STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335556	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rochester Center for Rehabilitation and Nursing	525 Beahan Road Rochester, NY 14624

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 0693 Level of Harm - Actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure residents receiving enteral nutrition, (tube placed in the stomach via the abdomen to receive nutritional support) were provided treatment and services in accordance with physician orders and professional standards of practice to prevent complications for three (3) of four (4) residents reviewed (Resident #5, Resident #7, and Resident #9). Specifically, Resident #5 did not receive prescribed enteral nutrition and hydration for multiple days and was hospitalized ; Resident #7 and Resident #9 had significant inconsistencies in the administration of prescribed enteral nutrition and hydration without physician orders, clinical justification, or documented refusals. This deficient practice resulted in actual harm, that was not Immediate Jeopardy, for Resident #5 who developed dehydration (a condition caused by insufficient fluid intake resulting in fluid imbalance), hypotension (low blood pressure), and new onset atrial fibrillation with rapid ventricular response (an irregular and often rapid heart rhythm that can lead to poor blood flow) requiring hospital transfer, intravenous fluid resuscitation (the rapid administration of fluids directly into the bloodstream to treat shock or severe low blood volume caused by sepsis or dehydration), and admission to the intensive care unit.The findings include:The facility policy Enteral Feeding Administration dated 02/25/2026 documented enteral nutrition would be administered per physician orders, evidence based clinical practices, resident rights, and federal regulation.1. Resident #5 had diagnoses including aspiration pneumonia (a lung infection caused by inhaling food, liquid, or stomach contents into the lungs), gastrostomy (a medical device inserted through the abdomen directly into the stomach to deliver nutrition, fluids, and medications), and hemiplegia/hemiparesis (paralysis or weakness affecting one (1) side of the body) following cerebral infarction (a type of stroke caused by blockage of blood flow to the brain affecting the right dominant side). The Minimum Data Set Assessment (a resident assessment tool) dated 12/05/2025 documented Resident #5 was cognitively intact.Review of the Comprehensive Care Plan on 04/16/2026 revealed Resident #5 required tube feeding related to dysphagia (difficulty swallowing). Interventions included to administer tube feeding and water flushes per Registered Dietician recommendation and physician orders. Review of Physician Orders dated 03/13/2026 included nothing by mouth and enteral nutrition Isosource 1.5 at 70 milliliters per hour beginning at 8:00 AM for a total volume of 840 milliliters daily, with verification of total volume infused and documentation of total volume delivered. Orders also included administration of 30 milliliters of water before and after feeding and 100 milliliters of water every four (4) hours six (6) times a day.Review of the March 2026 Medication Administration Record revealed no documented administration of enteral nutrition on 03/16/2026, 03/17/2026, and 03/18/2026 with the amount documented as zero (0). Additional entries included blank boxes with no indication if enteral nutrition or hydration was administered or held. Water flush documentation was also incomplete with missing entries on 03/12/2026, 03/16/2026, and 03/17/2026 at 8:00 AM, 10:30 AM, and 1:00 PM.Review of a nursing progress note dated 03/19/2026, Licensed Practical Nurse #1 documented Resident #5 did not receive enteral nutrition per order on 03/18/2026 day shift. At approximately 9:00 PM on 03/18/2026, Licensed Practical Nurse #1 obtained an order to initiate (continued on next page)

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

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F 0693 Level of Harm - Actual harm Residents Affected - Few	enteral nutrition; however, Resident #5 expressed distress and requested transfer to the hospital.Review of hospital records dated 03/18/2026 revealed Resident #5 was transported from the facility to the emergency department for reports of missed enteral nutrition and concern for dehydration. Resident #5 presented with hypotension, tachycardia (elevated heart rate), and clinical findings (including elevated laboratory values) consistent with dehydration. Medical evaluation documented dehydration and new onset atrial fibrillation with rapid ventricular response requiring intravenous fluid resuscitation, and admission to the intensive care unit. Resident #5 was later discharged to another skilled nursing facility. During an interview on 04/16/2026 at 11:28 AM, Licensed Practical Nurse #1 stated Resident #5 did not receive enteral nutrition prior to the start of