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	01/28/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility did not ensure residents were treated with respect, dignity, and care in a manner and in an environment that promoted maintenance or enhancement of quality of life for two (2) of five (5) residents reviewed (Residents #13 and #166). Specifically, Resident #13 waited more than 45 minutes for their lunch meal after all other residents had been served resulting in emotional distress, and Resident #166 was repeatedly visible from the hallway while unclothed. This findings include: The facility policy titled Meal Service, revised September 2001, included the responsibility of the Licensed Nurse and Certified Nursing Assistant was to distribute food trays to residents in resident rooms, dining rooms, and ancillary dining rooms in a timely manner. A tray sequence may be used in dining rooms, so all residents seated at a table were served at the same time. Resident #13 had diagnoses including diabetes, cerebral palsy, and anxiety disorder. The Minimum Data Set (a resident assessment tool) included the resident was cognitively intact and required set-up assistance with meals. During a dining observation on 01/20/2026 at 12:44 PM, the first meal tray was passed to a resident in the dining room, followed shortly by several other residents. Resident #13 was observed watching a resident seated across from them eat while Licensed Practical Nurse #1 informed Resident #13 their meal would arrive shortly. During a dining observation on 01/20/2026 at 12:59 PM, Resident #13 remained the only resident in the dining room without a meal. Resident #13 was observed resting their right hand on the side of their face while staring at the meals of other residents seated nearby. At 1:18 PM, Licensed Practical Nurse #1 stated aloud they did not want to call the kitchen again due to the negative response received during a prior call. During an observation and interview on 01/20/2026 at 1:22 PM, Resident #13 had still not received their meal and left the dining room to return to their room. When interviewed at that time, Licensed Practical Nurse #1 stated the resident may have gotten tired of waiting and then contacted the kitchen to inquire about the meal. Licensed Practical Nurse #1 stated they did not know why the resident's meal was delayed and acknowledged the meal should have arrived with the other residents' meals. During an observation on 01/20/2026 at 1:30 PM, Resident #13 was lying in bed when their meal arrived on the unit. Licensed Practical Nurse #1 delivered the meal to the resident's room and stated awareness the resident had completed their meal ticket that morning. During an interview on 01/20/2026 at 1:32 PM, Resident #13 stated other residents routinely received their meals while they waited, with delays sometimes lasting 30 minutes to one hour after others were served. Resident #13 stated sitting across from residents eating while they waited made them feel bad and contributed to frustration, which led them to leave the dining room. During an interview on 01/23/2026 at 9:39 AM, Certified Nursing Assistant #1 stated they frequently contacted the kitchen regarding Resident #13's meal and were often told it would take additional time, even though other residents had already been served. During an interview on 01/23/2026 at 1:10 PM, Registered Nurse Manager #1 stated it was (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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	problematic Resident #13 did not receive their meal for more than 45 minutes after others. Registered Nurse Manager #1 stated meal tickets were completed in the morning, and Supervisor of Dining Services #1 had reviewed the resident's ticket but could not explain why the meal was not placed on the cart. During an interview on 01/27/2026 at 10:04 AM, Supervisor of Dining Services #1 stated meals were passed based on meal tickets and seating arrangements. Supervisor of Dining Services #1 acknowledged residents seated together were not always served together and attributed this to lack of attentiveness to seating sheets. During an interview on 01/27/2026 at 11:46 AM, the Director of Nursing stated awareness of dining concerns and confirmed other residents had reported long wait times. The Director of Nursing stated staff should have recognized the emotional impact on Resident #13 and ensured timely follow-up with the kitchen. Resident #126 had diagnoses including paraplegia (paralysis of both arms and legs), traumatic brain injury, and presence of a feeding tube (used to deliver essential nutrition, fluids, and medication directly into the stomach). The Minimum Data Set, dated [DATE] included the resident