimes there were not enough staff, and that the water (hot) temperature has been an issue.</p> <p>During an interview on 6/6/24 at 9:05 AM, Certified Nursing Assistant #6 stated Resident #87 did not like their hair greasy.</p> <p>2. Resident #76 had diagnoses of Alzheimer's disease, legal blindness, and hypertension. The Minimum Data Set Resident assessment dated [DATE], revealed Resident #76 was severely impaired of cognitive function.</p> <p>Review of the current Comprehensive Care Plan and Kardex revealed Resident #76 required the assistance of staff to complete personal hygiene and nail trimming and required verbal cues and encouragement to complete the tasks.</p> <p>In an observation on 5/28/24 at 9:17 AM, Resident #76 had long nails and several days growth of facial hair. Resident #76 stated at the time that they needed to be shaved.</p> <p>During an observation and interview on 5/30/24 at 11:13 AM, Resident #76 was in the dining room and remained unshaven and with long nails. Resident #76 stated they were not growing out their beard and needed to shave but needed somebody to do it.</p> <p>During observations on 5/31/24 at 4:37 PM, 6/2/24 at 5:19 PM, 6/3/24 at 12:11 PM, and 6/4/24 at 2:21 PM, Resident #76 continued to be unshaven and had long nails.</p> <p>Review of the May 2024 Treatment Administration Record revealed that showers were scheduled for Resident #76 weekly on Monday evenings. There was one shower documented for the month of May on 5/27/24.</p> <p>During an interview on 6/5/24 at 11:56 AM, Certified Nursing Assistant #5 stated that on shower days resident's nails should be cut and facial hair shaved, and this should be documented in the computer when provided or if a resident refused. Certified Nursing Assistant #5 they were a float from another unit and the surveyor would have to ask a unit Certified Nursing Assistant why it had not been completed for Resident #76.</p> <p>During an observation and interview on 6/6/24 at 10:55 AM, Registered Nurse Manager #1 stated the nurses have a section in the electronic health record to document showers and should document if refused. Registered Nurse Manager #1 said that shaving should be offered on shower days and that Resident #76 should have been assisted with shaving. When observed Resident #76 remained with facial hair and several jagged nails. Registered Nurse Manager #1 asked Resident #76 if they wanted a shave and Resident #76 stated yes.</p> <p>3. Resident #52 had diagnoses that included ankylosing spondylitis (a rare type of autoimmune disease that causes arthritis in your spine), hypertension, and schizoaffective disorder (a mental health condition). The Minimum Data Set Resident assessment dated [DATE], revealed that Resident #52 was cognitively intact and was dependent upon staff for grooming and personal hygiene.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Wesley Gardens Corporation		STREET ADDRESS, CITY, STATE, ZIP CODE 3 Upton Park Rochester, NY 14607	
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)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the current Comprehensive Care Plan and Kardex revealed Resident #52 required set-up help for personal hygiene.</p> <p>During an observation and interview on 5/28/24 at 12:20 PM, Resident #52 was in bed. Their hair touched their shoulder. Resident #52 stated they have wanted a haircut for awhile but there was no stylist in the facility and added that their family was trying to get them a haircut for their birthday.</p> <p>During an interview on 6/6/24 at 8:59 AM, the Activities Director stated that the last barber had left the facility over a month ago and the facility has not hired anyone yet. The Activities Director stated that they do not keep a list of requests for haircuts and had not been aware that Resident #52 wanted a haircut.</p> <p>10 NYCRR 415.12(a)(3)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Wesley Gardens Corporation		STREET ADDRESS, CITY, STATE, ZIP CODE 3 Upton Park Rochester, NY 14607	
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)		
<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assist a resident in gaining access to vision and hearing services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47641</p> <p>Based on observation, interview and record review conducted during a Recertification Survey the facility did not ensure that proper treatment to maintain hearing abilities was provided for one (Resident #51) of one resident reviewed for hearing. Specifically, Resident #51 did not have their ears flushed per Physician orders. This is evidenced by:</p> <p>The facility policy, Activities of Daily Living, dated May 2018, documented residents will be provided with care, treatment, and services to ensure that their activities of daily living do not diminish unless the circumstances of their clinical conditions demonstrate that diminishing activities of daily living are unavoidable.</p> <p>Resident #51 had diagnoses including chronic obstructive pulmonary disease, diabetes, and hypertension. The Minimum Data Set Resident assessment dated [DATE] documented the resident was cognitively intact and did not require the use of a hearing device and that the resident's hearing was adequate.</p> <p>Review of the Comprehensive Care Plan initiated 1/1/23 documented that Resident #51 was able to communicate her needs effectively and to refer to Audiology for hearing consult as ordered.</p> <p>In a nursing progress notes dated 3/11/24 the Registered Nurse documented that Resident #51 was seen at their family's request to evaluate their ears for cerumen (ear wax). Using video otoscope, the Registered Nurse found the left ear contained a large amount cerumen and the right ear was impacted with cerumen. A large amount of cerumen was removed but canal remains occluded.</p> <p>Review of a medical progress note, and Physician orders dated 4/17/24 revealed that Resident #51 complained of having wax in their ears not relieved with ear drops and the Physician ordered both ears flushed.</p> <p>Review of Resident #51's April 2024 and May 2024 Medication Administration Records revealed an order to please flush ears bilaterally - cerumen impaction. There was no documentation that the ear flushed were ever completed (all boxes were 'x' out).</p> <p>Review of Resident #51's nursing and medical progress notes from 4/17/24 to 6/4/24 revealed no mention of whether Resident #51's ears had been flushed or any refusals.</p> <p>In an interview on 5/28/24 at 12:38 PM and again on 6/5/24 at 9:33 AM Resident #51 stated that they could not hear and asked the surveyor to yell. Resident #51 stated that they could not hear out of either of their ears and that not being able to hear bothered them and having to say what did you say? to everyone was annoying.</p> <p>During an interview on 6/5/24 at 1:33 PM Licensed Practical Nurse Manager #1 stated they did not know that there was an order to flush Resident #51's ears and an x in the Medication Administration Record would mean that it was not scheduled for that date and time. Licensed Practical Nurse Manager #1 did not know who could flush a resident's ears at this facility and would have to ask where the equipment was kept.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Wesley Gardens Corporation		STREET ADDRESS, CITY, STATE, ZIP CODE 3 Upton Park Rochester, NY 14607	
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)		
<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 6/5/24 at 2:31 PM the Director of Nursing stated that a Licensed Practical Nurse or a Registered Nurse could flush a resident's ears. The Director of Nursing did not know why Resident #51's ears had not been flushed and does not know how the order got missed.</p> <p>During an interview on 6/6/24 at 9:35 AM Nurse Practitioner #1 stated when orders are put in (the system) the nurses are supposed to carry them out and that any nurse could flush a resident's ears. Nurse Practitioner #1 stated that if the nurses wanted medical to flush Resident #51's ears then they should have let them know and that they would have needed notice to bring their own otoscope and currettes as to their knowledge the facility does not have either available.</p> <p>10 NYCRR 415.12 (a)(3)(b)(1-3)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Wesley Gardens Corporation		STREET ADDRESS, CITY, STATE, ZIP CODE 3 Upton Park Rochester, NY 14607	
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)		