their evening shift on 03/18/2026 and the resident begged them to go to the hospital.During a telephone interview on 04/16/2026 at 2:14 PM, Physician Assistant #1 stated Resident #5 had not been receiving enteral nutrition at appropriate times and was transferred to the hospital on [DATE] to evaluate a change in condition.2. Resident #7 had diagnoses including dysphagia (difficulty swallowing), cerebral palsy (a neurological disorder affecting movement and muscle coordination), hyperosmolality and hypernatremia (elevated concentration of sodium and other substances in the blood due to fluid imbalance), and spastic quadriplegia (muscle stiffness and weakness affecting all four (4) limbs). The Minimum Data Set assessment dated [DATE] documented Resident #7 was cognitively intact and required enteral nutrition.Review of the Comprehensive Care Plan on 04/16/2026 revealed Resident #7 required tube feeding related to dysphagia. Interventions included to administer tube feeding and water flushes per Registered Dietician recommendation and physician orders. Review of Physician Orders dated 03/10/2026 included nothing by mouth and enteral nutrition Peptomen 1.5 at 70 milliliters per hour beginning at 4:00 PM for a total volume of 1000 milliliters to be delivered daily. Orders also included administration of 200 milliliters of water every eight (8) hours three (3) times a day and 50 milliliters of water before and after tube feeding administration, with instructions to verify infusion each shift, and document total volume infused.Review of the March 2026 and April 2026 Medication Administration Records revealed, based on the physician order, if enteral nutrition was initiated at 4:00 PM as prescribed, the expected volume infused by 11:00 PM would be approximately 490 milliliters. Documented volumes at 11:00 PM varied significantly and ranged from 560 milliliters to 1000 milliliters. There were multiple blank entries (no documentation of volume infused and/or nurse signatures). For the order to administer 200 milliliters of water every eight (8) hours three (3) times a day, there were no documented administrations on 03/20/2026 at 2:00 PM, 03/29/2026 at 6:00 PM and 8:00 PM, 04/03/2026 at 6:00 PM, and 04/05/2026 at 6:00 PM and 8:00 PM. Additional review of physician orders, progress notes, and intake/output records included no documented evidence of orders to hold or adjust enteral nutrition or hydration, clinical justification for inconsistent volumes, or resident refusal. There was no alternate documentation to support administration when the Medication Administration Record was incomplete (blank entries) or inconsistent (variable documentation).During an observation on 04/08/2026 at 4:05 PM, Resident #7's enteral feeding was not running and the feeding bag hanging near the bed was empty and dated 04/07/2026. At 5:02 PM, the feeding was still not running. At 5:33 PM, Licensed Practical Nurse #7 initiated the feeding and stated the second nurse assigned to the unit was not coming in.3. Resident #9 had diagnoses including dysphagia (difficulty swallowing), gastrostomy status (presence of a feeding tube inserted into the stomach), and convulsions (sudden, involuntary muscle contractions often associated with seizure activity). The Minimum Data Set, dated [DATE] documented the resident had severely impaired cognition and required enteral feeding. Review of the Comprehensive Care Plan on 04/16/2026 revealed Resident #9 required tube feeding related to dysphagia. Interventions included to administer tube feeding and water flushes per Registered Dietician recommendation and physician orders. Review of Resident #9's physician orders dated 04/11/2026 included nothing by mouth and enteral nutrition Nutren 1.5 at 65 milliliters per hour beginning at 5:00 PM for a prescribed total daily volume of 1315 milliliters. Orders also included administration of water (continued on next page)

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F 0693 Level of Harm - Actual harm Residents Affected - Few	via enteral tube through both automatic flushes at a rate of 30 milliliters per hour with a total volume of 500 milliliters and 150 milliliters of water flushes six (6) times a day. Orders required verification of infusion each shift, confirmation of total volume delivered through pump settings, and documentation of total volume infused.Review of the February 2026, March 2026, and April 2026 Medication Administration Records revealed, based on physician orders, the expected volume at 7:00 AM would be approximately 910 milliliters of enteral nutrition and approximately 420 milliliters of water flush. Documented enteral nutrition volumes at 7:00 AM varied significantly and ranged from 113 milliliters to 1315 milliliters. Documented water flush volumes varied widely ranging from 120 milliliters to 1035 milliliters. There were multiple blank entries across all shifts.Additional review of physician orders, progress notes, and intake/output