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	01/31/2025

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 0550 Level of Harm - 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** 49447 Based on observations, interviews, and record review conducted during the Extended Recertification Survey and complaint investigation (#NY00349354) from 01/21/2025 to 01/31/2025, for four (4) (Resident #8, #28, #48, and #350) of seven (7) residents reviewed, the facility failed to 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. Specifically, Residents #8 and #350 did not receive timely emptying of their urinal (a device used to urinate in) resulting in spillage on the resident or having to empty the urinal out a window in order to use it. Resident #28 did not receive timely incontinence care and had not received a shower for four (4) weeks. Resident #48 was observed on multiple occasions with urine soaked through their incontinence brief, incontinence pad, and bed linens. This resulted in psychosocial harm to Resident #8, #28, and #48 that is not Immediate Jeopardy and no actual harm with potential for more than minimal harm that is not Immediate Jeopardy for Resident #350. This is evidenced by the following: 1. Resident #48 had diagnoses that included stroke (blood flow to the brain is interrupted), right sided hemiplegia (paralysis or weakness on one side of the body), and diabetes (too much sugar in the blood). The Minimum Data Set Resident Assessment (assessment tool) dated 10/30/2024 documented Resident #48 was cognitively intact, was always incontinent of urine and stool, and was dependent on staff for toileting. The Comprehensive Care Plan dated 01/14/2025 and the current Kardex (care plan used by the Certified Nursing Assistant for daily care needs) documented the resident required a check (for incontinence) and change (change as needed) for incontinence and/or toileting assist every two (2) to four (4) hours. During an observation and interview 01/23/2025 at 12:45 PM Resident #48's family reported to nursing staff that Resident #48 was soaking wet and had not received incontinence care for hours. In an immediate interview Resident #48 stated no one had cleaned them up since breakfast (approximately five (5) hours ago) and they were soaked through. Resident #48's brief was saturated through; their gown was wet with multiple dried brown stains on it and there was a strong smell of urine present. Resident #48 stated it was dehumanizing to be left soiled for so long and it made them feel forgotten and unimportant. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335564	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/31/2025
NAME OF PROVIDER OR SUPPLIER Ontario Center for Rehabilitation and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0550 Level of Harm - Actual harm Residents Affected - Few	During an interview on 01/24/2025 at 12:10 PM Registered Nurse Manager #1 stated incontinence care and toileting should be provided every two (2) to four (4) hours, as needed, and upon request. Registered Nurse Manager #1 stated Resident #48 often complains about not getting incontinence care, but they are unsure if the complaints are valid or not. During a follow-up observation and interview on 01/27/2025 at 10:00 AM Resident #48 stated they had put their call bell on several times for assistance and staff turned it off without assisting them. Resident #48's gown, incontinence brief, incontinence pad, and linens were again visibly wet. In an immediate interview with Certified Nursing Assistant #6, they stated Resident #48 appeared to be soaked through and had gone a lot longer than two (2) hours without being changed. 2. Resident #28 had diagnoses including stroke, major depressive disorder, and diabetes. The Minimum Data Set Resident assessment dated [DATE] documented Resident #28 was cognitively intact, required assistance from staff with showering, was dependent on staff for toileting hygiene, and was always incontinent of urine and stool. Review of the resident's Comprehensive Care Plan and Certified Nursing Assistant Kardex both dated 04/23/2024 included to check and change for incontinence every two (2) to four (4) hours. During an observation and interview on 01/21/2025 at 11:08 AM Resident #28 stated they had been waiting approximately five (5) hours for incontinence care and that they had not received a shower or had their hair washed in four weeks. Resident #28 was itching their head during the interview and their hair appeared unwashed. During a follow up interview at 1:58 PM Resident #28 stated they received incontinence care at 12:30 PM (approximately six and a half hours after waking up) and had to eat lunch while soiled. During an observation and interview on 01/24/2025 at 11:37 AM, Resident #28's incontinence brief was visibly saturated with urine. During an immediate interview, Certified Nursing Assistant #9 stated Resident #28 was so soiled that they looked like they had been incontinent multiple times. Certified Nursing Assistant #9 stated Resident #28's shower day was Tuesday (three (3) days prior); however, showers were often not completed due to short staffing. During an interview on 01/30/2025 at 1:02 PM, Resident #28 stated they felt embarrassed to be soiled and to have to wait so long for someone to finally help them. 3. Resident #8 had diagnoses including morbid obesity, dementia, and a history of Extended Spectrum Beta Lactamase (ESBL) Resistance (infection resistant to antibiotics) in the urine. The Minimum Data Set Resident assessment dated [DATE] documented the resident had moderately impaired cognition and was frequently incontinent of bowel and bladder. Review of Resident #8's current Kardex revealed the resident required two (2) staff assist for toileting, use of a bed pan or urinal every two (2) hours, and to offer to take the resident to the toilet at around same time each day. During an observation and interview on 01/21/25 11:51 AM, Resident #8 was incontinent of stool and stated that they had been waiting since they woke up (approximately four (4) hours prior) to be changed but had no response to their call light. (continued on next page)

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

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F 0550 Level of Harm - Actual harm Residents Affected - Few	In a telephone call to the New York State Department of Health complaint line on 01/21/2025 at 5:01 PM, Resident #8 stated they had gone to the bathroom (in their brief) that morning and were still waiting to be cleaned up, so they were sitting there with stool all over them. Resident #8 reported sometimes they have to wait all night to get cleaned up and they are sick of it. They said they had to eat their lunch like this (soiled) and they (the facility) are not taking care of them and should know it is not nice to do this to a veteran. In an interview on 01/23/25 at 12:35 PM, Resident #8 stated staff never come to help, and they sometimes have to urinate on themselves when their urinal is full or dump it out the window. The resident's room had an overwhelming odor of urine. In an interview on 01/24/2025 at 12:24 PM, Licensed Practical Nurse Manager #1 stated Resident #8 can use the urinal but is sometimes incontinent. Licensed Practical Nurse Manager #1 stated sometimes Certified Nursing Assistants do not have time to empty urinals. 4. Resident #350 had diagnoses that included diabetes, peripheral vascular disease (a condition where arteries and/or veins become narrowed or blocked, reducing blood flow to the limbs), and chronic venous ulcers (wounds caused by reduced blood flow in the limbs). The Minimum Data Set Resident assessment dated [DATE] documented Resident #350 was cognitively intact, required assistance from staff for toileting and was frequently incontinent of urine. The Comprehensive Care Plan dated 01/08/2025 and Certified Nursing Assistant Kardex, effective as of 01/24/2025, included check resident every two (2) to four (4) hours for incontinence and assist with toileting as needed. During an interview on 01/21/2025 at 10:54 AM, Resident #350 stated their urinal is often not emptied and they cannot use it because it is full, or it spills on them. During an observation at this time, Resident #350's urinal was on the bedside table three quarters full. During an interview on 01/25/2025 at 1:22 PM, Resident #350 stated no one had emptied their urinal since this morning (approximately six (6) hours ago) and the urinal was getting too full to use without spilling. During an interview on 01/25/2025 at 1:33 PM, Certified Nursing Assistant #4 stated they emptied Resident #350's urinal at 7:30 AM, saw that it had urine in it around 9:00 AM and did not empty it at that time, but should have. Certified Nursing Assistant #4 stated urinals should be emptied during rounds every two (2) to four (4) hours. During an interview on 01/27/2025 at 11:19 AM, the Director of Nursing stated emptying urinals and performing incontinence care should be completed every two (2) to four (4) hours, as needed, and per request. If residents are not receiving timely incontinence care and are left soiled for extended periods or not getting their urinals emptied (which subsequently spill on them), it could have a negative psychological effect on the resident making them feel bad or dehumanized. (continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Few	During an interview on 01/31/2025 at 11:25 AM, the Medical Director stated not getting incontinence care, not answering call bells, and not helping with activities of daily living (emptying urinals) could be considered neglect. This could cause feeling of anxiousness, frustration, or being upset, which could affect them mentally and psychologically and negatively impact their physical health and delay recovery. 10 NYCRR 415.5 (a)

