STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335564	A. Building B. Wing	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ontario Center for Rehabilitation and Healthcare	3062 County Complex Drive Canandaigua, NY 14424

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility did not ensure comfortable and safe temperature levels were maintained for residents residing on two (2) of two (2) resident use floors (Second (2nd) floor and Third (3rd) floor). Specifically, multiple residents were exposed to cold ambient air temperatures, reported feeling cold, and one (1) resident was observed actively shivering.The findings include: The facility policy Temperature - Room, dated August 2022, documented facility rooms would be maintained at an ambient air temperature range between 71 to 81 degrees Fahrenheit. Temperatures would be measured as needed when there was a complaint about air temperature and concerns would be reported to maintenance and administration for review and further actions as necessary. In the event temperatures were affected through equipment failure, temperatures would be measured periodically throughout the facility to provide comfortable and safe temperature levels and blankets and closing the curtains could be utilized to warm temperatures to a comfortable level.Review of past weather temperatures outside the facility on 03/16/2026 at 12:00 PM revealed it was 64 degrees Fahrenheit, and at 6:00 PM it was 38 degrees Fahrenheit. On 03/17/2026 at 12:00 AM it was 29 degrees Fahrenheit and snowing, at 7:00 AM it was 20 degrees Fahrenheit and snowing, and at 12:00 PM it was 24 degrees Fahrenheit.During an observation and interview on 03/17/2026 at 10:49 AM, Resident #14 was in bed with a sheet covering them and stated their room was freezing and they were always cold. Ambient air temperature measured closest to the resident was 69.1 degrees Fahrenheit and approximately four (4) feet across the room closest to the heater air temperature measured 65.8 degrees Fahrenheit. The heater was blowing cold air. Resident #14 stated the heater had not been working and maintenance staff informed them the heater needed bleeding (releasing trapped air from radiators or pipes using a valve, allowing hot water to circulate properly to resolve uneven heating) and had not returned.During an observation and interview on 03/17/2026 at 11:03 AM, Licensed Practical Nurse Manager #1 was sitting at the nurse's station and stated they were working from that location because their office was an ice box. Licensed Practical Nurse Manager #1 stated Resident #11 had been complaining of feeling cold.During an observation and interview on 03/17/2026 at 11:07 AM, Resident #11 was in bed with a blanket up to their neck and stated they were cold and had woken up in the middle of the night because their nose was freezing. Resident #11 stated nursing staff and Maintenance Technician #1 informed them staff were aware it was cold and were trying to determine the cause. Ambient air temperature in room [ROOM NUMBER] measured 60.3 degrees Fahrenheit, the heater was blowing cold air, and above the heater air temperature measured 57.6 degrees Fahrenheit.During an interview on 03/17/2026 at 11:10 AM, the Administrator stated Maintenance Technician #1 had been on the roof attempting to address the heat by clearing fans and staff ensured windows were closed when staff arrived that morning. The Administrator stated Resident #14 could go to the Administrator office or activities room where it was warmer.During an observation and interview on 03/17/2026 at 11:37 AM, Resident #78 was in bed with a blanket up to their neck, their entire body was shaking and actively shivering. Resident #78 stated they were cold. Ambient air temperature measured 64.8 degrees Fahrenheit.During an interview (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on 03/17/2026 at 11:41 AM, the Regional Administrator stated pumps had been shut off and were turned back on and heat should resume shortly. The Regional Administrator was informed several residents reported feeling cold and ambient air temperatures were in the low 60's. The Regional Administrator stated staff would begin moving residents to warmer areas.During an interview on 03/17/2026 at 12:44 PM, the Administrator stated residents were relocated if they requested, heaters were bled, and vendors were present with additional vendors expected to evaluate boilers, pumps, and fans.During an interview on 03/17/2026 at 12:53 PM, Licensed Practical Nurse #5 stated residents complained of feeling cold when they arrived for their shift at approximately 7:00 AM and they provided blankets and reported concerns to Maintenance Technician #1 and administration.During an observation and interview on 03/17/2026 at 12:56 PM, Resident #122 was in the common area on the Second (2nd) floor unit and stated it was really cold, and they had just been given a blanket.During an interview on 03/17/2026 at 1:30 PM, Regional Administrator #1 stated they