records included no documented evidence of orders to hold or adjust enteral nutrition or hydration, clinical justification for inconsistent volumes, or resident refusal. There was no alternate documentation to support administration when the Medication Administration Record was incomplete or inconsistent.During an interview on 04/17/2026 at 9:09 AM, the Director of Nursing stated documentation contained blank entries and they could not confirm if Residents #5, #7, and #9 received enteral nutrition and hydration as ordered. The Director of Nursing acknowledged staffing concerns and system issues.During an interview on 04/16/2026 at 12:22 PM, Nurse Practitioner #1 stated there were significant communication gaps between nursing staff and the provider, and staff did not consistently notify the provider when medications, treatments, or enteral feedings were late or not administered. Nurse Practitioner #1 stated they expect physician orders to be carried out as written and to be notified if care is not provided as ordered. Nurse Practitioner #1 stated no nursing staff had notified them of missed or late enteral feedings or hydration, nor had staff expressed concern residents were not being fed or receiving enteral nutrition as prescribed. Nurse Practitioner #1 stated failure to administer enteral nutrition and hydration as ordered could result in dehydration, aspiration, and clinical decline.During an interview on 04/17/2026 at 12:25 PM, the Medical Director stated there were significant system concerns within the facility, including missed medications and enteral feedings, and lack of oversight to ensure ordered care was provided. The Medical Director stated they had been notified of missed medications but were not provided details regarding what was missed and expressed concern regarding the absence of a clear process to identify and address missed care. The Medical Director stated if enteral feeding pumps are not set up correctly or if feedings are not administered as ordered, residents may not receive prescribed nutrition and hydration, which could result in dehydration, aspiration, and potentially death. The Medical Director stated current staffing levels, including one (1) nurse for 40 to 42 residents, were not sufficient to ensure safe care. Title 10 New York Codes, Rules and Regulations 415.12(g)(2) and 415.12(j)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure sufficient nursing staff were available to provide nursing services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for residents in the facility. Specifically, staffing levels were insufficient to meet resident care needs, the facility did not consistently meet its own identified minimum staffing levels, and the facility failed to implement sufficient contingency staffing measures to address known staffing shortages, resulting in missed medication administrations, delayed medication administration, and inability to complete ordered treatments.The findings include: The Facility assessment dated [DATE] documented the facility was licensed for 124 beds with a daily census of 120 to 122 residents. The Facility Assessment included staffing would be adjusted based on resident acuity and included a minimum staffing plan of two (2) nurses on the first floor during day shift from 7:00 AM to 3:00 PM, one (1) nurse during evening shift from 3:00 PM to 11:00 PM, and one (1) nurse during night shift from 11:00 PM to 7:00 AM. The second and third floors each required one (1) nurse on day shift from 7:00 AM to 3:00 PM, one (1) nurse on evening shift from 3:00 PM to 11:00 PM, and one (1) nurse on night shift from 11:00 PM to 7:00 AM, for a total of 10 nurses per 24 hours.During the entrance conference on 03/03/2026 at 8:45 AM, the Administrator stated the facility census was 121 residents.Review of medication administration audits from 02/01/2026 to 04/16/2026 revealed 17 days in which 20 or more residents had missed medication administrations.Review of time punch records for nursing staff on the 17 identified days revealed two (2) evening shifts and nine (9) night shifts in which three (3) or fewer nurses were working in a facility with approximately 120 residents. There were 13 days in which nursing staff punched in more than one (1) hour late and four (4) days in which nursing staff punched out more than one (1) hour early, resulting in reduced staffing levels for significant portions of scheduled shifts.Review of medication administration audits from 02/01/2026 to 04/16/2026 revealed multiple residents experienced delayed medication administration: Resident #10 had 282 medications administered more than one (1) hour late in February 2026, 327 medications administered more than one (1) hour late in March 2026, and 117 medications administered more than one (1) hour late from 04/01/2026 to 04/16/2026. Resident #5 had 188 medications administered more than one (1) hour late in February 2026, 170 medications administered more than one (1) hour late in