<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46526</p> <p>Based on Observations, interviews and record review conducted during a Recertification Survey, the facility did not ensure that residents with limited range of motion received appropriate treatment, equipment, and services to increase range of motion and/or to prevent further decrease in range of motion for two (Resident #37 and #90) of two residents reviewed. Specifically, the residents were observed on multiple occasions not wearing their therapy recommended hand splints. This is evidenced by the following:</p> <p>1. Resident #37 has diagnoses including dementia, malnutrition, and contractures (permanent tightening of the muscles and tendons causing joint stiffness and pain and loss of function). The Minimum Data Set Resident assessment dated [DATE] documented that the resident was moderately impaired of cognitive function and had no impairment in range of motion to their upper extremities (shoulder, elbow, wrist and hands).</p> <p>Review of Resident #37's current Comprehensive Care Plan and Kardex (care plan used by Certified Nursing Assistants for daily care) revealed the resident has contractures and required assist to don (put on) resting hand splints in the morning and doff (remove) at night.</p> <p>Review of an Occupational Therapy Discharge Summary dated 4/29/24 revealed a goal that the resident will tolerate having resting hand splints (one at a given time) to decrease pain and minimize contractures in both hands 100% of the time. The goal was identified as met on 4/29/24.</p> <p>During observations on 5/28/24 at 9:34 AM, 5/30/24 at 11:59 AM, on 6/4/24 at 11:57 AM and again at 3:38 PM Resident #37 was not wearing either hand splint which was observed on their bedside table and one on the floor. On 5/30/24 at 11:59 AM a sign was observed above the resident's bed that included directions to staff to don a splint in the morning and doff at night.</p> <p>In a medical progress note dated 5/6/24 Nurse Practitioner #1 documented that Resident #37 had pain in their hands and wrists due to joint stiffness.</p> <p>In an Occupational Therapy Progress notes dated January 2024 through April 2024 therapists documented that the residents hand splints are applied intermittently.</p> <p>During an interview on 6/4/24 at 12:30 PM Licensed Practical Nurse #2 stated that Resident #37 gets hand splints for straightening due to contractures and that therapy comes up and puts them on and if staff see them off, they will apply them.</p> <p>During an interview on 6/5/24 at approximately 9:30 AM the Certified Occupational Therapist Assistant #1 stated they trained the Certified Nursing Assistants, nurses, and the Nurse Managers on the floor to apply the splints once the residents are discharged from therapy. Certified Occupational Therapist Assistant #1 stated Resident #37 was discharged from therapy 4/29/24 with two hand splints and should have them applied in the morning and removed at night to prevent contractures and increased pain.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Wesley Gardens Corporation		STREET ADDRESS, CITY, STATE, ZIP CODE 3 Upton Park Rochester, NY 14607	
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)		
<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 6/5/24 at 10:12 AM Occupational Therapist #1 stated Resident #37 should have a right- and left-hand splint and a schedule to have one splint on at a time so the resident can have one hand free and to provide stretching. When applied at this time to the resident's left hand, Resident #37 stated the pain was less.</p> <p>In an interview on 6/6/24 at 8:59 AM Certified Nursing Assistant #4 stated Resident #37 has a left-hand splint that is supposed to go on in the morning and off at night and that they put it on when the resident asks and takes it off when the resident asks.</p> <p>2. Resident #90 had diagnoses including a dementia, seizures, and a stroke. The Minimum Data Set Resident assessment dated [DATE] documented that the resident was severely impaired cognitively and had functional limitation in range of motion to the upper extremity on one side.</p> <p>Review of Resident #90's current Kardex revealed that the resident had a left resting hand splint with finger separators, to don in the morning and doff at night during care.</p> <p>Review of an Occupational Therapy Discharge summary dated 3/28/24 revealed a goal that the resident would follow a splint schedule 100% of the time with a comment that therapy will don the splint during therapy but that staff on the floor are non-compliant with donning the splint despite visual reminders in the resident care plan and in their room. The summary included that prognosis to maintain level of function was good with consistent staff follow-through.</p> <p>In a therapy progress note Certified Occupational Therapist Assistant #1 documented that the Nurse Manger was educated on how to don and doff the resident's hand splint.</p> <p>In observations on 5/28/24 at 12:29 PM, Resident #90 was up and dressed and in the hallway. There was no splint on either hand.</p> <p>During observations on 5/31/24 at 12:17 PM (splint observed on nightstand), on 6/3/24 at 4:07 PM and on 6/4/24 at 10:29 AM and again at 12:12 PM Resident #90 was not wearing their hand splint. A sign in the resident's room included a splint schedule and directions for placement of the splint with photo.</p> <p>During an interview on 6/4/24 at 12:15 PM CNA #2 stated that they forgot to put Resident #90's hand splint on. CNA #2 stated they did not have Resident #90 the previous days so did not know why the resident had not been wearing their hand splint.</p> <p>During an interview on 6/4/24 at 10:40 AM Occupational Therapist #1 stated Resident #90 has had contractures for a while and that in using the splints, they are trying to maintain the resident's level (of function). After they are discharged from therapy, the Certified Nursing Assistants are responsible for applying the splint. Occupational Therapist #1 stated that staff were educated (on applying the splint) in May and that Resident #90 does not refuse to wear the splint that they knew of. Occupational Therapist #1 said that the resident's current pain could be from lack of stretching due to not wearing the splint.</p> <p>During an interview on 6/7/24 at 1:38 PM the Director of Nursing stated that the residents care plan should be followed and if a resident refuses, this should be documented.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Wesley Gardens Corporation		STREET ADDRESS, CITY, STATE, ZIP CODE 3 Upton Park Rochester, NY 14607	

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10 NYCRR 415.12(e)(2) 49368

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Wesley Gardens Corporation		STREET ADDRESS, CITY, STATE, ZIP CODE 3 Upton Park Rochester, NY 14607	
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)		
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47642</p> <p>Based on observations, interviews, and record review conducted during the Recertification Survey and Complaint Investigations (NY00315983, NY00318393), for one (Resident #42) of two residents reviewed for respiratory care, the facility did not ensure residents who needed respiratory care were provided such care consistent with professional standards of practice. Specifically, Resident #42 did not have a physician order in place for oxygen use, did not have a person-centered comprehensive care plan for oxygen, and was not provided a clean well-functioning oxygen concentrator. This is evidenced by the following:</p> <p>The facility policy, Oxygen Administration, dated October 2010 included to verify there was a physician's order, review the resident's care plan to assess for any special needs, check equipment to be sure it was in good working order, and document in the resident's medical record how the resident tolerated the oxygen.</p> <p>Resident #42 had diagnoses that included respiratory failure, congestive heart failure, and hypertension. The Minimum Data Set Resident assessment dated [DATE] revealed the resident was cognitively intact and received oxygen therapy while a resident in the facility.</p> <p>The current Comprehensive Care Plan reviewed on 5/28/24 did not include that Resident #42 was receiving oxygen therapy.</p> <p>Review of physician orders for oxygen therapy revealed an order to discontinue oxygen on 8/22/23. There were no further orders for oxygen therapy until 5/29/24 (after surveyor intervention) which included oxygen at 6 liters per minute continuously.