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F 0568 Level of Harm - Potential for minimal harm Residents Affected - Some	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. 49447 Based on interviews and record reviews conducted during the Extended Recertification Survey from 01/21/2025 to 01/31/2025 for one (Resident #10) of two residents reviewed, the facility did not ensure that individual financial records were provided to the residents through quarterly statements. Specifically, neither Resident #10 nor their identified resident representative were provided with any quarterly personal fund statements over an extended period of time. This is evidenced by the following: The facility policy Resident Funds Account last reviewed August 2020 included the facility will provide on request, and at least quarterly to the resident or the resident's designated or legal representative, a statement showing the account balance including funds deposited and withdrawn and interest accrued. 1. Resident #10 had diagnoses that included paranoid schizophrenia, high blood pressure, and diabetes. The Minimum Data Set Resident Assessment completed 12/17/2024 documented the resident was cognitively intact. During an interview on 01/22/2025 at 9:11 AM Resident #10 stated they did not receive quarterly statements from the facility, were not given any money to buy things like pizza and did not know if or how much money they had in their account. Review of a Resident Statement Landscape form dated 01/30/2025 revealed Resident #10 had a personal funds account with a balance of $9,800.12. Review of Resident Fund Statements from 03/29/2024 to present revealed all quarterly statements had been signed by the facility as rep payee (the facility manages the resident's Social Security benefits if they are unable to). When requested, the facility was unable to provide evidence that Resident #10 or their representative were provided with any statements of Resident #10's personal fund account. During an interview on 01/30/2025 at 4:15 PM the Business Office Manager stated Resident #10 had fluctuating levels of cognition, the facility was the rep payee, and statements are not sent to residents who are not cognitively intact. The Business Office Manager stated copies of the quarterly Resident Fund Statements for personal funds accounts should be sent the resident representatives if they had one,but was unsure if Resident #10 had a representative. During an interview on 01/30/2025 at 5:11 PM with the Administrator and the Corporate Administrator, the Corporate Administrator stated cognitively intact residents, resident representatives of cognitively impaired residents, and both representatives and residents with fluctuating cognition should receive quarterly statements for personal funds accounts. Review of Resident #10's medical record revealed the resident's brother was their Health Care Proxy (resident representative). (continued on next page)

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F 0568 Level of Harm - Potential for minimal harm Residents Affected - Some	10 NYCRR 415.26(h)(5)(iii)

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46526 Based on record review and interviews conducted during the Extended Recertification Survey and complaint investigations (NY00370078, NY00362904 and NY00349354) from 01/21/2025 to 01/31/2025, the facility did not ensure that thorough and prompt efforts were made to resolve grievances for two (Residents #88 and #350) of 27 residents reviewed. Specially, Resident #88's grievances were not thoroughly investigated and there was no follow-up when the resident voiced dissatisfaction with the facility's resolution to one of their grievances. For Resident #350, there was no evidence a thorough investigation was completed to determine if abuse, neglect, or mistreatment had been ruled out, and the facility did not follow-up with the residents regarding grievance resolution. This is evidenced by the following: The facility policy Grievances, dated 07/02/2024, included a resident and/or representative may file a grievance concerning their treatment, medical care, the behavior of other resident(s) or staff members(s), missing property, theft of property, or violation of their right(s) without fear of discrimination, threat or reprisal in any form. Upon receipt of a grievance, the applicable department would complete and document the investigation of the grievance within seven business days. Grievances related to care concerns would be referred to the Director of Nursing or Nursing Supervisor on duty for immediate review and determination of appropriate follow-up and investigation. The Grievance Officer would oversee timely investigation and resolution by the applicable department(s). The Administrator/designee would review the investigation and resolution of the grievance to validate a thorough investigation, and appropriate resolution was conducted and completed. The facility would immediately report all alleged incidents of neglect or abuse, including injuries of unknown source, and/or misappropriation of resident property, to the Administrator, Director of Nursing or designee and as mandated by state law or federal, whichever is more stringent. 1.Resident #88 had diagnoses including bipolar disorder, diabetes, and anxiety. The Minimum Data Set Resident assessment dated [DATE] revealed Resident #88 was cognitively intact and frequently incontinent of bladder and bowel. The Comprehensive Care Plan dated 01/24/2025 included to check Resident #88 and assist with toileting every two to four hours as tolerated. During an interview on 01/23/2025 at 1:09 PM, Resident #88 said they had filed three grievances, and there were three overnight shifts where they had not been changed (assisted with incontinence care) at all. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a grievance filed by Resident #88 dated 10/31/2024, revealed the resident had not been changed (provided incontinence care) during the previous two-night shifts. The facility's investigation included they would review (nursing staff) schedules and assignments and would interview residents and staff. Review of the facility's investigation did not include documented evidence staff interviews had been conducted or staff statements had been obtained. A Grievance Form, signed by the Administrator on 11/06/2024, included Resident #88 had been notified of the actions taken, they were not satisfied with the actions taken, and the resident stated there was no change and it was the same problem every night. There was no documented evidence any further actions were taken to address Resident #88's dissatisfaction. Review of a grievance filed by Resident #88 dated 11/13/2024, revealed the certified nursing assistant assigned to their care on the day shift had not provided cares and had not handled a sore area with enough gentleness. The facility's investigation included they would review staff schedules and assignments, interview the resident and staff, and determine if appropriate education was needed. Review of the facility's investigation revealed no documented evidence staff interviews had been conducted or staff statements had been obtained. Review of two grievances filed by Resident #88 on 12/16/2024, revealed concerns they were not changed during the overnight shifts (10:00 PM to 6:00 PM) on 12/13/2024 and 12/14/2024. An Accident/Incident Statement form dated 12/17/2024, included the Director of Social Work had interviewed several residents about the overnight events on 12/13/2024, with one resident stating they thought they waited over two hours for someone to answer their call bell, another resident could not recall the date but said it was common to wait hours for the call light to be answered during overnight shift, and a third resident stated they had their call light on but fell asleep before anyone came in. Review of the facility's investigation revealed no documented evidence that staff interviews had been conducted or that staff statements had been obtained. The facility investigation did not include action(s) taken in response to the grievance, if evidence of abuse or neglect had been identified, or a follow-up conducted with the resident and/or representative. 2. Resident #350 had diagnoses that included diabetes, peripheral vascular disease (a condition where arteries or veins become narrowed or blocked, reducing blood flow to the limbs), and chronic venous ulcers (wounds caused by reduced blood flow to the limbs). The Minimum Data Set Resident assessment dated [DATE] documented Resident #350 was cognitively intact and had seven venous and/or arterial ulcers (wounds). Review of a grievance filed by Resident #350 dated 01/09/2025 revealed they had reported they did not have their wound dressing changed on 01/08/2025. The Grievance form, completed by the Director of Social Work, did not include if abuse, neglect, mistreatment had been ruled out and did not include if the resident was notified of any actions taken. The undated facility form, Investigation/Follow-Up to Complaint/Grievance, included to see tracker for Director of Nursing summary. The facility was unable to provide the Director of Nursing's summary of the investigation and actions taken to address the grievance. The facility form, Grievance - Resident Notification Summary, referenced the grievance filed on 01/09/2025, but did not include a description of the grievance, who addressed the grievance, a summary of actions taken, or a signature by the resident or their representative to indicate they had been informed of the facility's response to the grievance. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a special Resident Council meeting held on 01/22/2025 at 1:31 PM with five Resident Council members in attendance, one resident stated some grievances and recommendations had been ongoing for months (including staffing). Sometimes updates were provided, but the residents were always given the same response and there was not a final resolution. During an interview on 01/24/2025 at 11:52 AM, the Director of Social Work stated grievances were any concern a resident had that should be looked in to and they were the facility's designated Grievance Officer. The Director of Social Work stated their involvement with grievances included obtaining a statement from the individual (filing the grievance), documentation of the grievance, and informing the Administrator and Director of Nursing to determine next steps. The Director of Social Work stated a completed grievance form describing the concerns, was provided to the department heads to document a summary of their investigation findings and actions taken. Any grievances that could be potential abuse or neglect would go to the Director of Nursing and any care related grievances would go the Director of Nursing or the Assistant Director of Nursing. The Director of Social Work stated follow-up was then provided to the resident or representative by the appropriate facility staff, depending on the situation. During a telephone interview on 01/27/2025 at 11:07 AM, the Director of Nursing stated when a grievance was received, depending on the concern, it would be given to the appropriate department head for investigation to determine the etiology and a resolution. The Director of Nursing stated an investigation would include obtaining statements, interviewing other residents and staff, and reviewing relevant documentation. They had received a few grievances about residents not receiving assistance with activities of daily living (showers, incontinence care) and as a result, staffing levels were looked at due to staff call ins. The Director of Nursing stated a grievance follow-up would include education provided to the staff or if disciplinary action occurred. The Director of Nursing stated upon investigation of concerns related to wound care, there was no indication why dressing changes were not being done and investigations of any grievances related to incontinence or wound care should include if abuse or neglect had been ruled in or out. During an interview on 01/27/2025 at 12:55 PM, the Regional Director of Clinical Services stated care related grievances (not getting showers, incontinence care not done or done timely, or dressing changes not being done) could potentially be resident neglect and ruling out abuse or neglect would be part of the investigation for every grievance. The Regional Director of Clinical Services stated if a resident (or representative) did not agree with the grievance resolution, they would ask them for input on an agreeable resolution. Upon review of Resident #88's grievance dated 10/31/2024, the Regional Director of Clinical Services stated it was not a complete and thorough investigation and there should have been further follow-up based on the resident statement that things had not changed, and it was the same problem every night. Upon review of Resident #88's grievance dated 11/13/2024, the Regional Director of Clinical Services stated there were no staff statements obtained, including from the involved Certified Nursing Assistant, therefore the investigation was not complete. Upon review of Resident #88's grievances dated 12/13/2024 and 12/14/2024, the Regional Director of Clinical Services stated it was not a complete and thorough investigation since there were other residents with similar concerns that should have been addressed, there were no statements obtained from the involved staff, and it did not look as though the problem was fixed. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Administrator and the Corporate Administrator on 01/27/2025 at 1:47 PM, the Administrator stated they have reviewed grievances to make sure they were done correctly and signed off properly. The Administrator stated they would expect staff statements to be obtained and documentation that abuse or neglect was ruled out (or in) for all grievances. The Administrator stated they were aware of grievances related to timeliness of incontinence care and residents not getting showers, and to address the concerns, some staff had been let go and customer service education (timeliness of answering call lights and appropriate attitudes when providing care) had been provided. The Administrator stated the care issues had been brought to the facility's Quality Assurance and Performance Improvement committee and there was discussion about monitoring the concerns and performing call bell audits, but they had not seen any follow up yet. The Corporate Administrator stated, about a week or two prior, Corporate had identified issues with resident grievances at the facility and a Quality Assurance and Performance Improvement meeting was held with the interdisciplinary team, which included discussions related to the grievance policy and what grievances looked like. The Corporate Administrator stated they set up a weekly call to ensure grievances were identified and the process completed from start to finish but had not yet checked if recommendations had been implemented. 10 NYCRR 415.3(d)(1)(ii)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46526 Based on observations, interviews and record reviews conducted during the extended Recertification Survey and complaint investigations (#NY00349354, #NY00357725, #NY00362904) from 01/21/2025 to 01/31/2025, the facility failed to ensure residents' right to be free from abuse, mistreatment or neglect for six (6)(Residents #8, #48, #65, #73, #76 and #350) of eight (8) residents reviewed for abuse and neglect. Specifically, Resident #8 and Resident #48 did not receive timely incontinence care. Resident #65 did not receive wound care as ordered by the physician for multiple days and was not assisted with toileting or incontinence care for approximately six hours. Resident #73 was left sitting in their wheelchair in their room for approximately 14 hours without incontinence care despite multiple attempts to alert staff via call light and telephone calls to the nurse's station. Resident #76 waited approximately 21 hours for incontinence care to be provided and wet linens changed. Resident #350 did not receive wound care as ordered by the physician for multiple days. In addition, multiple grievances were filed by the residents related to these issues that were not followed up on by the Administration team. These issues resulted in the likelihood of serious injury, serious harm or death for all 95 residents in the facility, which resulted in Immediate Jeopardy. This is evidenced by the following: 1. Resident #350 had diagnoses that included diabetes (a chronic disease that affects how the body uses sugar for energy), peripheral vascular disease (a condition where arteries and/or veins become narrowed or blocked, reducing blood flow to the limbs), and chronic venous ulcers (wounds caused by reduced blood flow in the limbs). The Minimum Data Set Resident assessment dated [DATE] documented Resident #350 was cognitively intact and had seven (7) venous and/or arterial ulcers (wounds). The Comprehensive Care Plan dated 01/08/2025 included Resident #350 had venous wounds to both legs and to apply treatments per physician orders. Review of the physician orders dated 01/09/2025 revealed 12 different wounds on the resident's left and right lower extremities that required daily dressing changes. The dressing changes included cleansing and drying the wounds and applying different wound treatments (including a wound treatment often used for heavily draining/infected wounds to two of the areas) and dressings to all wounds. During an observation on 01/21/2025 at 10:54 AM, Resident #350 had both legs wrapped in gauze dressings that were undated and heavily soiled with serosanguinous (clear blood-tinged fluid) drainage that had soaked through both dressings, the right sock, and the top and bottom sheets on the bed. In an immediate interview, Resident #350 stated they were supposed to receive dressing changes daily, but it had been several days since they were last changed. As a result of that, their rehabilitation sessions were cut short, and they were unable to attend due to too much drainage from the dressings. Resident #350 said they recently had to wait five hours after their shower with no dressings on any of the wounds because the nurse had been too busy to put the dressings on their legs. Review of Resident #350's Treatment Administration Records dated 01/09/2025 to 01/20/2024 revealed no documented evidence that the resident's dressing changes to both legs were completed on 01/10/2025, 01/12/2025, 01/14/2025, 01/18/2025, 01/19/2025 and 01/20/2025. (continued on next page)

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 01/24/2025 at 11:26 AM, Licensed Practical Nurse #2 stated wound dressings should be completed per physician orders, and if missed they should be passed on to the next shift. They stated there are not enough staff to ensure all ordered treatments are completed and they have told the Director of Nursing and Administrator that they are unable to complete all treatments as ordered. During an observation on 01/25/2025 at 1:22 PM Resident #350's dressings to the right and left legs were undated with dried serosanguinous drainage through the outside of the dressing. During an interview on 01/25/2025 at 1:58 PM, Licensed Practical Nurse #2 stated they had not been able to change Resident #350's dressings that day because they were short staffed, and they did not have enough time. 2. Resident #65 had diagnoses that included a right femur fracture (break in the thigh bone on the right side of the body), Parkinson's disease (neurodegenerative disorder that affects movement, balance, and coordination), and malnutrition (lack of sufficient nutrients in the body). The Minimum Data Set Resident assessment dated [DATE] documented Resident #65 was cognitively intact, incontinent of bladder and bowel, and required assistance from staff for transfers and toileting. The resident's Comprehensive Care Plan initiated 12/24/2024 documented Resident #65 had an active skin impairment to the right shin and right thigh and for staff to apply treatments as ordered. Resident #65's Kardex dated 01/23/2024 documented to check (for incontinence) and change (as needed) every two (2) to four (4) hours and to assist the resident with toileting as needed. Review of physician orders dated 01/03/2025 revealed daily wound care to the right thigh that included cleansing, applying a prescribed wound treatment, and a cover dressing. Review of the resident's Treatment Administration Record dated 01/03/2025 to 01/20/2025 revealed no documented evidence that the right thigh dressing had been changed on 11 of 18 days reviewed with the last date signed off as completed being 01/15/2025 (six days prior). During an observation and interview on 01/21/2025 at 10:27 AM, Resident #65 had an adhesive foam dressing on the inner right thigh dated 1/15. In an immediate interview Resident #65 stated they do not know how often the dressing was supposed to be changed. During an observation on 01/25/2025 at 1:20 PM, Resident #65 was sitting in bed naked with a saturated brief hanging around their knees. There was a strong smell of urine in the room and the resident's thigh dressing was dated 1/23. During an interview on 01/25/2025 at 1:33 PM, Certified Nursing Assistant #4 stated that Resident #65 was on their assignment, and they had changed their incontinence brief last at 7:30 AM (approximately six (6) hours ago). Certified Nursing Assistant #4 stated Resident #65 told them they needed help to go to the bathroom around lunch (12:30 PM) but sometimes the resident took themselves, so they did not assist the resident. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 01/25/2025 at 1:58 PM, Licensed Practical Nurse #2 stated that they were not sure if Resident #65 had wound treatments ordered, and they had not yet completed all ordered treatments on their assignment due to short staffing. 3. Resident #48 had diagnoses that included a stroke (blood flow to the brain is interrupted), hemiplegia (paralysis on one side of the body) and diabetes. The Minimum Data Set Resident assessment dated [DATE] documented Resident #48 was cognitively intact, was always incontinent of urine and stool, and was dependent on staff for toileting. The Comprehensive Care Plan dated 01/14/2025 and the current Kardex (care plan used by the Certified Nursing Assistant for daily care needs) dated 01/23/2025 included the resident required a check (for incontinence) and change (as needed) and/or toileting assist every two (2) to four (4) hours. During an observation and interview 01/23/2025 at 12:45 PM, Resident #48's family came to the nursing station and reported to nursing staff Resident #48 was soaking wet and had not received incontinence care for hours. In an immediate interview, Resident #48 stated no one had cleaned them up since breakfast (approximately five hours ago) and they were soaked through. Resident #48's brief was visibly saturated; their gown was wet with multiple dried brown stains on it and there was a strong smell of urine present. During an interview on 01/23/2025 at 12:57 PM, Certified Nursing Assistant #4 stated they had not provided incontinence care to Resident #48 since their first rounds (approximately five hours ago). Certified Nursing Assistant #4 stated residents should be checked and changed for incontinence every two hours. but Resident #48 can call when they need to be changed; they had not called, so Certified Nursing Assistant #4 did not go in their room to check. During an observation and interview on 01/24/2025 at 9:10 AM, Resident #48 stated they had not received incontinence care since last night at 8:00 PM (approximately 13 hours ago). They had put their call bell on this morning and the certified nursing assistant that answered turned the call bell off and had not come back to assist them. Resident #48's incontinence brief, gown, and incontinence pad were saturated and there was a strong odor of urine present. During an interview on 01/24/2025 at 9:13 AM, Certified Nursing Assistant #5 stated Resident #48 was soaked through their incontinence brief, pad, and gown with urine, but they had not changed the resident yet because they were short staffed. They stated nursing leadership and administration knew they needed more help. During an interview on 01/24/2025 at 11:26 AM, Licensed Practical Nurse #2 stated checking and changing for incontinence should happen every two to four hours and as needed if someone was wet. There are not enough staff on the floor to take care of all the residents and they have told the Director of Nursing and Administrator multiple times about their concerns that residents were not getting taken care of. During an interview on 01/24/2025 at 12:10 PM, Registered Nurse Manager #1 stated they were aware of concerns from residents that incontinence care was not being completed timely and wound care was not provided. Registered Nurse Manager #1 said their concerns have been shared with the Director of Nursing and the Administrator. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	4. Resident #8 had diagnoses including morbid obesity, dementia, and a history of Extended Spectrum Beta Lactamase (ESBL) Resistance (infection resistant to antibiotics) in the urine. The Minimum Data Set Resident assessment dated [DATE] documented the resident had moderately impaired cognition and was frequently incontinent of bowel and bladder. Review of Resident #8's undated Comprehensive Care Plan revealed the resident was incontinent. Interventions included to check the resident every two (2) hours, assist with toileting as needed and to provide a bedpan/bedside commode. Review of Resident #8's current Kardex revealed the resident required two staff assist for toileting, using a bed pan or urinal every two hours and offer to take the resident to the toilet at around the same time each day. During an observation and interview on 01/21/2025 at 11:51, AM Resident #8 was incontinent of stool and stated that they had been waiting since they woke up (approximately four hours prior) to be changed but had no response to their call light. At this time Resident #8's lunch tray was delivered and they requested to be changed before eating lunch. When checked Resident #8's call light was not working. In an interview on 01/23/2025 at 12:35 PM, Resident #8 stated staff never come to help, and they have to urinate on themselves sometimes when their urinal is full, or they have to dump it out the window. The resident's room had an overwhelming odor of urine. In a telephone call placed to the New York State Department of Health complaint line on 01/21/2025 at 5:01 PM, Resident #8 stated they had gone to the bathroom that morning and were still waiting to be cleaned up, as they were sitting there with stool all over them. Resident #8 reported sometimes they have to wait all night to get cleaned up and they are sick of it. They said they had to eat their lunch like this, and they (the facility) are not taking care of them and should know it is not nice to do this to a veteran. In an interview on 01/24/2025 at 12:24 PM, Licensed Practical Nurse Manager #1 stated Resident #8 can use a urinal, is sometimes incontinent of urine, and always incontinent of stool. Staff do the best they can, sometimes the Certified Nursing Assistants don't have time to empty urinals, and the nurses try to help. 5. Resident #73 had diagnoses that included a stroke with right-sided weakness, expressive aphasia (partial loss of the ability to speak), and left side below the knee amputation. The Minimum Data Set Resident Assessment, dated 10/14/2024, documented the resident had no behaviors, and was dependent on two (2) or more staff for transfers and toileting. A Social Work Assessment and Documentation Form dated 01/08/2025 documented the resident was cognitively intact. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #73's current Comprehensive Care Plan revealed the resident required assistance with all activities of daily living for toileting, two (2) staff assistance with a mechanical lift for transfers, and frequent repositioning (initiated 10/31/2022). The care plan also included the resident was at risk for impaired skin integrity and pressure ulcer development with interventions to minimize extended exposure of skin to moisture by providing frequent incontinence care and prompt removal of wet/damp clothing and sheets; turn and reposition every two (2) to four (4) hours as needed (initiated 10/12/2022). During an observation and interview on 01/21/2025 at 3:12 PM, Resident #73 was sitting in their room in their wheelchair. There was no call light accessible. Resident #73 was unable to provide a full verbal interview but was able to nod yes and no when interviewed and was able to relay that when they do not have their call light nearby, they need their roommate to call for help for them. During an interview on 01/21/2025 at 3:24 PM, Resident #73's roommate (Resident #299), identified by the facility as alert and oriented, stated staff had gotten Resident #73 up at 10:00 AM on Sunday (two days prior) and they remained in their wheelchair until 1:00 AM Monday morning (15 hours later). Resident #299 stated they had used their call light and tried to reach the front desk multiple times to get help for Resident #73 but received no response. During an interview on 01/24/2025 at 3:06 PM, Certified Nursing Assistant #1 stated they put Resident #73 to bed on 01/20/2025 between 12:00 AM and 12:30 AM, due to short staffing. Certified Nursing Assistant #1 stated it is hard to check on residents every two (2) hours and to get help for a two-person assist when there are only two (2) or three (3) people on the whole floor (census 48). 6. Resident #76 had diagnoses that included bilateral below-the-knee amputations, history of deep vein thrombosis (blood clot), and anxiety. The Minimum Data Set Resident Assessment, dated 12/10/2024, documented the resident was cognitively intact and required moderate assistance with toileting . Review of Resident #76's current Comprehensive Care Plan, initiated 09/06/2023, revealed the resident required assistance of staff with all activities of daily living, and was at risk for pressure ulcers. Interventions included to minimize extended exposure of skin to moisture by providing frequent incontinence care and prompt removal of wet/damp clothing and sheets as needed; turn and reposition every two (2) to four (4) hours as needed. Review of Resident #76's Kardex dated 01/30/2025 revealed to check the resident every two (2) to four (4) hours as tolerated during waking hours and assist with toileting as needed. During an interview on 01/21/2025 at 12:10 PM, Resident #76 stated they were concerned with not being changed on 01/19/2025 from 8:30 AM until 01/20/2025 at 5:30 AM (21 hours). The resident said they had been so soaked- their sheets were soiled and wet and they had put their call light on numerous times, but it was turned off by staff who stated they knew the resident needed assistance, but they were short staffed. Resident #76 stated they had to urinate and defecate several times in their brief; this was not the first time they had to wait long hours to be changed when soiled and they felt very neglected. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 01/24/2025 at 10:36 AM, Certified Nursing Assistant #3 stated that when they arrived to work on 01/20/2025 at 6:00 AM, Resident #76 was very soiled, and the resident and their roommate had stated they had not been changed at all during the night. Certified Nursing Assistant #3 stated sometimes there were only two (2) Certified Nursing Assistants on the third floor (census 48) for the 6:00 AM to 2:00 PM shift and it was hard to provide care timely, especially when residents required the assistance of two (2) staff. The facility was very understaffed and many of the residents required two staff for assistance. During an interview on 01/27/2025 at 11:05 AM, the Director of Nursing stated the assigned nurse is responsible for completing wound care as ordered. The nurse manager is responsible for completing audits to ensure treatments are being completed and following up with staff when they are not documented as complete. The Director of Nursing stated nurses should notify their Nurse Manager, the Assistant Director of Nursing, or Director of Nursing if wound care cannot be completed. The Director of Nursing said residents should be toileted or checked and changed per their care plan. They have received grievances related to lack of wound care, assistance with toileting, and incontinence care not being completed due to short staffing. The Director of Nursing said they and their Assistant Director of Nursing have assisted on the units to help when staff call in. They have terminated some staff and attempted to re-educate staff regarding these ongoing issues. During an interview on 01/27/2025 at 1:47 PM, the Administrator stated they had received grievances related to wound care, toileting assistance, and incontinence care not being provided. They stated the Director of Nursing should be following up on these concerns but was unsure if they had. During an interview on 01/31/2025 at 11:25 AM, the Medical Director stated not getting incontinence care, not answering call bells, and not helping with activities of daily living could be considered neglect. This could cause feelings of anxiousness, frustration, or being upset that could then affect residents mentally and psychologically and have a negative impact on their physical health. On 01/28/2025, the New York State Department of Health survey team identified and declared Immediate Jeopardy. The facility Administrator was notified at 4:56 PM. On 01/29/2025 at 4:30 PM, the New York State Department of Health survey team declared the Immediate Jeopardy was removed based on the following corrective actions taken by the facility: -A QAPI meeting was held on 1/28/2025 at 5:30 PM with all members present, to discuss Immediate Jeopardy issues. -100% of staff working the previous three (3) shifts, including staff on-site at the time of Immediate Jeopardy removal, received education on Abuse, Neglect, Mistreatment; Call Bells; Activities of Daily Living Care and Support; Grievances; Skin and Pressure Injury Prevention; and a newly implemented shift-to-shift report. -Interviews completed with multiple staff, including direct care staff and licensed nursing staff on two (2) of two (2) resident care units, revealed appropriate knowledge of the Abuse, Neglect and Mistreatment; call light response and accessibility; incontinence care; wound prevention and wound care; shift-to-shift report; and grievance process. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-Observations of random call bells on two (2) of two (2) units revealed call bells in working order. Two (2) resident call bells on Unit 3 were not in reach of the resident. Observations of the two (2) rooms were made with Administration present. Both residents will be evaluated by therapy for ability to use call bell and call bell placement. -Approximately 30/40 total active nursing staff, including licensed nurses and Certified Nursing Assistants, were educated on Abuse, Neglect, and Mistreatment; call light response; Activities of Daily Living Care and Support; Grievances; Skin and Pressure Injury Prevention; and a newly implemented shift-to-shift report. -Five (5) per diem staff members and four (4) staff members who are on vacation and/or sick leave have been notified and will be educated prior to their next scheduled shift. -Four (4) of four (4) leadership staff, including Administrator, Director of Nursing, Assistant Director of Nursing and Director of Social Work, were educated on the grievance process. -A weekly on-call rotation for clinical leadership was implemented. -A full house skin sweep audit was completed, newly identified wounds had treatments ordered and were scheduled for wound rounds to be completed 01/29/2025. -Full house treatment completion audit conducted with no wound care treatments identified as missing or incomplete. -Full house call bell audit completed with three (3) call bells replaced. -Full house incontinence rounding completed with incontinence care provided as needed. -Audits to be continued each shift for wound treatment completion, call light accessibility and function, and incontinence care. 10 NYCRR 415.4 (b)(1)(i)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 47642 Based on, interviews, and record review conducted during the Extended Recertification Survey from 01/21/2025 to 01/31/2025 for three (Residents #20, #76, and #248) of three residents reviewed the facility did not ensure that a copy of resident's transfer and/or discharge notices were sent to a representative of the Office of the State Long Term Care Ombudsman. This is evidenced by the following: Resident #20 had diagnoses that included urinary retention (unable to empty the bladder), benign prostatic hyperplasia (enlargement of the prostate), and chronic kidney disease. A review of the electronic health record revealed Resident #20 was transferred to the hospital on 11/05/2024, 11/14/2024, 12/02/2024, 12/19/2024, and 12/24/2024. Resident #76 had diagnoses that included bilateral below the knee amputations, history of deep vein thrombosis (blood clot), and anxiety. A review of the electronic health record revealed Resident #76 was transferred to the hospital on 11/28/2024. Resident #248 had diagnoses including cerebral vascular accident (stroke), diabetes, and chronic obstructive pulmonary disease. A review of the electronic health record revealed that Resident #248 was transferred to the hospital on 12/12/2024. During an interview on 01/22/205 at 10:21 AM the Ombudsman from the Office of the State Long Term Care Ombudsman Program stated that they had not received the facility's notices of transfers and discharges from the facility for the past year. During an interview on 01/30/2025 at 11:41 AM the Director of Social Work stated residents' discharge/transfer notices were not currently being sent to the Ombudsman though it was the responsibility of the Social Worker to send them. The Director of Social Work stated the last notification sent was in October 2024. During an interview on 01/31/2025 at 2:25 PM the Administrator stated they were not aware the facility was not sending copies of the notice of resident discharges/transfers to the Long-Term Care Ombudsman program, The facility was unable to provide any documentation that the Office of the State Long Term Care Ombudsman office had been notified of residents' transfers and discharges per the regulations. 10 NYCRR 415.3(i)(1)(iii)(a-c)

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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** 47642 Based on observations, interviews, and record review conducted during the Extended Recertification Survey and complaint investigations (#NY00357725, #NY00349354) from 01/21/2025 to 01/31/2025, for three (Residents #28, #48, #65) of nine residents reviewed, the facility did not ensure that residents who were dependent on staff for assistance received the necessary services to maintain grooming and personal hygiene. Specifically Resident #28 did not receive incontinence care timely and did not receive showers and hair washing for an extended period of time. Resident #48 did not receive incontinence care timely. Resident #65 was not assisted to the bathroom by staff for an extended period resulting in being incontinent. This is evidenced by the following: Review of the facility policy Activities of Daily Living Care and Support dated 03/13/2024 included that Activities of Daily Living Care will be provided for residents who are unable to carry them out independently, with the consent of the resident and in accordance with the resident's assessed needs, personal preferences, and individualized plan of care. Activities of Daily Living Care includes but is not limited to supervision and assistance with hygiene (bathing, dressing, grooming), elimination (toileting) and incontinence care. Residents' baths or showers will be scheduled as per the resident preference and assessed needs at a minimum of weekly. Toileting/incontinence care will be provided as needed. 1.Resident #28 had diagnoses including morbid obesity, diabetes and heart failure. The Minimum Data Set Resident assessment dated [DATE] documented the resident was cognitively intact. Resident #28's Comprehensive Care Plan dated 04/23/2024 and current Kardex (care plan used by the Certified Nursing Assistants for daily care) included to check the resident every two to four hours during waking hours and assist with toileting as needed. Shower/bath on Tuesday and Friday day shift with the assist of one staff. During an interview on 01/21/025 at 11:08 AM Resident #28 stated they are incontinent of urine and have been waiting since they woke up several hours ago (approximately four to five hours) to be changed. Resident #28 stated they do not know when they are scheduled for a shower, but it has been 4 weeks since they had one or had their hair washed. Resident #28's hair was greasy looking. Review of the resident's electronic health record revealed no documented evidence that the resident had received a shower for the past four weeks. During an observation and interview on 01/24/2025 (Friday) at 11:37 AM Certified Nursing Assistant #9 provided care (bed bath) to Resident #28 who was heavily incontinent of urine. Certified Nursing Assistant #9 stated that Resident #28 was so saturated with urine they had probably urinated several times. Certified Nursing Assistant #9 stated they were unable to complete all the resident care tasks including showers when they have 17 residents on their assignment today. In an interview on 01/24/2025 at 12:00 PM Licensed Practical Nurse Manager #1 stated the Certified Nursing Assistants are unable to get all the tasks done and that it is discussed daily in morning meetings with the Director of Nursing. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident #48 had diagnoses that included a stroke, hemiplegia (paralysis on one side of the body) and diabetes. The Minimum Data Set Resident assessment dated [DATE] documented Resident #48 was cognitively intact, was always incontinent of urine and stool, and was dependent on staff for toileting hygiene. The Comprehensive Care Plan dated 01/14/2025 and Certified Nursing Assistant Kardex effective as of 01/24/2025 included the resident required a check and change and/or toileting assist every two to four hours. During an observation and interview 01/23/2025 at 12:45 PM Resident #48's family came out to the nursing station and reported to nursing staff Resident #48 was soaking wet and had not received incontinence care for hours. In an immediate interview Resident #48 stated no one had cleaned them up since breakfast (approximately five hours ago) and they were soaked through. Resident #48's brief was visibly saturated through; their gown was wet and there was a strong smell of urine present. During an interview on 01/23/2025 at 12:57 PM Certified Nursing Assistant #4 stated they had not provided incontinence care to Resident #48 since their first rounds (approximately five hours ago). Certified Nursing Assistant #4 stated residents should be checked and changed when incontinent every two hours but Resident #48 can call when they need to be changed and had not called, so they did not go in their room to check on them. During an observation and interview on 01/24/2025 at 9:10 AM Resident #48 stated they had not received incontinence care since last night at 8:00 PM (approximately 13 hours ago), had put their call bell on this morning but the certified nursing assistant that answered the bell turned it off and had not come back. Resident #48's incontinence brief and incontinence pad were visibly saturated, and their gown was wet. There was a strong odor of urine present. During an interview on 01/24/2025 at 9:13 AM Certified Nursing Assistant #5 stated Resident #48 was soaked through the incontinence brief, pad and gown with urine, but they had not changed the resident yet because they were short staffed. During an interview on 01/24/2025 at 12:10 PM Registered Nurse Manager #1 stated incontinence care should be completed every two to four hours and as needed and they were aware of concerns from residents that this was not being done. 3. Resident #65 had diagnoses that included a right leg fracture, Parkinson's disease, and malnutrition. The Minimum Data Set Resident assessment dated [DATE] documented Resident #65 was cognitively intact, incontinent of bladder and bowel, and required assistance from staff for transfers and toileting. Resident #65's Comprehensive Care Plan dated 12/24/2024 and the Certified Nursing Assistant Kardex dated 01/23/2025 included to check the resident every two to four hours during waking hours and assist with toileting as needed with the assist of one staff member. (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 01/21/2025 at 10:25 AM Resident #65 had been incontinent and their brief was visibly wet. In an immediate interview Resident #65 stated they had not received any assistance yet this morning from the nursing staff and was currently wet. Resident #65 stated they were able to walk to the bathroom with help, but when nursing staff do not help, they have to urinate in their brief. During an observation on 01/25/2025 at 1:20 PM Resident #65 was in bed naked with a saturated brief hanging around their knees. There was a strong smell of urine present in the room. During an interview on 01/25/2025 at 1:33 PM Certified Nursing Assistant #4 stated Resident #65 was on their assignment, and they had changed their incontinence brief last at 7:30 AM (approximately 6 hours ago). Certified Nursing Assistant #4 stated Resident #65 told them they needed help to go to the bathroom around lunch (12:30 PM) but sometimes the resident went by themselves, so they did not assist the resident. During an interview on 01/27/2025 at 11:05 AM the Director of Nursing stated residents who can use the bathroom should be toileted and not left to be incontinent. 