March 2026, and 43 medications administered more than one (1) hour late from 04/01/2026 to 04/16/2026. Resident #8 had 83 medications administered more than one (1) hour late in February 2026, 249 medications administered more than one (1) hour late in March 2026, and 75 medications administered more than one (1) hour late from 04/01/2026 to 04/16/2026.During an interview on 03/04/2026 at 11:11 AM, Licensed Practical Nurse #4 stated during evening shift on the third floor there was one (1) nurse and two (2) certified nursing assistants assigned to 42 residents and there were occasions with only one (1) certified nursing assistant available. Licensed Practical Nurse #4 stated when assigned alone they were unable to complete required resident care tasks and reported medications were not administered to portions of the unit.During an interview on 04/15/2026 at 1:50 PM, Licensed Practical Nurse #5 stated there was frequently one (1) nurse assigned to the unit and they were unable to complete ordered treatments due to administering medications.During an interview on 04/16/2026 at 11:04 AM, Licensed Practical Nurse #6 stated medication administration required the entire shift and no break was taken.During an interview on 04/16/2026 at 1:46 PM, Licensed Practical Nurse #2 stated they had been the only nurse assigned to a unit on multiple occasions and were unable to complete wound care without additional nursing staff. Licensed Practical Nurse #2 stated there were instances when a nurse would punch in to work, leave the facility for several hours, and returned later before the end of the shift. During an interview on 04/16/2026 at 2:14 PM, Physician Assistant #1 stated they had been made aware of instances where (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	entire resident units did not receive medications and reported significant medications were not administered.During an interview on 04/17/2026 at 9:09 AM, the Director of Nursing stated each unit was expected to have two (2) nurses during day and evening shifts and one (1) nurse during night shift; however, there were occasions when only one (1) nurse was assigned per unit during day and evening shifts. The Director of Nursing stated each unit had 40 to 42 residents and there was currently one (1) unit manager in the facility.During an interview on 04/17/2026 at 12:25 PM, the Medical Director stated one (1) nurse assigned to 40 to 42 residents was not safe.During an interview on 04/22/2026 at 2:22 PM, the Scheduling Coordinator stated they were responsible for staffing each unit to ensure adequate coverage and were unaware of staffing concerns. During an interview on 04/22/2026 at 2:34 PM, the Administrator stated they were aware of residents not receiving medications through reports from residents, families, staff, internal audits, and corporate oversight and acknowledged nurses were not always able to administer medications or complete care within expected timeframes. The Administrator stated staffing levels followed minimum corporate requirements and acknowledged difficulty retaining unit managers.Title 10 New York Codes, Rules and Regulations 415.13(a)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure medications were administered in accordance with physician orders, resulting in clinically significant medication errors, for 11 of 11 residents reviewed (Residents #1, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13). Specifically, Resident #8 received duplicate dosing of a controlled medication (drugs regulated due to their potential for abuse, misuse, or dependence), and several residents experienced omissions of ordered medications, and/or medications administered outside the ordered timeframe and there was no documented evidence a medical provider was notified. These failures included high-risk medications such as insulin (used to treat high blood sugar levels), anticoagulants (blood thinner), anti-seizure medications, cardiac medications (used to treat heart conditions), antibiotics (used to treat infections), and narcotics (controlled medications used to treat severe pain). The findings include: The facility policy Medication Administration dated December 2019 documented medications were to be administered in a safe and timely manner and in accordance with physician orders, including required timeframes. The facility policy Medication Administration - Documentation dated January 2019 documented medication administration must be recorded immediately after administration and must include reasons medications were not administered.1. Resident #8 had diagnoses including heart disease, diabetes, and left lower leg amputation. The Minimum Data Set (a resident assessment tool) dated 03/13/2026 documented Resident #8 was cognitively intact.Review of current physician orders revealed Resident #8 was prescribed the following: Oxycodone (a controlled medication used to treat pain) five (5) milligrams three (3) times daily, ordered on 01/08/2026 