STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335562	A. Building B. Wing	10/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Livingston County Center for Nursing and Rehabilit	11 Murray Hill Drive Mount Morris, NY 14510

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review conducted during an Abbreviated Survey (Intake ID: 02610304) from 09/29/2025 to 10/10/2025, the facility did not ensure the residents' environment remained as free of accident hazards as possible for two (2) (Residents #2 and #4) of three residents reviewed. Specifically, medications were left unsupervised at the bedsides of Resident #2 and Resident #4, and there was no evidence the residents had medical orders or were assessed for their ability to safely and competently self-administer medications. Additionally, an unlocked medication cart was left unattended in a common hallway.The findings are:The facility policy Medication Administration last reviewed 02/12/2025 included, but was not limited to, medications may not be left for resident self-administration outside of the licensed nurse's view. During administration of medications, the licensed nurse must maintain line of sight of the medication cart and when not physically at the medication cart, it must be kept closed and locked. The facility policy Self-Administration of Drugs at the Bedside last reviewed 07/20/2016 included, but was not limited to, the care planning team will assess each resident to determine if the resident is capable of safe self-administration. Residents will not be permitted to self-administer or retain medications in their rooms unless the attending physician and the interdisciplinary team agree the resident is safe and competent to do so. 1. Resident #2 had diagnoses including hypertension (high blood pressure), atrial fibrillation (rapid heart rate), and heart failure. The Minimum Data Set (a resident assessment tool) dated 06/26/2025 documented the resident was cognitively intact.Resident #2's Comprehensive Care Plan, last reviewed on 06/30/2025, did not include measurable goals or interventions related to the self-administration of medications.Additional review of the health record did not include documented evidence Resident #2 had a medical order or was assessed for their ability to safely and competently self-administer medications.Review of a Medication Discrepancy/Error Report dated 09/06/2025, revealed Licensed Practical Nurse #1 set a medication cup on Resident #2's overbed table containing Resident #3's bedtime medications, including anticoagulants and cardiovascular (heart) medications. Licensed Practical Nurse #1 left the bedside and Resident #2 self-administered the medications intended for Resident #3. During an interview on 09/29/2025 at 11:55 AM, Resident #2 confirmed the nurse left the pills behind and they accidentally took them.2. Resident #4 had diagnoses including osteoarthritis (degeneration of joint cartilage and bone that causes pain and stiffness), rheumatoid arthritis (a chronic autoimmune disease causing inflammation of the joints resulting in swelling and stiffness), and chronic pain. The Minimum Data Set, dated [DATE] documented the resident was cognitively intact.Resident #4's current Comprehensive Care Plan, reviewed on 09/29/2025, did not include measurable goals or interventions related to the self-administration of medications.Additional review of the health record did not include documented evidence Resident #4 had a medical order or was assessed for their ability to safely and competently self-administer medications.During an observation and interview on 09/29/2025 at 12:45 PM, there was an unmarked medication cup sitting unattended on Resident #4's tray table with approximately one-half inch of a white topical cream. When interviewed at that time, Licensed Practical Nurse #2 stated the cream was Voltaren (an arthritis medication) and Resident #4 did apply the cream independently but had not been care planned or assessed for the self-administration of medications. During an interview on 9/29/2025 at 2:10 PM, the Assistant Director of Nursing stated licensed nursing staff are educated on the facility policy and procedure for medications which includes medications cannot be left in a resident's room unattended by a nurse.During an interview on 09/30/2025 at 1:45 PM, Resident #4 stated the nurse left the Voltaren cream on the tray table for the resident to apply themselves.3. During an observation on 09/29/2025 at 12:25 PM, a medication cart was unlocked and unattended in the hallway near Room #B238. During an observation and interview on 09/29/2025 at 12:28 PM, Licensed Practical Nurse #4 opened and exited the door of Room #B229. When interviewed at that time, Licensed Practical Nurse #4 stated they were trying to get things done but should not have left the medication cart unlocked and out of their view. During an interview on 10/01/2025 at 9:15 AM, the Administrator stated nurses are repeatedly educated not to leave medications in resident rooms, but it still happens. During an interview on 10/01/2025 at 10:45 AM, the Director of Nursing stated leaving medications unsupervised in a resident's room is a safety concern and residents with cognitive impairment could unintentionally take another resident's medications or take medications by the wrong route, such as eating a topical (a medication applied to the skin for local treatment) medication. The Director of Nursing stated there are residents with mild dementia on Residential