</p> <p>During an observation and interview on 5/28/24 at 9:47 AM, Resident #42 was lying in bed and had complaints of difficulty breathing. They were wearing a nasal cannula (a device that delivers additional oxygen through a person's nose) connected to a concentrator (a device that filters air from a person's surroundings and delivers oxygen to breathe) set at 8 liters of oxygen per minute. Resident #42's oxygen saturation level as taken by Licensed Practical Nurse #5 at this time was 86 percent (considered a low level that may require medical attention). Licensed Practical Nurse #5 moved the nasal cannula tubing to an oxygen tank in the room and Resident #42's oxygen saturation increased to 96 percent. Licensed Practical Nurse #5 stated a lot of the equipment (oxygen concentrators) in the facility did not work.</p> <p>During an interview on 5/28/24 at 10:34 AM, Licensed Practical Nurse Manager #1 stated that Resident #42 had been using oxygen for a while but after review the the resident's orders, they stated the resident did not have a physician order in place for the oxygen.</p> <p>During an observation and interview on 5/28/24 at 11:10 AM, the oxygen concentrator in Resident #42's room had a filter that was covered with dust. Resident #42 stated the facility staff had just brought in that particular concentrator.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Wesley Gardens Corporation		STREET ADDRESS, CITY, STATE, ZIP CODE 3 Upton Park Rochester, NY 14607	
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)		
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/31/24 at 2:52 PM, the Corporate Infection Preventionist stated there were no preventive maintenance inspections for patient care related equipment (including oxygen concentrators).</p> <p>During an interview on 6/4/24 at 1:15 PM, Registered Nurse Manager #3 stated Resident #42 had no care plan for oxygen and that they had been working with the Director of Nursing to make care plans better.</p> <p>During an interview on 6/6/24 at 10:13 AM with the Administrator and Director of Nursing, the Director of Nursing stated they were not aware of any concerns related to oxygen administration and that there was a quality assurance initiative in place that included ensuring the oxygen supply company was coming as scheduled and checking all concentrators to ensure they were serviced as needed.</p> <p>10 NYCRR 415.12(k)(6)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Wesley Gardens Corporation		STREET ADDRESS, CITY, STATE, ZIP CODE 3 Upton Park Rochester, NY 14607	
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)		
<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47642</p> <p>Based on observations, interviews, and record review conducted during the Recertification Survey and Complaint Investigation (NY00318393) it was determined that for one (Resident #52) 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 resident's goals and preferences. Specifically, Resident #52's pain medication was not administered as ordered on multiple occasions without Physician notification and the resident did not have a comprehensive care plan for chronic pain that included measurable goals and person centered interventions. This is evidenced by the following:</p> <p>The facility policy Pain - Clinical Protocol dated March 2018, included that with input from the resident to the extent possible, the physician and staff will establish goals of pain treatment. The physician will order appropriate non-pharmacological and medication interventions to address the individual's pain.</p> <p>Resident #52 had diagnoses including ankylosing spondylitis (an inflammatory disease that can cause some of the bones in the spine to fuse), complex regional pain of left lower limb, cervicalgia (neck pain), arthropathic psoriasis (a form of arthritis), temporomandibular joint dysfunction (pain and compromised movement of the jaw joint and surrounding muscles), and schizoaffective disorder (a mental health condition) with hallucinations. The Minimum Data Set Resident assessment dated [DATE], revealed the resident was cognitively intact and had pain that was rated as 9 out of 10 almost constantly making it hard for them to sleep at night, limited their participation in rehabilitation therapy sessions, and limited their day-to-day activities.</p> <p>Resident #52's Comprehensive Care Plan last revised on 4/17/24 included the resident takes pain medication due to history of chronic pain with interventions to monitor for effectiveness of pain medication and document adverse reactions. The care plan did not include person centered goals or any non-pharmacological person centered interventions.</p> <p>During an interview on 5/28/24 at 12:11 PM Resident #52 stated they were in alot of pain both in their back and their legs. The resident was observed in bed on multiple occasions throughout the day shift.</p> <p>Current Physician orders included Tylenol twice daily and as needed at night for jaw pain, Lyrica (pain medication) twice daily for neuropathy (nerve damage outside the brain and spinal cord that causes pain or numbness), and oxycodone (narcotic pain reliever) three times daily for pain.</p> <p>Review of the Medication Administration Records for April 2024 and May 2024 revealed that on 4/21/24 there was no documented evidence that Resident #52 had received their morning prescribed doses of Tylenol or oxycodone and on 5/29/24 there was no documented evidence that the resident received their evening prescribed doses of Lyrica and oxycodone.</p> <p>Review of the June 2024 Medication Administration Records along with the Control Substance Count (narcotic) sheets for Resident #52's oxycodone revealed the following:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Wesley Gardens Corporation		STREET ADDRESS, CITY, STATE, ZIP CODE 3 Upton Park Rochester, NY 14607	

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)
<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- On 6/2/24 the records documented that Resident #52 received less than the prescribed dose in the [NAME] and more than the prescribed dose for the afternoon and evening doses. There was no documentation that any of the oxycodone had been wasted.</p> <p>- On 6/3/24 at 6:00 AM the records documented that Resident #52 received more than the prescribed dose. There was no documentation that any of the oxycodone had been wasted. There is no documentation of any oxycodone being removed at the 12:00 PM or 5:00 PM scheduled times.</p> <p>When interviewed on 6/4/24 at 1:02 PM and again on 6/6/24 at 10:31 AM Resident #52 stated that recently they were unable to receive their Lyrica medication (unavailable) and only received a partial dose of their oxycodone which caused them to have an increase in pain which caused an increase in their hallucinations. Resident #52 stated that they had pain in their back described as throbbing and sometimes stabbing, had bursitis (painful swelling in the joints) in both hips, neuropathy (nerve pain) of their left leg and foot, neck pain and recently they developed jaw pain. Resident #52 stated that the prescribed medications do help reduce the pain from a 9 to a 5 or 6 out of 10. The resident said staff do not offer them anything such as ice or heat therapy or any topical medications and that they used to get patches for their hips that helped but thought they were too expensive.</p> <p>During a telephone interview on 6/6/24 at 9:45 AM, Nurse Practitioner #1 stated if Resident #52 does not receive the correct dose or missed a dose of their pain medication, it could cause increased pain and anxiety for the resident.</p> <p>When interviewed on 6/6/24 at 11:11AM, Registered Nurse Manager #3 stated that the resident's care plan for pain was not individualized and knew from experience that Resident #52 had said nothing helps their pain and they were just looking for more pain medication.</p> <p>10 NYCRR 415.12</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Wesley Gardens Corporation		STREET ADDRESS, CITY, STATE, ZIP CODE 3 Upton Park Rochester, NY 14607	

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)