and discontinued on 04/13/2026. Oxycodone five (5) milligrams every eight (8) hours, ordered on 04/10/2026. Gabapentin (a medication used to treat nerve pain) 300 milligrams twice daily, ordered on 04/10/2026. Lispro insulin (a short-acting insulin used to treat high blood glucose levels) per sliding scale (a method of insulin administration where the dose is calculated based on a person's blood sugar level at that specific moment) every morning and at bedtime, ordered on 04/10/2026. Ipratropium-albuterol (an inhaled medication used to treat respiratory conditions) twice daily, ordered on 04/10/2026. Symbicort (a combination inhaler medication used to treat respiratory conditions) two (2) puffs twice daily, ordered on 04/10/2026.Review of Resident #8's Medication Administration Record from 03/01/2026 through 04/15/2026 revealed the following: Oxycodone five (5) milligrams was not administered thirteen (13) times during March 2026 and five (5) times between 04/01/2026 and 04/15/2026. Between 04/10/2026 and 04/13/2026, Resident #8 had two (2) active oxycodone orders and received doses under both orders, resulting in administration of a controlled medication in excess of the ordered frequency. During this timeframe, morning blood glucose monitoring and lispro insulin administration, scheduled between 7:00 AM and 10:00 AM, were not completed on three (3) occasions and on seven (7) occasions were completed/administered outside the ordered timeframe, including administration between 1:00 PM and 2:58 PM. On 03/28/2026 and 04/09/2026, blank entries (undocumented, empty spaces for specific dates and times where a medication signature, initial, or refusal code should have been recorded) on the Medication Administration Record indicated Resident #8 did not receive evening medications, including duloxetine (an antidepressant medication), propranolol (a medication used to treat heart conditions and blood pressure), blood glucose monitoring with lispro insulin, Lantus insulin (a long-acting insulin used to treat high blood glucose levels), acetaminophen (a medication used to treat pain and fever), gabapentin, Symbicort, tamsulosin (a medication used to treat urinary symptoms), melatonin (a medication used to assist with sleep), and ipratropium-albuterol.Review of Medication Administration Audits (system-generated audits from the electronic health record used to verify medication safety, compliance, and accuracy) from 02/01/2026 to 04/19/2026 identified Resident #8 had 411 occurrences where their medications were administered over one (1) hour late. Review of the Narcotic Count Sheet (a log used to track controlled (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	medications) entries for Resident #8 revealed missing documentation for 8 occurrences in February 2026, 13 occurrences in March 2026, and 5 occurrences between 04/01/2026 and 04/10/2026. Between 04/11/2026 and 04/15/2026, Resident #8 received seven (7) additional doses of oxycodone with some doses administered three (3) hours apart, resulting in administration of a controlled substance medication in excess of the ordered frequency.Review of the facility records did not include documented evidence a medical provider was notified when medications were omitted or administered outside the ordered timeframe for Resident #8.During an interview on 04/15/2026 at 11:30 AM, Resident #8 stated they had yet to receive their medications scheduled for that morning. Resident #8 stated medications were frequently not administered as scheduled and reported delays in receiving medications, including morning medications at times received after 3:00 PM.During an interview on 04/16/2026 at 12:22 PM, Nurse Practitioner #1 stated Resident #8 should have had only one (1) active oxycodone order and the original order should have been discontinued.2. Resident #10 had diagnoses including diabetes, heart failure (a chronic condition where the heart cannot pump blood efficiently, causing fatigue, shortness of breath, and fluid retention), and respiratory failure (occurs when the lungs cannot adequately transfer oxygen to the blood or remove carbon dioxide, causing severe shortness of breath or low oxygen levels). The Minimum Data Set, dated [DATE] documented Resident #10 was cognitively intact. Review of current physician orders dated 04/11/2026 revealed Resident #10 was prescribed the following: Duloxetine (an antidepressant medication) 120 milligrams daily Lovenox (an anticoagulant medication used to prevent blood clots) 40 milligrams every twelve (12) hours Insulin Aspart (a short-acting insulin used to treat high blood glucose levels) eight (8) units before meals with sliding scale coverage Insulin Glargine (a long-acting insulin used to treat high blood glucose levels) 35 units twice daily Melatonin three (3) milligrams at bedtime Metoprolol Succinate (a medication used to treat high blood pressure) 50 milligrams daily Torsemide (a medication used to treat fluid retention) 20 