10 NYCRR 415.12(a)(3)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46526 Based on observations, interviews, and record review conducted during the Extended Recertification Survey and complaint investigation (NY00363528) from 01/21/2025 to 01/31/2025, the facility did not ensure that residents received care in accordance with professional standards of practice for two (Residents #12 and #350) of 27 residents reviewed. Specifically, Resident #350 did not receive wound care treatments per physician orders on multiple occasions and Resident #12's ordered x-ray was not performed until 15 days after it was ordered. This is evidenced by the following: 1. Resident #350 had diagnoses that included diabetes, peripheral vascular disease (a condition where arteries and/or veins become narrowed or blocked, reducing blood flow to the limbs), and chronic venous ulcers (wounds caused by reduced blood flow in the limbs). The Minimum Data Set Resident assessment dated [DATE] documented Resident #350 was cognitively intact. Review of the physician orders as of 01/09/2025 revealed 12 different wounds on the residents left and right lower extremities that required daily dressing changes. The dressing changes included cleansing and drying the wounds, applying different wound treatments (including a wound treatment often used for heavily draining/infected wounds to two of the areas) and cover dressings to all wounds. During an observation on 01/21/2025 at 10:54 AM, Resident #350 had both legs wrapped in gauze dressings that were undated and heavily soiled with serosanguinous (clear blood-tinged fluid) drainage that had soaked through both dressings, the right sock, and the top and bottom sheets on the bed. In an immediate interview, Resident #350 stated they were supposed to receive dressing changes daily, but it had been several days since they were last changed. Resident #350 said they waited five hours after their shower recently with no dressings on any of the wounds because the nurse was too busy to put the dressings on their legs. Review of Resident #350's Treatment Administration Records dated 01/09/2025 to 01/20/2024 revealed none of the 12 wounds had been signed off as completed since 01/17/2025 (four days prior). Additionally, on 6 of the 12 days reviewed resident's wound treatments were not signed off as completed. During an interview on 01/24/2025 at 12:10 PM, Registered Nurse Manager #1 stated nurses should complete wound care and document in the Treatment Administration Record. A blank box in the Treatment Administration Record means the treatment would be considered not done. During an observation on 01/25/2025 at 1:22 PM, Resident #350's dressings to the right and left legs were again undated with dried serosanguinous drainage through the outside of the dressing. During an interview on 01/25/2025 at 1:58 PM, Licensed Practical Nurse #2 stated they had not been able to change Resident #350's dressings that day because they were short staffed, and they did not have enough time. During an interview on 01/27/2025 at 11:05 AM, the Director of Nursing stated wound care should be completed as ordered by the assigned nurse. Wound care that could not be completed should be passed to the next shift (to be completed). Wounds should not go multiple days without being changed because it can cause them to get worse or infected. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident #12 had diagnoses including low back pain, osteopenia (low bone density making them weak) and dementia. The Minimum Data Set Resident assessment dated [DATE] revealed Resident #12 was moderately impaired cognitively. In a medical progress note dated 01/09/2025 at 4:44 PM Physician #1 documented Resident #12 complained of pain and pointed to both sides of their lower back and they were awaiting results of a urine study. Review of the physician order at 4:56 PM revealed a lumbosacral spine x-ray was ordered. During an interview on 01/21/2025 at 11:51 AM, Resident #12 said they have had constant back pain for a long time and a doctor had said two to three weeks prior that they would get an x-ray, but nothing had been done yet. In a medical progress note dated 01/23/2025 Physiatry (a medical specialty that helps residents regain function and quality of life after injury or illness) Nurse Practitioner #1 documented that Resident #12 was picked up by therapy for rehabilitation due to generalized weakness, poor endurance, functional decline and low back pain. Physiatry Nurse Practitioner #1 documented that Resident #12 was pending a lumbosacral spine x-ray which appeared to have not been done yet, and the primary care provider and Director of Nursing were made aware. Review of Resident #12's Radiology Results Report dated 01/24/2025, revealed the x-ray was obtained on 01/24/2025 at 2:20 PM, and the findings included a compression fracture of the lower spine that was not identified on a previous study 11/16/2021. The report included no further follow-up necessary at this time. During an interview on 01/31/2025 at 9:55 AM, Registered Nurse #1 said a new order for a diagnostic test (x-ray) would go into the computer system (electronic health record) and they should be told in report if an x-ray needed to be done. Registered Nurse #1 said it the Assistant Director of Nursing, the Director of Nursing or the Physician are responsible to ensure the x-ray was done. Registered Nurse #1 stated they did not recall Resident #12 having an x-ray ordered on 01/09/2025. During an interview on 01/31/2025 at approximately 10:30 AM, Registered Nurse Manager #1 said there was a certain format to follow when entering x-ray orders and both nurses and medical providers are able to enter the x-ray orders. Registered Nurse Unit Manager #1 stated x-rays are not always completed on the day shift, and if not, it should be passed on to the next shift or call to find out why it had not been done. Registered Nurse Unit Manager #1 stated they were not aware Resident #12 had an x-ray ordered. Registered Nurse Manager #1 stated the delay could have been because the ordering provider did not know how to put the order in the computer, and they do not always inform nursing staff know when an order is entered. 10 NYCRR 415.12

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49447 Based on observations, interviews, and record review conducted during the Extended Recertification Survey from 01/21/2025 to 01/31/2025 for one (Resident #65) of four residents reviewed, the facility did not ensure residents received the necessary care, treatment and services consistent with professional standards of practice to promote the healing of a pressure ulcer, prevent infection, and prevent new ulcers from developing (unless the individual's clinical condition demonstrates they were unavoidable). Specifically, Resident #65 who preferred to spend most of their time in bed, was not assisted with toileting, and was left incontinent of urine for multiple hours. Resident #65 developed a pressure ulcer to their right buttock and had not received treatments to the area for several days. This is evidenced by the following: The facility policy, Skin and Pressure Injury Prevention, dated 06/27/2024 included staff are to inspect the skin when performing or assisting with personal care or activities of daily living. Risk factors increasing a resident's susceptibility to develop or prevent pressure injury healing include, but are not limited to, exposure of skin to urinary and fecal incontinence, impaired or decreased functional ability, and nutrition or hydration concerns. Prevention measures included to change position frequently based on residents' individual needs, provide personal hygiene, and address causes of moisture if possible (incontinence). The facility policy, Wound Identification and Wound Rounds, dated 11/06/2023 included upon discovery of a newly identified skin impairment, the Registered Nurse should complete a skin assessment, including documentation of size, depth, stage if applicable and appearance of the skin impairment. The licensed nurse will notify the medical provider and obtain a treatment order. Resident #65 had diagnoses that included right leg fracture, Parkinson's disease, and malnutrition. The Minimum Data Set Resident assessment dated [DATE] included Resident #65 was cognitively intact, was incontinent of urine, required assistance from staff for transfers and toileting, was at risk for pressure ulcers, and had no pressure ulcers present. Review of the Comprehensive Care Plan, dated 01/25/2025, included Resident #65 was at risk for pressure ulcers related to immobility and incontinence and required assistance with toilet transfers and toileting hygiene. Interventions included to check for and assist with incontinence care every two to four hours, minimize extended skin exposure to moisture by providing frequent incontinence care, and to monitor, document, and report to the medical provider any changes in skin status. The current (undated) Kardex (a daily care plan used by the certified nursing assistants to provide daily care) included Resident #65 had bladder incontinence, required the assistance of one staff for transfers and toileting, and to assist with toileting or incontinence care every two to four hours. Review of a Braden Scale Assessment (used to determine risk for pressure ulcers) dated 12/25/2024, revealed Resident #65 was at moderate risk for developing pressure ulcers. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 01/25/2025 at 1:20 PM, Resident #65 was sitting in bed naked with a saturated brief around their knee and there was a strong smell of urine present. Resident #65 stated no one had assisted them with care today. During an interview and observation on 01/25/2025 at 1:33 PM, Certified Nursing Assistant #4 stated Resident #65 was on their assignment, and they had changed their incontinence brief last at 7:30 AM (approximately 6 hours ago). Certified Nursing Assistant #4 stated Resident #65 told them they needed help to go to the bathroom around lunch time (12:30 PM) but sometimes the resident took themselves, so they did not assist the resident. They stated they had not turned or repositioned the resident since assisting them with care earlier that morning. During an observation of incontinence care at this time, Certified Nursing Assistant #4 removed a foam dressing fromt the resident's buttocks area dated 01/23/2025 and was saturated with urine. The surrounding area was reddened and had an open wound measuring approximately one quarter inch by one quarter inch. During an interview on 01/25/2025 at 1:58 PM, Licensed Practical Nurse #2 stated they did not know if the open wound on Resident #65 was new. Review of Resident #65's electronic health record from 01/01/2025 to 01/27/2025 revealed no documentation of a skin impairment or pressure ulcer to the right buttock and no wound treatment orders were in place. During an observation and interview on 01/28/2025 at 8:22 AM, the Assistant Director of Nursing assessed Resident #65. The incontinence brief was removed and there was no dressing covering the open wound on Resident #65's buttock. The surrounding area remained reddened wotj the wound edges macerated (the softening and breaking down of skin due to prolonged exposure to moisture). The wound was not measured. When interviewed at that time, the Assistant Director of Nursing stated the open wound looked like a stage two pressure ulcer and there was no documentation of the wound in Resident #65's medical record. The staff should have reported the new skin impairment, and the nurse should have documented a note in the electronic health record when it was discovered. The Assistant Director of Nursing stated Resident #65 was at high risk for pressure ulcers and being left in bed and not assisted with incontinence care or toileting needs could potentially cause a pressure ulcer to develop. During an interview on 01/31/2025 at 1:20 PM, the Director of Nursing stated any new skin impairment should be reported immediately to the registered nurse, assistant director of nursing, director of nursing, and medical provider so an assessment could be completed and wound treatment orders placed. Resident #65 was at high risk for pressure ulcer development and the pressure ulcer could have been prevented by timely addressing their incontinence and toileting needs. 