<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Post nurse staffing information every day.</p> <p>46880</p> <p>Based on observations, interviews, and record review conducted during a Recertification Survey, the facility did not ensure the nurse staffing information was posted daily and included the required information. Specifically, the nurse staffing information did not consistently include the accurate number and total hours worked by licensed and unlicensed nursing staff who were directly responsible for resident care, the accurate daily resident census (the number of residents currently residing in the facility), and did not include any staffing changes (to include any changes in nurse staffing throughout the day) as per regulations. This is evidenced by the following:</p> <p>During observations on 5/28/24 at 8:32 AM, 5/29/24 at 3:40 PM, 5/31/24 at 9:00 AM and again at 1:43 PM, and 6/4/24 at 10:19 AM the facility's nurse staffing information posted did not document a resident census. The posted information did not include the accurate hours worked for licensed and unlicensed nursing staff when compared to the provided nursing schedules.</p> <p>In an observation on 6/2/24 at 5:02 PM the facility's nurse staffing information posted was dated for 5/31/24 and revealed the same information from the observation on 5/31/24 at 9:00 AM and 1:43 PM.</p> <p>Review of the daily staffing information from 4/1/24 to 5/31/24 revealed multiple days that did not include resident census or the accurate number and hours worked by each discipline when reviewed with the staffing schedules.</p> <p>During an interview on 6/5/24 at 10:31 AM, the Staffing Coordinator stated they post the nurse staffing information during the week, however they do not post them on the weekends and had not discussed with the facility as to who posted them on the weekends. The Staffing Coordinator stated they were not aware that the posted nurse staffing should be changed to reflect the current staffing per shift, and they were not aware that the census should be documented on the posted nurse staffing form.</p> <p>In an interview on 6/05/24 at 2:31 PM, the Director of Nursing stated the Scheduling Coordinator was responsible for posting and making changes to the nurse staffing information during the week and reception would be responsible on the weekends. The Director of Nursing stated they did not know who would be responsible for adding the census to the nurse staffing information and was not aware that the census had not been on them. The Director of Nursing stated that they were not aware that there was no consistent posting on weekends or changes made throughout the day.</p> <p>10 NYCRR 415.13</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Wesley Gardens Corporation		STREET ADDRESS, CITY, STATE, ZIP CODE 3 Upton Park Rochester, NY 14607	
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)		
<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p>20765</p> <p>Based on observations, interviews and record reviews conducted during the Recertification Survey the facility did not ensure the resident received the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care for one (Resident #52) of one resident reviewed. Specifically, Resident #52 did not receive medication changes as recommended, did not have a comprehensive care plan that included an individualized person-centered approach to address their behavioral health needs, and did not receive consistent psychiatric services. This is evidenced by the following:</p> <p>The facility policy Behavioral Health Services, dated March 2019, included the facility will provide and the residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care. The interdisciplinary team will evaluate behavioral symptoms in residents to determine the degree of severity, distress, and potential safety risk to the resident and develop a plan of care accordingly. Interventions will be individualized and part of an overall care environment that supports physical, functional, and psychosocial needs, and strives to understand, prevent, or relieve the resident's distress or loss of abilities.</p> <p>The facility policy Psychiatric Consultation dated 2/2/24, included the facility will have an established process to ensure residents receive appropriate psychiatric evaluation, treatment, and follow-up services when clinically indicated. Residents receiving psychiatric treatment will have their care plans updated to reflect the associated interventions, monitoring parameters and responsible disciplines.</p> <p>Resident #52 has diagnoses including schizoaffective disorder (a mental health condition), major depressive disorder with psychotic features, visual hallucinations, anxiety disorder, and insomnia. The Minimum Data Set Resident Assessment, dated 4/19/24, revealed the resident was cognitively intact, had moderate depression and was dependent on a wheelchair for mobility.</p> <p>During an interview on 5/28/24 at 11:59 AM Resident #52 stated that their motorized wheelchair was damaged in a flood from the floor above months before and was still not fixed. Resident #52 stated they would prefer to use their own wheelchair (versus a non-motorized one) due to increased pain.</p> <p>Physician orders dated 6/4/24 included Ambien (medication used to treat insomnia) at hour of sleep, lorazepam (antianxiety) three times daily, mirtazapine (antidepressant) at night, Seroquel (antipsychotic) at noon and at hour of sleep.</p> <p>Resident #52's Comprehensive Care Plan last revised on 4/17/24, included the resident had schizoaffective disorder, personality disorder, anxiety, visual and auditory hallucinations, and at times digs at their legs and arms. The interventions including to administer medications per order and to continue to see telepsychiatry for medication management. The Comprehensive Care Plan did not include person-centered interventions to address the identified issues.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Wesley Gardens Corporation		STREET ADDRESS, CITY, STATE, ZIP CODE 3 Upton Park Rochester, NY 14607	
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)		
<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Department of Telepsychiatry progress note dated 9/14/23, included recommendation to increase the Seroquel by adding 25 milligrams at noon and to continue 50 milligrams in the morning and 400 milligrams at hour of sleep and to follow-up in two months.</p> <p>Review of Physician orders history revealed that the noon dose of Seroquel 50 milligrams had not been added until 11/2/23 and the morning dose of Seroquel 50 milligrams had been discontinued on 11/8/23 with no explanations as to why the orders differed from the psychiatry recommendations.</p> <p>Review of a purchase order dated 1/25/24 for an evaluation of the resident's power wheelchair revealed a quote from a surgical supply company dated 2/5/24 for the repairs needed for Resident #52's power wheelchair. There was no mention when the power wheelchair would be repaired or if the quote had been accepted. The facility was unable to provide any evidence when the resident could expect their power wheelchair to be repaired and returned to them.</p> <p>In a Department of Telepsychiatry progress note dated 2/7/24 Psychiatric Nurse Practitioner #1 documented that this was the first routine follow-up since 9/14/23 (despite the recommendation for a two month follow up). Psychiatric Nurse Practitioner#1 documented that the recommended medication changes from 9/14/23 had not been made, that Seroquel 50 milligrams in the morning and olanzapine (an antipsychotic medication that the resident was on at the time) had been discontinued with reason unknown. Psychiatric Nurse Practitioner #1 documented they would not recommend any dose reductions of the resident's other psychotropic medications (medications used to treat mental illness) given significant potential for decompensation due to the resident's chronic mental illness. Psychiatric Nurse Practitioner #1 documented that Resident #52 continued to be reclusive in their room as their power wheelchair remained broken and that they reported fluctuation in their tactile, auditory, and visual hallucinations which triggered their anxiety. Recommendations included to increase the Seroquel to 50 milligrams in the morning, 50 milligrams at noon, and 400 milligrams at bedtime and within 10 to 14 days after increasing the Seroquel increase the mirtazapine to 22.5 milligrams at hour of sleep and to follow-up in 4-6 weeks.</p> <p>In a Department of Telepsychiatry progress dated 3/6/24 Psychiatric Nurse Practitioner #1 documented that the recommendations for medication changes made on 2/7/24 had not been implemented. Psychiatric Nurse Practitioner #1 documented Resident #52 continued to report ongoing anxiety, depression, and frustration with the disorganization of their care and the new onset of temporomandibular joint dysfunction (pain and compromised movement of the jaw joint and surrounding muscles). Psychiatrist Nurse Practitioner #1 documented that they had contacted Nurse Practitioner #1 (facility medical team) who had indicated that they had not received the psychiatrist's notes with the recommendations, that they were agreeable to instituting the medication changes as noted and a plan to follow up in four to six weeks.</p> <p>Review of a wound care note dated 3/26/24 revealed that Resident #52 had several wounds of varying sizes and depths in an area measuring 15 centimeters by 10 centimeters on their left lower leg and was reported by the resident that they dig and scratch due to their psychiatric condition.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Wesley Gardens Corporation		STREET ADDRESS, CITY, STATE, ZIP CODE 3 Upton Park Rochester, NY 14607	