milligrams daily Trazodone (an antidepressant medication) 50 milligrams at bedtimeReview of Resident #10's Medication Administration Records revealed: On 02/28/2026, 03/28/2026, and 04/09/2026, blank entries indicated Resident #10 did not receive evening medications, including blood glucose monitoring with insulin aspart, insulin glargine, Lovenox, melatonin, and trazodone. Between 03/11/2026 and 03/31/2026, there were seven (7) occurrences where morning medications were not administered (blank entries), including blood glucose monitoring with insulin aspart, insulin glargine, Lovenox, duloxetine, metoprolol, and torsemide.Review of Medication Administration Audits from 02/01/2026 to 04/19/2026 identified Resident #10 had 726 occurrences where their medications were administered over one (1) hour late.Review of the facility records did not include documented evidence a medical provider was notified when medications were omitted or administered outside the ordered timeframe for Resident #10.During an interview on 04/22/2026 at 11:22 AM, Resident #10 stated medications were not administered consistently and reported delays in receiving medications, including morning medications at times received after 1:00 PM. Resident #10 stated blood glucose monitoring and insulin administration often were not completed prior to meals.3. Resident #9 had diagnoses including seizure disorder (with recent seizure activity on 02/05/2026 and 02/28/2026), diabetes, and history of cerebrovascular accident (a condition where blood flow to the brain is interrupted). The Minimum Data Set, dated [DATE] documented the resident had severely impaired cognition.Review of current physician orders dated 04/11/2026 revealed Resident #9 was prescribed the following: Zonisamide (an anti-seizure medication used to control seizures) 1000 milligrams daily Amlodipine Besylate (a medication used to treat high blood pressure) five (5) milligrams daily Carvedilol (a medication used to treat high blood pressure) 25 milligrams twice daily Apixaban (an anticoagulant medication used to prevent blood clots) five (5) milligrams twice daily Levetiracetam (an anti-seizure medication used to control seizures) 1500 milligrams every twelve (12) hours Sertraline (an antidepressant medication) 50 milligrams daily Valproate Sodium (an anti-seizure medication used to control seizures) 375 milligrams three (3) times dailyReview of Resident #9's Medication Administration Records revealed: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Between 02/06/2026 and 04/06/2026, there were eleven (11) occurrences where morning medications were not administered (blank entries), including anti-seizure medications and anticoagulant medication. Between 02/02/2026 and 04/11/2026, there were eleven (11) occurrences where evening medications were not administered (blank entries), including carvedilol, apixaban, levetiracetam, and valproate Sodium. Review of Medication Administration Audits from 02/01/2026 to 04/19/2026 identified Resident #9 had 331 occurrences where their medications were administered over one (1) hour late.Review of the facility records did not include documented evidence a medical provider was notified when medications were omitted or administered outside the ordered timeframe for Resident #9.4. Resident #12 had diagnoses including osteomyelitis (a bone infection), right ankle and foot, acquired absence of right great toe, and hypertension (high blood pressure). The Minimum Data Set, dated [DATE] documented Resident #12 was cognitively intact. Review of current physician orders revealed Resident #12 was prescribed the following: Amoxicillin-potassium clavulanate (an antibiotic medication used to treat infection) 875-125 milligrams every twelve (12) hours from 02/27/2026 through 03/13/2026, ordered on 02/27/2026. Hydralazine (a medication used to treat high blood pressure) 25 milligrams every eight (8) hours, ordered on 04/10/2026. Carvedilol 25 milligrams daily, ordered on 04/15/2026. Torsemide 40 milligrams daily, ordered on 04/15/2026. Gabapentin 100 milligrams three (3) times daily, ordered on 04/10/2026.Review of Resident #12's Medication Administration Records revealed: Between 02/27/2026 and 03/06/2026, there were six (6) occurrences where evening doses of Amoxicillin-Potassium Clavulanate were not administered. Between 03/01/2026 and 03/17/2026, there were six (6) occurrences where hydralazine was not administered. On 03/31/2026, blank entries indicated Resident #12 did not receive evening medications, including carvedilol, torsemide, and gabapentin.Review of the facility records did not include documented evidence a medical provider was notified when medications were omitted or administered outside the ordered timeframe for Resident #12.During an interview on 04/16/2026 at 12:22 PM, Nurse Practitioner #1 stated residents had reported medications were not administered as ordered and confirmed they had not been notified of medications that were omitted or