10 NYCRR 415.12 (c)(1)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47642 Based on observations, interviews, and record review conducted during the Extended Recertification Survey from 01/21/2025 to 01/31/2025, for two (Residents #20 and #351) of two residents reviewed, the facility did not provide appropriate treatment and care, based upon current standards of practice and the residents' comprehensive assessment and care plan to prevent urinary tract infections to the extent possible. Specifically, Resident #20 had a history of urinary tract infections and was observed with their indwelling urinary catheter drainage bag (including the drainage port and catheter tubing) lying uncovered (no barrier) on a soiled chair and above the level of the bladder. Resident #351's indwelling urinary catheter drainage bag was observed on the ground without a barrier and above the level of the bladder on multiple occasions. Additionally Resident #20 had a physician order for a urinalysis that was not obtained timely. This is evidenced by the following: The facility policy Catheter Guidelines; Urinary, revised 09/11/2023, included the following guidelines for indwelling urinary catheter management, infection prevention and control: urinary catheter use will adhere to the principles of dignity to include discrete use and privacy (for example, covering urinary catheter drainage bags), position urinary drainage bags below the level of the bladder and secure to avoid kinks and tubing obstruction, do not position catheter drainage bag touching the floor, and empty the urinary drainage bag as regularly and as frequently as necessary to avoid excess pulling on the catheter tubing. 1. Resident #20 had diagnoses that included urinary retention (unable to fully empty the bladder), benign prostatic hyperplasia (enlargement of the prostate), and chronic kidney disease. The Minimum Data Set Resident Assessment, dated 11/25/24, documented the resident had moderately impaired cognition, was dependent on staff for toileting hygiene, and had an indwelling catheter. Review of the current Comprehensive Care Plan and Kardex (care plan used by the Certified Nursing Assistants for daily care) revealed Resident #20 had a suprapubic urinary catheter (catheter inserted directly into the bladder via the abdomen to drain urine-initiated 08/23/2023). Interventions included catheter care, maintain privacy bag, maintain urine collection bag below the level of the bladder, and report to medical signs and symptoms of urinary tract infection. In a medical progress note dated 12/26/2024 the Medical Director documented Resident #20 was seen for a follow up visit after a recent hospitalization for a urinary tract infection and had completed the antibiotics on 12/27/2024. Review of current physician orders included suprapubic catheter care every shift (ordered on 06/23/2024) and a urinalysis (test of the urine to rule out an infection) dated 01/27/2025. During observations on 01/21/2025 at 9:43 AM Resident #20's urinary collection bag was lying uncovered directly on a heavily soiled reclining chair and above the level of the bladder. At 11:57 AM the drainage bag remained above the level of the bladder and was full of urine to the maximum filled line as indicated on the bag. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #20's electronic health record on 01/30/2025 revealed no results of the urinalysis (ordered 3 days prior). During an interview on 01/30/2025 at 11:21 AM, Licensed Practical Nurse Manger #1 stated they were unable to find the urinalysis results in the computer and would call the hospital. At 12:19 PM Licensed Practical Nurse Manager #1 stated the hospital had not received the urine sample for testing and at 1:15 PM Licensed Practical Nurse Manger #1 stated the test would have to be reordered. Licensed Practical Nurse Manger #1 stated an indwelling urinary catheter's drainage bag should be placed below the bladder and covered. During an interview on 01/31/2025 at 10:51 AM, Nurse Practitioner #2 stated a urinalysis should be completed within 24 hours and if not, there could be a delay in treatment. Nurse Practitioner #2 stated Resident #20's urinalysis order had never been collected and that Resident #20 had history of urine infections and they wanted the urinalysis because they felt the resident had an infection brewing. During an interview on 01/31/2025 at 11:01 AM, the Registered Nurse Manger #1 stated that orders pending confirmation could be removed by any nurse including a urinalysis order, all nurses should be checking to see what orders were pending and nurse mangers were responsible to check for pending orders before they left for the day. If a urinalysis was ordered, the expected turnaround time should be within 24 hours (confirmed and obtained). If the order was not confirmed and the urinalysis not obtained, it could cause a potential infection to get worse and lead to a delay in treatment. 2.Resident #351 had diagnoses that included neurogenic bladder (impaired bladder function due to damaged nerves), a leg fracture and depression. The Minimum Data Set Resident assessment dated [DATE] included Resident #351 had severe cognitive impairment, had an indwelling urinary catheter, and had a urinary tract infection in the last 30 days. Review of Resident #351's Comprehensive Care Plan dated 01/22/2025 and the Certified Nursing Assistant Kardex dated 01/04/2025 revealed instructions to maintain the urine drainage bag below the level of the bladder. During an observation on 01/23/2025 at 11:40 AM and 3:55 PM the urine drainage bag was in bed next to the resident at the level of the bladder. During an immediate interview Resident #65 stated the drainage bag was placed there by staff. During an observation on 01/25/2025 at 1:26 PM the urine drainage bag was hanging at the head of bed and above the level of the bladder. During an observation and interview on 01/25/2025 at 1:58 PM Licensed Practical Nurse #2 removed the urine drainage bag from the head of the bed, placed it on the floor without a barrier and emptied it. In an immediate interview Licensed Practical Nurse #2 stated urinary catheter drainage bags should be kept below the level of the bladder, but they find the drainage bags above the bladder a lot. Licensed Practical Nurse #2 stated they should not have placed the drainage bag on the ground without a barrier as it could lead to infection. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/30/2025 at 10:22 AM Certified Nursing Assistant #2 stated they are responsible for providing catheter care, cleaning and emptying the urine drainage bag, and making sure the bag is off the floor and below the level of the bladder. During an interview on 01/30/2025 at 1:20 PM the Director of Nursing stated urinary catheter drainage bags should be off the floor and below the level of the bladder to prevent back flow and potential infection that could cause a urinary tract infection. 10 NYCRR 415.12(d)(1)

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F 0725 Level of Harm - Actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 46526 Based on observations, interviews, and record review conducted during the Extended Recertification Survey from 01/21/2025 to 01/31/2025, for two (Second Floor and Third Floor) of two resident units, the facility did not ensure sufficient staffing to provide nursing services to attain or maintain the highest practical physical, mental, and psychosocial well-being for residents in the facility. Specifically, there were multiple observations of residents incontinent of bladder or bowel for extended periods of time, several residents who reported going weeks without showers and observed unkept with unclean hair. This resulted in psychosocial harm to Residents' #8, #28, #65, #73 and #76 that is not Immediate Jeopardy and is evidenced by the following: For additional information see the Centers for Medicare/Medicaid Services Form 2567: F600 Free from Abuse and Neglect, F677 Activities of Daily Care Provided for Dependent Residents, F585 Grievances, F550 Resident Rights/Exercise of Rights, F684 Quality of Life, and F686 Treatment/Services to Prevent/Heal Pressure Ulcers. Review of the Facility Assessment, revised 01/03/2025, revealed the facility was licensed for 98 beds with an average daily census of 94 residents. Resident care and services included, but were not limited to, assistance with daily living, bowel and bladder care, and monitoring of skin integrity. The facility's minimum staffing pattern listed five Certified Nursing Assistants total for day shift, four for evening shift and two for night shift. The minimum staffing pattern listed two Licensed Nurses (Registered Nurse and/or Licensed Practical Nurse) for day shift, one and a half for evening shift and one for night shift. The facility's staffing plan did not list a direct care staff (Certified Nursing Assistant) to resident ratio. During entrance conference on 01/21/2025 at 9:23 AM, with the Facility Administrator and Corporate Administrator, it was reported that the facility census was 95 residents. Observations and interviews on 01/21/2025 on the second-floor resident unit (census of 46) included: -At 9:18 AM, Registered Nurse Manager #1 said there were only two Certified Nursing Assistants on the unit because the facility had nine call ins for the shift. -At 10:25 AM, Resident #65 was in bed with several days of beard growth and stringy, greasy hair. Resident #65 stated showers were hit or miss and they had gone two to three weeks without a shower. Resident #65 stated no one had been in to help them yet that morning and they had last received care at 5:00 AM. Resident #65's brief was saturated and a strong odor of urine present. Resident #65 stated they knew when they needed to go to the bathroom but could not get help to the bathroom so they wore an incontinence brief and would have to wait to get cleaned up. -At 11:16 AM, Resident #350 said neither a nurse nor a Certified Nursing Assistant had come in to help them yet today, and therapy said they could not go to therapy because they were not ready. Resident #350 said there was not enough staff to help, and they have had to wait hours for care (assistance with incontinence care, dressing changes to their wounds and help with emptying their urinal). (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Some	-At 12:04 PM, Certified Nursing Assistant #3 said when their day started there were only two Certified Nursing Assistants (on the unit), and they had not gotten to all residents yet (to provide care). -At 1:50 PM, Resident #88 said the facility was short-staffed all the time and there was a day shift last month where there