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)		
<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with Resident #52 on 5/28/24 at 12:19 PM, they stated that they had not seen telepsychiatry since 3/6/24 because the last two appointments on 4/2/24 and 5/17/24 had been missed due to not having the computer access required to meet with Telepsychiatry. Resident #52 stated that since their last appointment they have had two episodes of scratching themselves and that receiving psychotherapy services helped them a lot as they were able to create new coping skills for managing the hallucinations and the pain.</p> <p>When interviewed on 6/4/24 at 9:57 AM, the Corporate Director of Resident Services (acting Social Worker) stated that there had been a discrepancy with telepsychiatry visits as last week the telepsychiatry providers called and cancelled due to the facility not having clinical staff to sit with the residents during their appointments. The Corporate Director of Resident Services stated that the telepsychiatry providers are refusing to see residents without a clinical staff present due to the recommendations not being followed and the facility medical providers reporting that were not made aware of the recommendations. When asked about the repair of Resident #52's power wheelchair, the Corporate Director of Resident Services stated that the facility should have the power wheelchair fixed as it was due to a facility incident that it is inoperable.</p> <p>During an interview on 6/4/24 at 12:40 PM Registered Nurse Manager #3 stated the Social Worker sets up all telepsychiatry appointments and if there are recommendations they should be sent to their mailbox and then they review them, initial them, and make Nurse Practitioner #1 aware. Registered Nurse Manager #3 stated Nurse Practitioner #1 would make any medication changes themselves as they input their own orders into the electronic medical record.</p> <p>During an interview on 6/4/24 at 1:02 PM and on 6/6/24 at 10:25 AM Resident #52 stated they recalled speaking with telepsychiatry about increasing their Seroquel to help with the hallucinations but was not aware that the Seroquel dose had not been increased but that they had not noticed any improvements in the hallucinations either. Resident #52 stated they used to get out of bed more often when they had their power wheelchair and would use it a lot more if they had it. Resident #52 said that they also used to receive psychotherapy (group therapy or talk therapy) but have not received any since last year and has not been offered any since then. Resident #53 said that the facility staff do not keep them informed of medication changes and that what they are taking for depression is not working and does not feel that the facility is meeting their psychiatric needs.</p> <p>When interviewed via telephone on 6/6/24 at 9:35 AM, Nurse Practitioner #1 stated that they do not change psychiatric medications without being told to and that they do not review the telepsychiatry notes and knew nothing about the recommendations for Resident #52 until this week.</p> <p>During an interview on 6/6/24 at 11:11 AM, Nurse Manager #3 stated that Resident #52's care plan is not individualized to meet the residents needs.</p> <p>When interviewed on 6/6/24 at 10:15 AM, the Administrator (with Director of Nursing present) stated that the previous Social Worker had left employment without providing any notice and the regional Social Worker was providing services until a replacement is found.</p> <p>10 NYCRR 415.12</p> <p>47642</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Wesley Gardens Corporation		STREET ADDRESS, CITY, STATE, ZIP CODE 3 Upton Park Rochester, NY 14607	
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)		
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39181 46526</p> <p>Based on interviews, and record review conducted during the Recertification Survey and Complaint Investigation (NY00318393), it was determined that for 4 of 10 residents reviewed for medication administration, the facility did not ensure that the residents were free from significant medication errors. Specifically, there was no documented evidence that Resident #37 had received multiple prescribed medications on multiple days, that Resident #42 received the correct dose of narcotic pain medication on several days, that Resident #52 received the correct doses of narcotic pain medication on several days, and that Resident #100 had received the full ordered course of an antibiotic as ordered. This is evidenced by the following:</p> <p>The facility policy Administering Medications, dated April 2019, included that medications are to be administered in accordance with prescribed orders, including any required time frame. The policy noted that the individual administering the medication checks the label three times to verify the right resident, right medication, right dose, right time, and right method (route) of administration before giving the medication.</p> <p>The facility policy, Adverse Consequences and Medication Errors, dated revised April 2014, defined a medication error as the preparation or administration of drugs or biological which is not in accordance with physician's order, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services. Examples of a medication error would include but not limited to, an omission (a drug is ordered but not administered) and the wrong dose.</p> <p>1. Resident #42 had diagnoses that included heart failure, diabetes, and a pressure ulcer. The Minimum Data Set Resident assessment dated [DATE], included that Resident #42 was cognitively intact.</p> <p>The current Physician orders included oxycodone 5 milligrams daily and give 30 minutes before the pressure ulcer dressing change for pain.</p> <p>Review of the Medication Administration Record for 5/14-5/29/24, revealed that oxycodone 5 milligrams had been signed off as administered daily.</p> <p>Review of the Control Substance Record (the list of narcotic medications the nurses remove from the narcotic cabinet per resident) revealed that on 5/16, 5/18, 5/21, 5/22, 5/24, 5/25, 5/26, 5/27, and 5/28 multiple (2 or 3) 5 milligrams oxycodone tablets had been removed for Resident #42 (versus one tablet).</p> <p>In a nursing progress noted dated 5/29/24, Nurse Practitioner #3 documented that more oxycodone may have been administered to Resident #42 than ordered.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Wesley Gardens Corporation		STREET ADDRESS, CITY, STATE, ZIP CODE 3 Upton Park Rochester, NY 14607	
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)		