had severe cognitive impairment. Resident #126's comprehensive care plan and Kardex (a care plan used by certified nursing assistants to provide care), reviewed 01/23/2026, included the resident preferred not to wear clothing while in bed and required the privacy curtain to remain drawn at least halfway. During an observation on 01/20/2026 at 9:56 AM, Resident #126 was lying in bed unclothed with the room door open, genitals exposed and could be seen from the hallway. During an observation on 01/22/2026 at 09:12AM, Resident #126's room door was open, they were lying in bed unclothed, wearing only an incontinence brief, with stool present between the resident's legs. The resident could be seen from the hallwayDuring an interview on 01/27/2026 at 2:32 PM, Certified Nursing Assistant #3 stated Resident #126 preferred to be unclothed and acknowledged the room lacked a privacy curtain. Certified Nursing Assistant #3 stated staff sometimes left the bathroom door open to conceal the resident from view. During an interview on 01/27/2026 at 2:52 PM, Licensed Practical Nurse #5 stated staff covered the resident with a top sheet and left the bathroom door open to partially conceal the resident due to their preference not to wear clothing. During an interview on 01/27/2026 at 3:13 PM, Registered Nurse Manager #3 stated staff attempted to preserve the resident's dignity by covering them but was unaware the resident was frequently visible from the hallway. During an interview on 01/22/2026 at 4:01 PM, the Director of Nursing stated it was staff responsibility to preserve resident dignity and acknowledged it was not dignified for Resident #126 to be visible from the hallway while unclothed. 10 NYCRR 415.3(d)(1)(i)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility did not ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good grooming and personal hygiene for four (4) of nine (9) resident's reviewed (Residents #166, #176, #185, and #225). Specifically, Resident #166 was observed on multiple occasions with overgrown facial hair. Resident #176 had long facial hair on the upper lip. Resident #185 had long chin hair and facial hair at the corners of their upper lip. Resident #225 had long facial hair. Additionally, the facility lacked documented evidence staff consistently offered, provided, or documented grooming services or refusals in accordance with the residents assessed needs and preferences.The findings include, but are not limited to:The undated facility policy titled Shaving the Resident indicated it was the policy of the center to follow established techniques when shaving residents' facial hair. Persons with basic responsibility for implementing this policy included Licensed Nurses and Nursing Assistants, with the purpose being to remove facial hair and improve the resident's appearance and morale.The facility policy titled Bathing a Resident (Shower) dated 06/23/2009 included the procedure for giving a shower to a resident included washing, drying and combing the resident's hair, shaving male residents daily and women as needed.Resident #166 had diagnoses including Alzheimer's disease, dementia, and depression. The Minimum Data Set (a resident assessment tool) dated 12/18/2025 indicated the resident had severe cognitive impairment and required maximum assistance with personal hygiene.Review of the current comprehensive care plan on 01/23/2026 included Resident #166 needed the assistance of a staff member to perform personal hygiene and grooming. Review of the current Kardex (a care plan used by certified nursing assistants to perform daily care) on 01/23/2026 included the resident required staff assistance with shaving.Review of Resident #166's electronic medical record from 11/01/2025 to 01/26/2026 did not include documented evidence staff offered, provided, or documented refusals of assistance with grooming or shaving.During an observation on 01/21/2026 at 9:53 AM, Resident #166 had long, patchy facial stubble and an overgrown mustache with hair curling into the mouth.During an observation on 01/23/2026 at 9:32 AM, Resident #166 continued to have long, patchy facial stubble and an overgrown mustache curling into the mouth.During an interview on 01/23/2026 at 9:34 AM, Resident #166's family member stated staff were expected to assist with shaving and the resident did not like having facial hair.During an interview on 01/27/2026 at 03:40 PM, Certified Nursing Assistant #4 stated residents were shaved on shower days and Resident #166 required staff assistance with shaving. The Certified Nursing Assistant stated the resident could be resistive to care at times.During an interview on 01/27/2026 at 03:50 PM, Registered Nurse Manager #2 stated residents were expected to be