administered outside ordered timeframes.During an interview on 04/17/2026 at 12:25 PM, the Medical Director stated medications must be administered as ordered. The Medical Director stated if residents do not receive prescribed medications they could die and the facility was potentially causing harm. During an interview on 04/16/2026 at 2:14 PM, Physician Assistant #1 stated nursing staff were expected to notify providers when medications were not administered and reported this did not consistently occur.During an interview on 04/22/2026 at 2:34 PM, the Administrator stated they were aware residents had not received medications through reports from residents, families, staff, internal audits, and corporate oversight, acknowledged nurses were not always able to administer medications within expected timeframes, and stated residents should receive their medications as prescribed. The Administrator stated nurses should have notified their supervisors and the medical providers when medications were omitted or administered outside ordered timeframes. Title 10 New York Codes, Rules and Regulations 415.12(m)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335556	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rochester Center for Rehabilitation and Nursing	525 Beahan Road Rochester, NY 14624

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure it was administered in a manner which enabled 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 failed to ensure administrative systems, including staffing oversight, medication administration monitoring, and quality assurance processes, were implemented and functioning to identify and correct deficient practices, resulting in a pattern of noncompliance across multiple areas of care, including sufficient nursing staffing, medication administration, and enteral nutrition management.The findings include:The facility policy Quality Assurance and Performance Improvement Program reviewed 04/28/2025 documented the program was designed to support continuous evaluation of facility systems, ensure care delivery systems function consistently and accurately, identify issues and concerns, and develop and implement plans to correct identified areas. The facility policy Quality Assurance and Performance Improvement Committee last reviewed December 2022 documented the committee would meet monthly and additional meetings would be conducted as needed to address identified concerns. The facility policy Medication Administration dated December 2019 documented medications were to be administered in a safe and timely manner in accordance with physician orders. The Facility assessment dated [DATE] documented staffing would be adjusted based on resident acuity and included minimum staffing levels for each unit and shift. The facility was licensed for 124 beds with a daily census of approximately 120 to 122 residents during the survey period. Residents residing in the facility required services including medication administration, enteral nutrition (delivery of liquid nutrition through a tube into the stomach or intestine), wound care, and assistance with activities of daily living.Review of facility records identified systemic failures in care delivery. For additional information, see Centers for Medicare and Medicaid Services Form 2567, reference F725 (Sufficient Nursing Staffing), which identified the facility did not consistently meet minimum staffing levels and did not implement sufficient contingency staffing measures, resulting in missed medication administrations, delayed medication administration, and inability to complete ordered treatments. Review of medication administration audits from 02/01/2026 to 04/16/2026 identified 17 days in which 20 or more residents had missed medication administrations. Review of time punch records identified multiple shifts in which three (3) or fewer nurses were present in a facility with approximately 120 residents.For additional information, see Centers for Medicare and Medicaid Services Form 2567, reference F760 (Free of Significant Medication Errors), which identified clinically significant medication errors for 11 of 11 residents reviewed, including omissions of medications, medications administered outside ordered timeframes, and duplicate dosing of a controlled medication (medications regulated due to potential for misuse or dependence), with no documented evidence a medical provider was notified. Review of medication administration audits from 02/01/2026 to 04/19/2026 identified hundreds of occurrences of medications administered more than one (1) hour late for individual residents.For additional information, see Centers for Medicare and Medicaid Services Form 2567, reference F693 (Tube Feeding Management), which identified failure to administer prescribed enteral nutrition, including lack of documented evidence residents received prescribed feeding volumes, and an adverse outcome in which a resident required hospital transfer and