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of a Nursing Medication Incident Report dated 5/29/24 signed by the Director of Nursing and a summary dated 5/29/24 signed by the Corporate Infection Preventionist revealed that the Director of Nursing notified the Medical Director and the consulting pharmacist of the error for Resident #42 and Licensed Practical Nurse #5 received immediate reeducation. The Incident Report included a statement from Licensed Practical Nurse #5 that they administered the increased narcotics to Resident #42 as per a previous order (versus the current order).</p> <p>In an interview on 6/6/24 at 9:14 AM, Resident #42 stated they believed they get their pain medication every eight hours but they did not feel it was working and could be stronger.</p> <p>In an interview on 6/6/24 at 11:26 AM Registered Nurse Manager #3 stated nurses should follow the Physician orders when giving medications.</p> <p>2. Resident #52 had diagnoses that included Ankylosing spondylitis (chronic inflammatory disease of the spine), complex regional pain syndrome of left lower limb, and depression. The Minimum Data Set Resident assessment dated [DATE], included that Resident #52 was cognitively intact.</p> <p>Review of current Physician orders, dated 5/9/24 revealed oxycodone 5 milligrams tablet, give 1.5 tablets (7.5 milligrams) three times daily (scheduled for 6:00 AM, 12:00 PM, and 5:00 PM).</p> <p>The June 2024 Medication Administration Record documented that nursing staff signed off that 7.5 milligrams of oxycodone was administered three times a day to Resident #52 as ordered.</p> <p>Review of the Control Substance Records (narcotic sheets for each resident) revealed the following documentation for Resident #52:</p> <p>a. On 6/2/24 at 6:00 AM and 5:00PM, one 5 milligrams tablet of oxycodone was removed (and no 2.5 milligram tablet) and at 12:00 PM two 5 milligrams oxycodone tablets were removed. There was no documentation of wasting any of the narcotic medication indicating that Resident #52 was undermedicated for two doses and over medicated for one dose per the documentation.</p> <p>b. On 6/3/24 at 6:00 AM, two 5 milligrams tablets of oxycodone were removed. There was no documentation of wasting any of the medication.</p> <p>c. On 6/3/24 at 12:00 PM and 5:00 PM there was no documentation that any oxycodone tablets had been removed from the narcotic cabinet for Resident #52.</p> <p>In an interview on 6/3/24 10:15 AM, Resident #52 stated the facility ran out of 2.5 milligram tablets of their oxycodone, so they only get 5 milligrams sometimes and they told the nurse to do what some of the other nurses do and cut one tablet in half.</p> <p>In an interview on 6/3/24 at 1:45 PM, Registered Nurse Manager #3 stated they were out of 2.5 milligram tablets and that what Licensed Practical Nurse #5 signed off on the narcotic sheet did not match what they signed off as administered on 6/2/24 and 6/3/24, as it appeared that 10 milligrams of oxycodone were removed at 6:00 AM and administered (versus the ordered 7.5 milligrams).</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Wesley Gardens Corporation		STREET ADDRESS, CITY, STATE, ZIP CODE 3 Upton Park Rochester, NY 14607	
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)		
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 6/4/24 at 1:04 PM Licensed Practical Nurse #5 stated Resident #52 ran out of 2.5 milligrams tablets of oxycodone, so they gave two 5 milligram tablets and did not document any waste.</p> <p>In an interview on 6/6/24 at 9:45 AM Nurse Practitioner #1 stated that not receiving the ordered dose or a partial dose of pain medication could cause increase anxiety and increased pain.</p> <p>There was no documented evidence that the Licensed Practical Nurse #5 was suspended pending a thorough investigation related to multiple narcotic medication errors for Residents #42 and #52.</p> <p>3. Resident #100 had diagnoses that included dementia, hypertension, and diabetes. The Minimum Data Set Resident assessment dated [DATE] revealed Resident #100 was severely impaired cognitively.</p> <p>Review of Physician orders dated 5/18/24 revealed Resident #100 was prescribed ceftriaxone (antibiotic) intramuscularly for three days for pneumonia, with a start date of 5/18/24.</p> <p>Review of the May 2024 Medication Administration Record revealed the first dose of ceftriaxone that was scheduled to be given on 5/18/24 was not documented as administered and was coded at 17 (hold per MD order) and that Resident #100 only received a total of two doses of antibiotic versus the three doses ordered.</p> <p>In a nursing progress note dated 5/18/24 at 9:22 PM Licensed Practical Nurse #4 documented that the ceftriaxone was awaiting pharmacy delivery. There was no documentation that the medical team was notified of the missing dose of antibiotic or that the medical team had ordered to hold the first dose of Resident #100's antibiotic.</p> <p>During an interview on 5/31/24 at 11:04 AM, the Corporate Infection Prevention Nurse said when an antibiotic is ordered, nurses can get a dose out of the Cubex (machine that securely stores and dispenses medications) which usually contains ceftriaxone (in order to give it immediately) or they can call the Pharmacy to get an antibiotic delivered immediately. If unable to get a medication, staff should notify the medical provider. The Corporate Infection Prevention Nurse stated there was no order for the antibiotic to be held and that it appeared as though Resident #100 had not received the full course of antibiotics as ordered and that they would consider that a significant medication error.</p> <p>During a telephone interview on 6/6/24 at 9:41 AM, Nurse Practitioner #1 stated they ordered ceftriaxone for Resident #100 for three days on 5/18/24 and that ceftriaxone should be available from the facility's emergency supply (for that first dose). They said that they had never been notified about the antibiotic being unavailable and should have been.</p> <p>4. Resident #37 had diagnoses that included dementia, hypertension, and depression. The Minimum Data Set Resident assessment dated [DATE] revealed Resident #37 was moderately impaired cognitively and received antipsychotic and antidepressant medications.</p> <p>Review of the May 2024 Medication Administration Record revealed no documented evidence that Resident #37 had received the following prescribed medications on 5/3/24 and/or 5/12/24:</p> <p>a. atorvastatin (medication for high cholesterol) - 5/3/24 and 5/12/24.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Wesley Gardens Corporation		STREET ADDRESS, CITY, STATE, ZIP CODE 3 Upton Park Rochester, NY 14607	
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)		
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>b. melatonin (medication for sleep) - 5/3/24 and 5/12/24.</p> <p>c. mirtazapine (medication for depression) - 5/3/24 and 5/12/24.</p> <p>d. trazodone (medication for depression) - 5/3/24 and 5/12/24.</p> <p>e. quetiapine (antipsychotic medication used to treat schizophrenia, bipolar and depression) - 5/3/24 and 5/12/24.</p> <p>f. metoprolol (medication used to treat high blood pressure) - 5/12/24.</p> <p>g. sennosides-docusate (medication used to treat constipation) - 5/12/24.</p> <p>h. acetaminophen (Tylenol) - 5/12/24.</p> <p>Review of nursing progress notes dated 5/3/24 and 5/12/24 did not reveal any documentation that the medications had been administered, that the medications had been unavailable, or that the medical provider had been notified.</p> <p>During an interview on 6/6/24 at 10:55 AM, Registered Nurse Manager #1 said when administering residents' medication, the nurse should make sure that the medications were available, that some medications are in-house stocked medications, and some ordered through a pharmacy and the nurses should order them when they are down to the last column of pills in the blister pack. If unavailable an order would be needed from the medical provider (to hold). Registered Nurse Manager #1 said a blank box on the Medication Administration Record may indicate missing documentation.</p> <p>The nurses scheduled for 5/3/24 and 5/12/24 were not available for interview.</p> <p>In an interview on 6/6/24 at 1:38 PM, Director of Nursing stated there would be no reason for a resident to receive an extra dose of a narcotic beyond what is ordered. The Director of Nursing stated if a medication was not available, nurses should see if it is stocked and available, call the pharmacy or notify the nurse manager or themselves (Director of Nursing) and let the provider know. The Director of Nursing said a blank box on the Medication Administration Record would indicate nothing was done (administered).</p> <p>10 NYCRR 415.12(m)(2)</p> <p>47642</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Wesley Gardens Corporation		STREET ADDRESS, CITY, STATE, ZIP CODE 3 Upton Park Rochester, NY 14607	