first (1st) became aware the facility was cold at approximately 11:41 AM.During an observation and interview on 03/17/2026 at 2:04 PM, Licensed Practical Nurse Manager #1 was closing dining room doors on the Third (3rd) floor and stated they were attempting to make the area warmer and multiple residents were moved to the dining room on the First (1st) floor where it was warmer.During an interview on 03/17/2026 at 2:11 PM, the Director of Nursing stated they became aware it was cold at approximately 8:30 AM during rounds and reported concerns to administration. The Director of Nursing stated staff ensured windows were closed and blinds were shut.During an interview on 03/17/2026 at 3:05 PM, the Administrator stated all resident rooms were above 70 degrees Fahrenheit.During an interview on 03/17/2026 at 4:38 PM, the Regional Administrator stated the heating system shut off and required time to restart.10 New York Codes, Rules and Regulations 415.5(h)(4)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility did not ensure assessments (Minimum Data Set (a resident assessment tool)) accurately reflected resident status for 6 of 22 residents reviewed (Residents #6, #70, #82, #101, #104, and #108). Specifically, cognitive assessments (Brief Interview for Mental Status (a cognitive screening tool)) were documented as not assessed without evidence the interview could not be completed, and required sections of the assessment were left incomplete.The findings include:Review of Minimum Data Set (a resident assessment tool) records on 03/16/2026 at 4:30 PM revealed: Resident #6 had a quarterly assessment dated [DATE] which documented the Brief Interview for Mental Status was not assessed. Resident #70 had an annual assessment dated [DATE] which documented the Brief Interview for Mental Status was not assessed. Resident #82 had quarterly assessments dated 12/10/2025 and 01/13/2026 which documented the Brief Interview for Mental Status was not assessed. Resident #101 had a comprehensive admission assessment dated [DATE] which documented the Brief Interview for Mental Status was not assessed. Resident #104 had an admission assessment with an Assessment Reference Date of 02/11/2026 which documented Section C (cognitive patterns) was not assessed. Resident #108 had an admission assessment with an Assessment Reference Date of 01/29/2026 which documented Section C was not assessed despite indicating the resident should have been interviewed.During a telephone interview on 03/17/2026 at 9:37 AM, Regional Social Worker #1 stated if interviews were not completed within the look-back period, the assessment would be coded as not assessed.During an interview on 03/17/2026 at 2:11 PM, Director of Nursing #1 stated they were not aware sections of assessments were incomplete.During an interview on 03/17/2026 at 4:10 PM with the Administrator, Director of Nursing and Regional Administrator, the Administrator stated they did not know why assessments were missing information and incomplete assessments was not identified through the Quality Assurance and Performance Improvement process.Minimum Data Set Coordinator #1 was unavailable for interview at the time of the recertification survey.10 New York Codes, Rules and Regulations 415.11(a)(1)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility did not provide services to meet professional standards of quality for one (1) of three (3) residents reviewed (Resident #18) for nutrition, for one (1) of five (5) residents reviewed (Resident #7) for drugs and medications, and for one (1) of one (1) residents reviewed (Resident #14) for respiratory care. Specifically, there was no documented evidence that weights (Resident #18) and vital signs (blood pressure and heart rate) (Resident #7) were obtained per the physician's orders and/or had documented results (numerical values). In addition, Resident #14 was receiving continuous oxygen without physicians orders. The findings are:The facility policy Charting and Documentation dated January 2020 documented all services provided to a resident shall be documented in the resident's medical record and should include the date, time, and assessment data collected. The facility policy Weight Management dated March 2024 documented a resident's weight shall be obtained as clinically indicated for the resident and documented in the resident's clinical record. The facility policy Oxygen Therapy and Administration dated September 2025 documented oxygen was to be administered with healthcare provider's orders, and the medical order should include the oxygen flow rate, delivery mode, and frequency.1. Resident #18 had diagnoses including hypertension (high blood pressure), heart failure, and dementia. The Minimum Data Set (a resident assessment tool) dated 10/22/2025 documented the resident had severely impaired cognition.Review of Resident #18's current comprehensive care plan provided by the facility documented weights should be obtained per orders. Review of Resident #18's current physician