shaved on shower days and was not aware of documented refusals for Resident #166.During an interview on 01/28/2026 at 11:56 AM, the Director of Nursing stated facial hair was expected to be groomed at least on shower days. The Director of Nursing further stated there was no designated area for staff to document grooming assistance, and refusals of personal care were expected to be documented in a progress note.Resident # 185 had diagnoses including cerebral infarction (stroke), diabetes, and hypertensive heart disease. The Minimum Data Set, dated [DATE], included the resident was cognitively intact, did not reject care, and required substantial assistance with personal hygiene, including hair combing and shaving.Review of Resident #185's current Comprehensive Care Plan on 01/23/2026, revealed the resident required assistance with grooming. Review of the Kardex included the resident had visual impairment and staff were to assist with hair combing and shaving.Review of Resident #185's Activities of Daily Living sheet for December 2025 and January 2026, grooming was to be completed after set-up (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assistance and did not include documented refusals of care. Staff were to reapproach the resident for care if applicable.During an observation and interview on 01/21/2026 at 11:08 AM, Resident #185 had long chin hair and stated they disliked having facial hair but did not want to bother staff.During an observation and interview on 01/23/2026 at 8:15 AM, Resident #185 had long chin hair and visible facial hair along both sides of the upper lip. Resident #185 stated staff had not offered assistance with facial hair removal and, due to impaired vision, could not safely remove the hair independently. The resident stated they did not refuse grooming care.During an interview on 01/23/2026 at 9:50 AM, stated Resident #185 did not refuse care and staff were expected to offer facial hair removal even when residents did not request it.During an interview on 01/23/2026 at 12:51 PM, Registered Nurse Manager #1 stated staff were expected to offer grooming assistance and Resident #185 had no history of refusing care.During an observation on 01/27/2026 at 10:09 AM, Resident #185 continued to have long chin hair and facial hair on the upper lip.During an interview on 01/27/2026 at 11:05 AM, the Director of Nursing stated staff were expected to remove facial hair based on resident preference and assessed needs.Resident #225 had diagnoses including Parkinson's disease, diabetes, and anxiety. The Minimum Data Set, dated [DATE] included Resident #225 was cognitively intact and required moderate assistance with personal hygiene.Review of the current Comprehensive Care Plan on 01/23/2026 revealed Resident #225 required staff assistance with grooming. Review of the current Kardex on 01/23/2026 revealed staff were to assist with shaving and trimming facial hair.Review of Skin Observation documentation (including bathing related information) from 11/01/2025 through 01/23/2026 did not include documented evidence staff offered, provided, or documented refusals of grooming assistance.During an observation and interview on 01/21/2026 at 1:08 PM, Resident #225 had a beard several inches long and a mustache curling into the mouth. An electric razor was observed in the resident's bathroom. Resident #225 stated they wanted assistance with trimming their beard and mustache and it had been months since grooming was last completed.During an observation and interview on 01/23/2026 at 10:08 AM, Resident #225's facial hair remained unchanged, and the resident stated grooming assistance had not occurred.During an interview on 01/27/2026 at 2:18 PM, Certified Nursing Assistant #5 stated they assist residents with facial grooming, which is usually done on shower days and reported to the licensed practical nurse for documentation. Certified Nursing Assistant #5 stated Resident #225 had not asked for any help trimming their facial hair.During an interview on 01/27/2026 at 4:08 PM, Licensed Practical Nurse #8 stated facial hair grooming would not be documented because it was a part of (bathing) care, and they would document if the resident refused a shower. Licensed Practical Nurse #8 stated Resident #225 had not asked for grooming assistance and would often refuse care.During an interview on 01/28/2026 at 9:31 AM, Registered Nurse Manager #4 stated staff were expected to assist residents with grooming and facial hair care but was unaware of recent requests from Resident #225.During an interview on 01/28/2026 at 12:12 PM, the Director of Nursing stated nursing staff were expected to assist residents with grooming based on resident preference and assessed needs.10 NYCRR 415.12(a)(3)