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)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47642</p> <p>Based on observations and interviews conducted during the Recertification Survey, the facility did not provide for safe and secure storage of medications and ensure that medications were labeled in accordance with currently accepted professional standards for two (3rd and 4th floor resident units) of two medication rooms and two (3rd and 4th floor) of four medication carts and one clean utility room (3rd floor) reviewed Specifically, medications were observed stored in an unlocked clean utility room, resident specific medications were not labeled, and medication carts contained several unidentified loose pills, and were unclear. This is evidenced by but not limited to the following:</p> <p>The facility policy, Storage of Medications, dated [DATE] documented that drugs and biologicals used in the facility were stored in locked compartments under proper temperature, light, and humidity controls. Only persons authorized to prepare and administer medications have access to locked medications. The nursing staff were responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner.</p> <p>During an observation on [DATE] at 1:07 PM, the 3rd floor resident unit clean utility room was unlocked and unsupervised (no staff in view). It contained cleaning supplies and an open cabinet with multiple bottles of over-the-counter medications and topical creams.</p> <p>During an observation and interview on [DATE] at 1:26 PM, the 3rd Floor resident unit medication room contained several bottles of insulin that were open and undated as to when opened or when expired. When interviewed at the time, Licensed Practical Nurse #5 stated any insulin bottle that was not dated should be thrown away.</p> <p>During an observation on [DATE] at 3:49 PM, with the 4th Floor Registered Nurse Manager #1, several opened and expired insulin pens were stored in the medication refrigerator.</p> <p>During an observation on [DATE] at 11:56 AM a 3rd Floor medication cart contained two unlabeled inhalers, multiple loose unidentified pills (medications), spilled red liquid on the bottom of the drawer, and a significant amount of dust and debris.</p> <p>During an observation on [DATE] at approximately 12:00 PM a 4th floor medication cart drawer contained approximately 40 loose unidentified pill medications. When interviewed at the time, Licensed Practical Nurse #6 said the night shift nurse was responsible for organizing the medication room and cleaning the medication carts.</p> <p>During an interview on [DATE] at 3:21 PM and again on [DATE] at 10:13 AM the Director of Nursing said medication cart audits and room audits should be completed weekly and all nurses should manage the cleanliness of these areas on a daily basis. The Director of Nursing said all medications should be kept behind locked doors and/or cabinets.</p> <p>10 NYCRR 415.18(d)(e) (.d+[DATE])</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Wesley Gardens Corporation		STREET ADDRESS, CITY, STATE, ZIP CODE 3 Upton Park Rochester, NY 14607	
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)		
<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>39181</p> <p>Based on observations, interviews, and record reviews conducted during the Recertification Survey, the facility did not ensure the facility was administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically, the facility did not provide housekeeping or maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; did not ensure all allegations of resident abuse and injuries with unknown origin were thoroughly investigated; did not ensure that residents who required assistance with activities of daily living received the necessary services to maintain good grooming and personal hygiene; did not ensure that each resident received necessary behavioral health care and services; did not ensure all residents were free of significant medication errors; and the facility did not properly maintain all essential mechanical, electrical, and resident care equipment in safe operating condition. This is evidenced by the following:</p> <p>Refer to the following citations:</p> <p>F584: Safe/Clean/Comfortable/Homelike Environment</p> <p>F610: Investigate/Prevent/Correct Alleged Violations</p> <p>F677: Activities of Daily Living (ADL) Care Provided for Dependent Residents</p> <p>F740: Behavioral Health Services</p> <p>F760: Residents are Free of Significant Medication Errors</p> <p>F908: Essential Equipment, Safe Operating Condition</p> <p>Review of the Facility Assessment, dated 5/15/24, revealed the facility's average daily census was 120 residents. Information regarding the residents based on facility characteristics included Minimum Data Set Resident Assessment results from 1/20/23. Services and care offered by the facility included, but was not limited to, assistance with activities of daily living, management of medical conditions and medication-related issues causing psychiatric symptoms and behavior, the administration of medications that residents needed, and the prevention of abuse and neglect. The Assessment included the facility resources needed to provide competent support and care daily to its residents included, but were not limited to; Administration (e.g., Administrator, Environmental Services, and Social Services), behavioral, psychiatric, and mental health providers, and support staff (e.g., maintenance and housekeeping staff). The staffing plan to meet the needs for care and support of the residents did not include positions such as social work, maintenance staff, and housekeeping staff. Additionally, the Assessment did not include a process to ensure the adequate supply, appropriate maintenance, or the replacement of physical equipment and other physical plant needs.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Wesley Gardens Corporation		STREET ADDRESS, CITY, STATE, ZIP CODE 3 Upton Park Rochester, NY 14607	
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)		
<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>For five (1st, 2nd, 3rd, 4th, and 5th floors) of five occupied resident-use floors and one of one basement, the facility did not provide housekeeping or maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Specifically, hot water was not maintained above 90 degrees Fahrenheit (F), floors, walls, and ceilings were dirty and/or in disrepair, bathrooms and shower rooms were dirty and in disrepair, ventilation exhaust in bathrooms, showers, and soiled utility rooms were not functioning resulting in foul odors, ice machines were dirty, ready stand lifts were dirty, plumbing fixtures were not maintained and/or working properly, there were ceiling plumbing leaks, overhead lights were not functional or functioning properly, light lenses and covers were missing, there were damaged electrical fixtures with exposed wiring, there was standing water on floors, and furniture and window blinds were in disrepair and dirty.</p> <p>During an interview on 5/31/24 at 10:45 AM, the Corporate Maintenance Director stated that for maintenance it was just themselves, because one of the maintenance staff was out on medical leave and the other one left about two weeks ago.</p> <p>For six residents reviewed for allegations of resident abuse and injuries with unknown origin, the facility could not provide evidence that the allegations were thoroughly investigated.</p> <p>During an interview on 6/3/24 at 10:05 AM, the Corporate Infection Preventionist stated it was identified in either February or March 2024 that investigations were missing, likely due to changes in facility leadership.</p> <p>For three residents reviewed 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 as related to nail care, shaving, bathing, hair washing and hair trimming.</p> <p>Resident #52 did not receive consistent psychiatric services, did not receive medication changes as recommended, and did not have a comprehensive care plan that included an individualized person-centered approach to address their behavioral health needs.</p> <p>During an interview on 6/4/24 at 9:57 AM, the Corporate Director of Resident Services stated that there had been a discrepancy with telepsychiatry visits as the telepsychiatry providers called and cancelled due to the facility not having clinical staff to sit with the residents during their appointments and issues with the providers not being made aware of the telepsychiatry recommendations.</p> <p>For four residents reviewed for medication administration, the facility did not ensure that the residents were free from significant medication errors as they related to omissions of significant medications being administered and incorrect doses of narcotic pain medication being administered.</p> <p>For five of five occupied resident-use floors and one of one basement the facility did not properly maintain all essential mechanical, electrical, and resident care equipment in safe operating condition. Specifically, laundry equipment, hot water boilers, a mechanical dish washing machine, patient care lifts, and ventilation systems were not maintained in working order.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Wesley Gardens Corporation		STREET ADDRESS, CITY, STATE, ZIP CODE 3 Upton Park Rochester, NY 14607	