orders revealed an order dated 01/28/2026 to obtain the weight and to notify a medical provider for a weight gain of five (5) pounds or greater. Review of Resident #18's electronic medical record (including but not limited to Medication and Treatment Administration Records, progress notes, and Weights and Vitals Summary from 01/01/2026 to 03/16/2026 revealed there was no documented evidence the resident's weight was obtained 2 of 10 instances per the physician's order, and no documented evidence the weights were recorded for 4 of 10 instances. During an interview on 03/16/2026 at 11:51 AM, Licensed Practical Nurse #4 stated when a resident had an order for a weekly weight, the weight should be obtained and documented in the electronic medical record. During an interview on 06/16/2026 at 12:50 PM, the Director of Nursing stated they expected the weight to be obtained weekly per the physician's orders, and the nurse should document the weight in the weights and vital signs (Weights and Vitals Summary). The Director of Nursing reviewed Resident #18's medical record and they stated it was a problem that there was not a supplemental order to prompt the entry of the weight and could not verify whether a weight was either obtained or documented as per the physician's orders.2. Resident #7 had diagnoses including hypertension, dementia, and stroke. The Minimum Data Set, dated [DATE] documented Resident #7 had severely impaired cognition and received medication for high blood pressure. Review of the current comprehensive care plan provided by the facility reviewed on 03/12/2026 documented to monitor vital signs as ordered. Review of Resident #7's current medical orders revealed an order dated 03/06/2026 to obtain a blood pressure and heart rate daily for hypertension and notify the provider if the heart rate was less than 60 per minute or for a systolic blood pressure (the first number in a blood pressure reading) greater than 140. Review of Resident #7's electronic medical record (including but not limited to Treatment and Medication Administration Records, progress notes, and Weights and Vitals Summary) revealed there was no documented evidence for 5 of 10 instances Resident #7's blood pressure was documented as obtained, and no documented heart rate for 4 of 10 instances Resident #7's heart rate was documented as obtained and did not include the numerical values. During an interview on 03/16/2026 at 10:31 AM, Certified Nursing Assistant #2 stated the nurses were responsible for checking vital signs. During an interview on 03/16/2026 at 12:35 PM, Licensed Practical Nurse #4 stated when a resident had orders for vital signs, the vital signs were to be signed (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	off as completed in the electronic Treatment Administration Record and the values documented in the vital sign section of the electronic medical record (Weights and Vitals Summary). During an interview on 03/17/2026 at 10:38 AM, Licensed Practical Nurse Manager #1 stated the blood pressure and heart rate should be documented in the electronic treatment administration record. Licensed Practical Nurse Manager #1 reviewed Resident #7's medical record and stated the blood pressure and heart rate were signed off as completed but they could not verify the blood pressure or heart rate was obtained because the results (numerical values) were not documented.During an interview on 03/17/2026 at 03:20 PM, the Director of Nursing stated they expected the blood pressure and heart rate results to be documented in the vital signs section (Weights and Vitals Summary) of the electronic medical record. The Director of Nursing stated the blood pressure and heart rate could not be tracked by the medical providers if they were not documented. 3. Resident #14 had diagnoses including congestive heart failure (chronic heart condition where the heart is unable to pump enough blood), chronic obstructive pulmonary disease (lung disease affecting the movement of air through the lungs), and supplemental oxygen dependence. The Minimum Data Set, dated [DATE] documented Resident #14 had severely impaired cognition. Review of the current comprehensive care plan provided by the facility reviewed on 03/11/2026 revealed oxygen was to be administered per medical orders and the oxygen tubing changed per facility protocol. The current Kardex provided by the facility documented the resident was to use oxygen as ordered and to notify the provider if the oxygen was not in use. During an observation on 03/11/2026 at 10:04 AM, Resident #14 was in bed with a nasal cannula (a medical device which delivers oxygen in the nose) with the tubing attached to an oxygen concentrator machine that was on and set at three (3) liters per minute. Review of Resident #14's current medical orders dated through 03/11/2026 revealed there were no physicians' orders for continuous oxygen. Further review revealed an order was obtained on 03/12/2026 for supplemental oxygen via nasal cannula at a