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews conducted during an Abbreviated Survey (Incident #2610304) completed from 09/29/2025 to 10/10/2025, the facility did not ensure residents are free of significant medication errors for two (2) of five (5) residents (Resident #2 and #3) reviewed. Specifically, Licensed Practical Nurse #1 prepared medications for Residents #2 and #3 at the same time, left the medications intended for Resident #3 at Resident #2's bedside, and Resident #2 mistakenly took the medications. This resulted in actual harm to Resident #2 that is not Immediate Jeopardy. The findings are:The facility policy Medication Administration, dated 02/12/2025, included medications may not be prepared in advance and may not be left for resident self-administration outside of the licensed nurse's view. Resident #2 had diagnoses including hypertension (high blood pressure), atrial fibrillation (rapid heart rate), and heart failure. The Minimum Data Set (a resident assessment tool) dated 06/26/2025 documented the resident was cognitively intact and taking anticoagulant (blood thinner) medication. Review of Resident #2's Comprehensive Care Plan, last reviewed on 06/30/2025, revealed the resident was at risk for injury related to Eliquis (a blood thinner and a medication used to prevent blood clots) use and had hypertension. Interventions included, but were not limited to, administer medications as ordered. There is no documented evidence Resident #2 had a medical order or was assessed for their ability to safely and competently self-administer medications.Review of a Medication Discrepancy/Error Report dated 09/06/2025, revealed Licensed Practical Nurse #1 set a medication cup on Resident #2's overbed table containing Resident #3's bedtime medications, including anticoagulants and cardiovascular (heart) medications. Licensed Practical Nurse #1 left the bedside and Resident #2 self-administered the medications intended for Resident #3. Review of Resident #2's September 2025 Medication Administration Record revealed on 09/06/2025, Resident #2 received prescribed medications including, but not limited to, Eliquis 2.5 milligrams for atrial fibrillation at 8:00 AM and 8:00 PM, furosemide (a diuretic medication) 20 milligrams at 8:00 AM for heart failure, and triamterene-hydrochlorothiazide (a combination medications of two diuretics used to treat high blood pressure and swelling) 37.5-25 milligrams at 8:00 AM for heart disease with heart failure.Review of Resident #3's September 2025 Medication Administration Record revealed medications prescribed and signed as administered on 09/06/2025 at 8:00 PM, included tamsulosin hydrochloride (a medication used to treat urinary symptoms or an enlarged prostate) 0.4 milligram capsule, Eliquis 5 milligrams tablet, metoprolol tartrate (a medication used to treat high blood pressure) 50 milligram tablet, and lisinopril (a medication used to treat high blood pressure and heart failure) 20 milligram tablet. In progress notes dated 09/06/2025, Registered Nurse #1 documented Resident #2 reportedly grabbed and ingested Resident #3's cup of bedtime medications including Eliquis, metoprolol tartrate, and tamsulosin. The incident was reviewed with Physician Assistant #1 who ordered blood pressure monitoring until the next afternoon. A manual blood pressure documented at 11:57 PM was 92/50. There was no documentation indicating the Physician Assistant was made aware of the low blood pressure.In a progress note dated 09/07/2025 at 5:43 AM, Licensed Practical Nurse #5 documented Resident #2 had a manual blood pressure reading at 4:00 AM of 90/52, the resident voiced feelings of nausea and shakiness, had two (2) episodes of vomiting, and the nursing supervisor was aware. There was no documentation indicating the Physician Assistant was made aware of the continued low blood pressure or change in status.In a progress note dated 09/07/2025 at 6:44 AM, Licensed Practical Nurse #6 documented Resident #2 had a manual blood pressure reading of 62/36, the resident was lethargic (sluggish), and had episodes of diarrhea and vomiting. The charge nurse was notified. In a progress note dated 09/07/2025 at 7:44 AM, Registered Nurse #2 documented the on-call provider was notified and directed to hold all of Resident #2's medications, except levothyroxine (a medication used to treat low thyroid hormone levels) and Eliquis. The nursing staff were to continue to push fluids, monitor blood pressures, and notify the on-call if Resident #2 became unresponsive or had a change in their status. In a progress note dated 09/07/2025 at 11:05 AM, Registered Nurse #3 documented Resident #2 was experiencing weakness, vomiting, and hypotension (low blood pressure) with a manual blood pressure reading of 68/40. Resident #2's responsible party was notified, Physician Assistant #1 was consulted, and Resident #2 was transported to the hospital via ambulance. In a hospital Discharge summary dated [DATE], Physician #1 documented Resident #2 arrived at the emergency room on [DATE] with nausea, vomiting, and hypotension after an accidental intake of their roommate's medication and was admitted to the Intensive Care Unit for monitoring until 09/10/2025