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)		
<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observations on 5/31/24 at 11:12 AM included one of the three commercial dryers and a smaller residential style washing machine in the first-floor laundry room were not functional. During an interview at that time, a laundry staff member stated the middle dryer had not worked in about a year and the smaller residential style washing machine (used for resident personal clothing) had not worked in about three to four weeks.</p> <p>During an interview on 6/4/24 at 11:05 AM, the Corporate Director of Maintenance stated that they were not aware of any issues with the exhaust ventilation in the building. Observations in the presence of the corporate maintenance director at 11:16 AM included two exhaust motors on the roof were not functional.</p> <p>During an interview on 6/6/24 at 10:13 AM, with the Administrator and Director of Nursing, the Administrator stated they were aware of environmental concerns due to turnover and had been working to address the areas of concern and continued to recruit maintenance staff. The Administrator stated they were not aware of concerns related to investigations of alleged abuse and that the facility had a process in place that once an incident was reported the facility completed and documented a thorough investigation. The Director of Nursing stated there had previously been a backlog of investigations, however, the facility was now current in their investigations. The Director of Nursing stated there was an ongoing Quality Assurance and Performance Improvement initiative to ensure that activities of daily living (including nail care, hair care, and showers) were being maintained and documented. The Director of Nursing stated they were aware the facility had concerns related to medication errors. When an error was discovered, each case was investigated and staff were given the opportunity to improve their performance, and if no improvement was achieved, the staff member would be terminated.</p> <p>10 NYCRR 415.26</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Wesley Gardens Corporation		STREET ADDRESS, CITY, STATE, ZIP CODE 3 Upton Park Rochester, NY 14607	
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)		
<p>F 0836</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>46880</p> <p>Based on observations, record review, and interview conducted during the Recertification Survey, it was determined that 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 in a building that has fuel-burning appliances. The findings are:</p> <p>On 5/30/24 at 10:00AM, records for inspection and testing of facility carbon monoxide detectors were provided to the surveyor for review. The logs included a monthly signoff and listing of the locations of carbon monoxide detectors in the following areas: boiler room, kitchen, generator, and laundry.</p> <p>Observations on 5/31/24 from 11:10 AM to 11:24 AM included carbon monoxide detectors were not present in the first-floor laundry room and kitchen. Further observations at this time included three natural gas-powered dryers were in the laundry room and a natural gas range was present in the kitchen. During an interview at this time, a laundry employee stated that they did not know if they had carbon monoxide detectors in the laundry room. In another interview at this time in the main kitchen, the Assistant Food Service Director pointed at the wall and stated that there was one (a carbon monoxide detector) but it is not where it should be.</p> <p>The 2015 edition of the International Fire Code (IFC), 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.</p> <p>10NYCRR: 415.29(a)(2), 711.2(a)(1);</p> <p>42 CFR: 483.70(b),</p> <p>2015 IFC: Section 915, 915.1, 915.1.4, 915.3</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Wesley Gardens Corporation		STREET ADDRESS, CITY, STATE, ZIP CODE 3 Upton Park Rochester, NY 14607	
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)		
<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Keep all essential equipment working safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45200</p> <p>Based on observations, interviews, and record review conducted during the Recertification Survey, it was determined that for five (1st, 2nd, 3rd, 4th, and 5th floors) of five resident use floors and one of one basement the facility did not properly maintain all essential mechanical, electrical, and resident care equipment in safe operating condition. Specifically, laundry equipment, hot water boilers, a mechanical dish washing machine, patient care lifts, an oxygen concentrator, and ventilation systems were not maintained in working order. The findings are:</p> <p>Observations during the initial tour of the facility on 5/28/24 from 9:52 AM to 2:30 PM included multiple exhaust vents in the ceilings were not drawing air out of the following rooms, which included, but were not limited to: the 3rd, 4th and 5th floor soiled utility rooms across from the nurse stations, bathroom in room [ROOM NUMBER], and the 2nd floor shower room near 218. There were significant urine and fecal odors noted throughout the facility on all five resident-use floors. Additionally, the main fire alarm annunciator panel behind the reception desk in the 1st floor lobby displayed several supervisory trouble signals related to the penthouse exhaust fans for toilets and lounges.</p> <p>In an interview on 5/28/24 at 9:47 AM resident #42 stated that it was difficult to breathe. It was observed at this time that an oxygen concentrator was running and set at 8-liters and was connected to resident #42 via tubing. The licensed practical nurse read the pulse oximetry of resident #42 at a concentration of 86% and stated that a lot of equipment does not work. The licensed practical nurse then and attached a mask to an oxygen cylinder for the resident and the pulse oximetry of resident #42 was observed to immediately increase to a concentration of 96%.</p> <p>Observations on 5/28/24 at 11:30 AM included two hooyer lifts in the 5th floor shower room (between the dining room and the nurse station) were marked with tags listing broken. There was no documentation to show that the lifts were taken out of service or were being repaired.</p> <p>During an interview on 5/31/24 at 10:45 AM, the regional maintenance director stated that currently two of the three hot water boilers are working and they are waiting on a circulating pump that has been ordered to fix the other one. Further observations included that the basement hot water boilers serve the entire facility. The regional maintenance director also stated that for maintenance it is just themself, because one of the maintenance staff is out on medical leave and the other one left about two weeks ago. Further record review at 2:52 PM revealed another maintenance technician was hired 5/2/24 and was terminated from employment 5/21/24.</p> <p>Observations on 5/31/24 at 11:12 AM included one of the three commercial dryers and a smaller residential style washing machine in the 1st floor laundry room were not functional. During an interview at this time, a laundry staff member stated that the middle dryer has not worked in about a year and the smaller residential style washing machine (used for resident personal clothing) has not worked in about three to four weeks.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Wesley Gardens Corporation		STREET ADDRESS, CITY, STATE, ZIP CODE 3 Upton Park Rochester, NY 14607	
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)		
<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/3/24 at 11:40 AM the Director of Dining Services stated that on Sunday 5/26/24 they reported no hot water to the New York State Department of Health. The Director of Dining Services also stated that they (the kitchen) had their own boiler, but something happened on Sunday, and they went to serving meals on paper because their boiler was being shared with the rest of the building and had to be turned down. The Director of Dining Services also stated that their dish machine was not getting hot enough to sanitize the dishes.</p> <p>During an interview on 6/4/24 at 11:05 AM the regional director of maintenance stated that they were not aware of any issues with the exhaust ventilation in the building. Observations in the presence of the regional maintenance director at 11:16 AM included two exhaust motors on the roof were not functional.</p> <p>10NYCRR: 415.29, 415.29(b), 415.29(f)(3), 415.29(h), 415.29(j)(1), 415.29(k)(9)</p>		