concentration of three (3) liters per minute. During an interview on 03/16/2026 at 12:35 PM, Licensed Practical Nurse #4 stated a physician's order would say how much oxygen (liter flow) a resident should be on.During an interview on 03/16/2026 at 11:47 AM, Registered Nurse #1 stated staff would know if a resident was on oxygen therapy based on physician's orders. During an interview on 03/16/2026 at 3:10 PM, Licensed Practical Nurse Manager #1 stated a physician order was required for continuous oxygen because oxygen was technically considered a medication, and the oxygen concentration (liter flow) would be in the medical order. During a telephone interview on 03/17/2026 at 1:48 PM, Nurse Practitioner #1 stated a medical provider order was needed for oxygen. Nurse Practitioner #1 stated oxygen is considered a medication. Nurse Practitioner #1 stated a medical order was needed because there was a risk for over-oxygenating (breathing in excessive amounts of oxygen which can lead to oxygen toxicity) a resident. 10 New York Code Rules Regulations 415.11(c)(3)(i)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, interviews, and record review, the facility did not ensure the infection prevention and control program was implemented to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for two (2) of two (2) residents reviewed (Resident #5 and Resident #96). Specifically, Resident #5 was provided a meal tray stored in a cart with soiled trays, creating a risk for cross-contamination and potential transmission of pathogens, and Resident #96 who was on enhanced barrier precautions (an infection control strategy using gloves and gowns during high-contact resident care to reduce the spread of infection) received high-contact care without appropriate personal protective equipment. In addition, the facility did not ensure staff handled soiled linens in a manner to prevent the spread of infection, as staff sorted soiled linens wearing cloth aprons which increased the risk of contamination.The findings include:The facility policy Enhanced Barrier Precautions last reviewed February 2026 included enhanced barrier precautions are applicable for residents who have but are not limited to wounds and are intended for high-contact care such as transferring. Additionally, the policy included donning (putting on) personal protective equipment such as gowns and gloves prior to resident contact.The undated facility policy Transporting Soiled Linen included wearing personal protective equipment when sorting soiled linen including gloves and impervious (waterproof) gowns.The facility policy Environmental Services - Subject: Handling of Personal Soiled Linen and Soiled Linen last revised March 2018 included staff were to apply gloves and a yellow precaution gown prior to sorting dirty laundry.Issue One (1):Resident #5 had diagnoses including dysphagia (difficulty swallowing), dementia, and progressive multiple sclerosis (can affect the nervous system and cause tremors). The Minimum Data Set (a resident assessment tool) dated 12/16/2025 documented Resident #5 had severe cognitive impairment and required staff assistance with eating.Resident #5's current Comprehensive Care Plan when reviewed on 03/11/2026 revealed the resident had limited physical mobility related to weakness, fatigue, multiple sclerosis, had contractures and required assistance with activities of daily living. Additionally, the resident required substantial assistance for eating.During an observation on 03/11/2026 at 11:41 AM, a lunch cart arrived on the Third (3rd) floor unit. At 12:27 PM another lunch cart arrived on the unit. At 12:39 PM staff were observed placing used trays into the cart. Certified Nursing Assistant #4 had not entered Resident #5's room prior to retrieving the meal tray. When asked how much Resident #5 ate, Certified Nursing Assistant #4 stated the feeders were at the top of the cart, removed a soiled tray, and retrieved Resident #5's meal tray which had not been consumed, and beverages remained unopened. Certified Nursing Assistant #4 then provided the meal tray to Resident #5 and fed the resident at bedside.During an interview on 03/17/2026 at 1:39 PM, Licensed Practical Nurse Manager #1 stated Certified Nursing Assistant #4 should have obtained a new meal tray, as retrieving a tray from a cart containing soiled trays created an infection control concern.During an interview on 03/13/2026 at 10:58 AM, the Infection Preventionist stated providing a meal tray stored in a cart with soiled trays posed a risk for contamination and potential spread of infection.During an interview on 03/17/2026 at 2:11 PM, the Director of Nursing stated concerns included the meal tray being stored with soiled trays, which created an infection control concern.Issue Two (2):Resident #96 had diagnoses including malnutrition, Parkinson's disease (a neurologic disorder that affects movement), and several open wounds. The Minimum Data Set (a resident assessment tool) dated 12/23/2025 documented the resident