treatment for dehydration.For additional information, see Centers for Medicare and Medicaid Services Form 2567, reference F868 (Quality Assurance and Performance Improvement), which identified the facility failed to ensure the Quality Assurance and Performance Improvement committee met at least quarterly, with a lapse of approximately five (5) months between meetings and lack of medical provider participation.During an interview on 04/16/2026 at 2:14 PM, Physician Assistant #1 stated they were aware of instances in which entire resident units did not receive medications and reported significant medications were not (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335556	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rochester Center for Rehabilitation and Nursing	525 Beahan Road Rochester, NY 14624

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	administered.During an interview on 04/17/2026 at 12:25 PM, the Medical Director stated one (1) nurse assigned to 40 to 42 residents was not safe and residents must receive medications as ordered.During an interview on 04/22/2026 at 2:34 PM, the Administrator stated they had been in the role since 02/09/2026 and acknowledged awareness of staffing concerns and missed or late medication administration. The Administrator stated residents and families reported not receiving medications and internal audits and corporate oversight identified missed medications. The Administrator stated reports were available on a dashboard and were expected to be reviewed by unit managers daily; however, there was only one (1) Director of Nursing available at times and unit manager positions were not consistently filled. The Administrator stated there were periods without an Assistant Director of Nursing, nurse managers, and nursing supervisors, and acknowledged difficulty maintaining staffing levels due to multiple staff departures. The Administrator stated the facility relied on agency staffing and ongoing recruitment efforts to address staffing shortages. The Administrator stated Quality Assurance and Performance Improvement meetings were conducted in March 2026 and after identification of issues related to enteral nutrition; however, the Medical Director was not present and there was no designated medical provider in attendance. The Administrator stated issues related to missed medications were sometimes identified through resident complaints, family reports, or external communication rather than through a consistent internal monitoring process.Title 10 New York Codes, Rules and Regulations 415.26

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	335556	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rochester Center for Rehabilitation and Nursing	525 Beahan Road Rochester, NY 14624

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on record review and interview, the facility failed to ensure the Quality Assessment and Assurance committee met at least quarterly, in accordance with regulatory requirements. Specifically, the facility had a lapse of approximately five (5) months between scheduled meetings.The findings include:Review of the facility's Quality Assurance and Performance Improvement Program reviewed 04/28/2025 included the purpose, which was to support the continuous evaluation of facility systems with the objectives of ensuring care delivery systems function consistently, accurately, and incorporate current and evidence-based practice standards, where available; preventing deviation from care processes, to the extent possible; identifying issues and concerns with facility systems, as well as identifying opportunities for improvement; and developing and implementing plans to correct and/or improve identified areas.Review of the facility's Quality Assurance and Performance Improvement Committee policy last reviewed December 2022 indicated the committee will meet monthly at an appointed time, and special meetings may be called by the coordinator as needed to address issues that cannot be held until the next regularly scheduled meeting.Review of the facility's Quality Assurance and Performance Improvement Meeting Minutes and Sign-In Sheets for meetings held on 05/29/2025, 09/26/2025, 10/31/2025, and 03/24/2026 revealed a lapse of approximately five (5) months between the meeting held on 10/31/2025 and the meeting held on 03/24/2026. Additionally, there was an approximate four (4) month interval between the meetings held on 05/29/2025 and 09/26/2025.Further review of the meeting attendance records revealed no medical provider was in attendance at the meeting held on 03/24/2026.During an interview on 04/22/2026 at 2:34 PM, the Administrator stated they had been in the role since February 2026 and confirmed a Quality Assurance and Performance Improvement meeting was held at the end of March 2026. The Administrator did not identify any additional meetings held between October 2025 and March 2026.Title 10 New York Codes, Rules and Regulations 415.27(c)(1)