had severe cognitive impairment and several unhealed pressure ulcers.When reviewed on 03/13/2026, Resident #96's current Comprehensive Care Plan and Kardex (care plan used by certified nursing assistants to direct care) documented the resident was on enhanced barrier precautions. Interventions included wearing a gown and gloves when providing high-contact care.During an observation on 03/09/2026 at 1:17 PM, two (2) Certified Nursing Assistants were observed repositioning Resident #96 in bed wearing gloves without gowns. A sign was posted outside the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident's room indicating enhanced barrier precautions were required.During an interview on 03/16/2026 at 10:31 AM, Certified Nursing Assistant #2 stated staff wear personal protective equipment when a resident has an open wound or when indicated by signage, including during high-contact care such as repositioning.During an interview on 03/13/2026 at 10:58 AM, the Infection Preventionist stated failure to wear appropriate personal protective equipment during high-contact care posed a risk for contamination and potential spread of infection to other residents.During an observation in the designated laundry area and interview on 03/12/2026 at 1:18 PM, Laundry Assistant #1 stated staff wore gloves and a cloth apron while sorting soiled laundry and the apron was laundered every few days.During an interview on 03/13/2026 at 10:58 AM, the Infection Preventionist stated sorting soiled laundry without an impervious gown posed a risk for contamination and potential spread of infection due to lack of protection against soak-through contamination.During an observation in the designated laundry area and interview on 03/13/2026 at 1:27 PM, the Infection Preventionist examined the aprons used for sorting soiled laundry and stated the aprons were cloth and not impervious (waterproof).During an interview on 03/17/2026 at 4:10 PM with the Administrator, Regional Administrator, and Director of Nursing, the Director of Nursing stated leadership was unaware staff were sorting soiled laundry wearing cloth aprons and indicated the practice was not sanitary.10 New York Codes, Rules and Regulations 415.19, 415.19(c)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observations, interviews, and record review, the facility did not properly maintain the nurse call system for one (1) of three (3) resident use floors (Second (2nd) floor). Specifically, a central station call system panel was not present and the audible component for the call system was not working properly. The findings include:Record review on 03/10/2026 at 12:30 PM, revealed the facility electrical equipment policy dated 12/18/2024, documented: 1. Patient Care Related Electrical Equipment (PCREE) shall be tested before being put into service for the first (1st) time and after any repair or modification that might have compromised electrical safety. 3. Testing and maintenance of the Patient Care Related Electrical Equipment will be based on manufacturer's service manual recommendations but tested annually at a minimum. 4. Documentation including a record of Patient Care Related Electrical Equipment tests, repairs and modifications, whether performed by facility staff or an outside vendor, will be maintained at the facility.When observed on 03/09/2026 at 10:00 AM there was a nurse call system visible indicator with an audible tone on the ceiling at the intersection of the East and North corridors on the Second (2nd) floor. Nurse call system stations in resident rooms 205, 206, 209, 216, and 231 were tested by the surveyor and when reset at the bedside or in the bathrooms, the visible indicator and audible tone on the ceiling at the intersection of the East and North corridors remained on and would not reset. When observed on 03/09/2026 at 10:04 AM, there was no central nurse call panel at the nurse station. During an interview at that time Maintenance Technician #1 stated the panel had not been at the nurse station for a few months because it stopped working, and the system was being bid out to be replaced. Maintenance Technician #1 also stated there were shorts in the system and they had the problem with the corridor stations staying lit up and the tone stayed on, and the system could be reset and would work properly again for a time. Record review on 03/10/2026 at 2:00 PM, revealed the most recent nurse call system inspection logs for the Second (2nd) floor were dated 10/24/2025 and no problems or recommendations were listed. When interviewed at that time, the Administrator stated the nurse call system on the Second (2nd) floor finally got a quote for full replacement. The Administrator also stated the call system on the Second (2nd) floor had been an issue shortly after the last survey and the main panel had been removed from the Second (2nd) floor a few months ago. 10 New York Codes Rules and Regulations 415.29, 415.29(b); 415.29(j)(1), 10 New York Codes Rules and Regulations 713-1.3(b), 713-3.25(g)