was one Certified Nursing Assistant for the entire unit and on one day a few months ago they were unable to get out of bed all day due to not enough staff. Observations and interviews on 01/21/2025 on the third-floor resident unit (census of 49) included: -At 9:09 AM, Licensed Practical Nurse Manager #1 said there were three Certified Nursing Assistants for the day shift (due to call-ins). -At 11:01 AM, Resident #28 said they were last changed (provided incontinence care) at 4:00 AM and day staff had not been in yet to help the resident get up or provide incontinence care. Resident #28 said they were incontinent of both bowel and bladder. Resident #28 said there had been only one Certified Nursing Assistant on the night shift. Resident #28 said they were told there was not enough staff to give them a shower, and it had been four weeks since they had received one or had their hair washed. -At 11:51 AM, Resident #8 was visibly incontinent of stool and stated they had been waiting since they woke up (approximately four hours ago) to be changed but had no response to their call light. -At 3:12 PM, Resident #73 was sitting in their wheelchair and was unable to provide an interview. The resident's roommate (Resident #299) who was alert and oriented stated staff got Resident #73 up at 10:00 AM on Sunday (two days prior) and they remained in their wheelchair until 1:00 AM (15 hours later). When interviewed, Certified Nursing Assistant #1 stated they did put Resident #73 to bed Monday morning at approximately 12:00 AM and 12:30 AM and it was due to short staffing. During an interview on 01/22/2025 at 1:24 PM, Resident #76 stated they were concerned with not being changed on Sunday (01/19/2025) from 8:30 AM until Monday (01/20/2025) at 8:30 AM. Resident #76 stated they were so soaked their sheets were soiled and wet, and they had put their call light on numerous times, but it was turned off by staff, who stated they knew the resident needed assistance but they were short staffed. During an interview on 01/24/2025 at 10:36 AM, Certified Nursing Assistant #3 stated when they arrived to work on 01/20/2025 at 6:00 AM, five to six residents including Resident #76 were very soiled, and Resident #76 and their roommate (Resident #74) stated they had not been changed at all during the night. During a special Resident Council meeting on 01/22/2025 at 1:31 PM with five residents present, one resident said their grievances about poor staffing and long wait times for assistance had been ongoing for months. Review of the monthly Resident Council meeting minutes from July 2024 to December 2024 revealed residents voiced concerns related to long wait times (including call bells) during four of six meetings. (continued on next page)

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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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F 0725 Level of Harm - Actual harm Residents Affected - Some	Review of scheduled nurse staffing sheets for the two units for the past six months revealed multiple night shifts where there were two nurses (Registered Nurse and/or Licensed Practical Nurse and two Certified Nursing Assistants for the entire facility (average census of 94). Review of a staffing spreadsheet for the past three weeks revealed the following nurse staffing levels with an average daily census of 94: -On 01/05/2025, there was one Licensed Practical Nurse in the entire facility from 10:00 PM to 6:00 AM. The facility provided separate documentation that included the Director of Nursing worked on 01/05/2025, but did not include the hours worked. -On 01/10/2025, there was three Certified Nursing Assistants for the entire facility from 10:00 PM to 6:00 AM. -On 01/19/2020 evening shift there was two Licensed Practical Nurses and three Certified Nursing Assistants for the whole facility. -On 01/19/2025 and 01/20/2025 night shift there was one Licensed Practical Nurse and three Certified Nursing Assistants for the whole facility. -On 01/24/2025, there were four Certified Nursing Assistants documented as having worked on the second floor from 6:00 AM to 2:00 PM but the facility could not provide documented evidence (via timecards or punches) that two of the four Certified Nursing Assistants had worked from 6:00 AM to 2:00 PM. During an interview on 01/21/2025 at 12:02 PM, the Director of Human Resources stated when nursing staff call in (unable to work), they try to call more staff in, and notify the administrative team (Administrator, the Director of Nursing and the Assistant Director of Nursing) of call ins. The Director of Human Resources said it was a record call in day (01/21/2025) with two nurses and seven certified nursing assistants that called in (for the day shift). During an interview on 01/24/2025 at 9:59 AM, Certified Nursing Assistant #4 said normal staffing should be five or six Certified Nursing Assistants (each unit), but they usually had four or even two or three (today). Certified Nursing Assistant #4 said when they only had two to three Certified Nursing Assistants, it would take longer to get to all the residents, showers were not done, and they could only round (provide cares) on residents one or two times during the shift (when they should be rounding every two hours). Certified Nursing Assistant #4 stated residents told them they were not getting changed at night at all. Certified Nursing Assistant #4 said they have told their nurse and/or nurse manager that residents were not getting changed or showered and rounds not being done. During an interview on 01/24/2025 at 11:26 AM, Licensed Practical Nurse #2 said there was not enough staff and not enough help to ensure the residents got the care they needed. Licensed Practical Nurse #2 stated there was usually only two Certified Nursing Assistants on the floor to take care of almost 50 residents, and they cannot get everything done. Licensed Practical Nurse #2 said often wound dressings did not get done because there was only one nurse. Licensed Practical Nurse #2 stated they have spoked to Registered Nurse Manager #1, the Director of Nursing, and the Administrator about the issues but they did not feel they were being addressed and were told they (leadership) were working on it. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Some	During an interview on 01/24/2025 at 12:10 pm, Registered Nurse Manager #1 said there were ongoing issues with staffing, which included a lot of staff call-ins, staff just not showing up and newly hired staff not staying. Registered Nurse Manager #1 stated at times they only had one Licensed Practical Nurse on the unit or only two Certified Nursing Assistants for the unit on day shift causing less time spent on each resident's care. During an interview on 01/28/2025 at 3:26 PM, the Director of Human Resources stated when there are call-ins, they send group messages to all staff (not on the schedule that day), the Administrator, the Director of Nursing, the Assistant Director of Nursing, unit managers, and nursing supervisors. The Director of Human Resources stated the minimum nurse staffing levels were four Licensed Nurses and eight Certified Nursing Assistants for the building for day and evening shift and two Licensed Nurses and four Certified Nursing Assistants for night shift. The Director of Human Resources said they do use agency nursing staff that were hired as in-house employees by the corporation but were unsure if there were any other agencies in use. During an interview with the Administrator and the Corporate Administrator on 01/30/2025 at 5:44 PM, the Administrator said minimum nurse staffing levels were based on clinical acuity, which was determined by the Regional Director of Nursing, who would see what the residents' needs were in the building and adjust accordingly. The Administrator stated the minimum nurse staffing levels for the entire building (average census 95) consisted of two Licensed Nurses and five Certified Nursing Assistants for the day shift, one and a one-half Licensed Nurses and four Certified Nursing Assistants for the evening shift, and one Licensed Nurse and two Certified Nursing Assistants for the night shift. The Administrator said they like to have one Registered Nurse for at least eight hours daily and one always on call. During an interview on 01/31/2025 at 10:04 AM the Director of Nursing said they did not have enough staff and have asked the Administrator for more staff. In a follow-up interview at 1:19 PM, the Director of Nursing said five to six Certified Nursing Assistants and two to three Licensed Nurses during the day shift would be needed to provide resident care. The Director of Nursing stated they thought 90% of Certified Nursing Assistants and 65% of Licensed Nurses were employed by an agency affiliated with the organization. The Director of Nursing said they were not privy to if the facility used third party agencies for staffing. During a telephone interview on 01/31/2025 at 11:24 AM, the Medical Director stated they were notified by Administration two to three weeks prior that there was a shift where medications had not been given or were not given on time due to staffing. 10 NYCRR 415.13 (a)(1)(i-iii)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49447 Based on observations, interviews, and record review conducted during the Extended Recertification Survey from 01/21/2025 to 01/31/2025, the facility did not ensure all drugs and biologicals were properly stored in accordance with State and Federal Laws for one (second-floor north medication cart) of two medication carts and one (third-floor medication room) of two medication rooms reviewed. Specifically, the second-floor north medication cart contained controlled medications (medications such as narcotics and opioids that have the potential for abuse and addiction) that were not in a permanently affixed compartment per the regulations and the third-floor medication room contained multiple undated/unlabeled medications. This is evidenced by the following: The facility policy Controlled Substance Management dated August 2022, included the proper storage of controlled drugs was in a double door, double locked, double keyed, steel, wall mounted drug cabinet during non-med pass times and in locked controlled drug compartment of medication cart during med pass times. During an observation on 01/22/2025 at 10:32 AM the third-floor medication room had a narcotic cabinet that was empty except for a pill box that contained approximately 80 undated/unlabeled pills. During an interview on 01/22/2025 at 10:42 AM Licensed Practical Nurse Manager #1 stated they did not have any residents on the floor who used a pill box and did not know whose it was but that any resident pill boxes should be labeled with resident identifiers. During an interview on 01/22/2025 at 11:20 AM Registered Nurse Manager #1 stated controlled substances are stored in the medication carts (two carts on the unit) and removed when a resident is discharged . During an observation on 01/23/2025 at 10:39 AM the second-floor north medication cart contained 25 blister packs of controlled medications for multiple residents including psychotropic (medications used to treat mental health conditions), antianxiety, antidepressant, and opioid medications that were stored in the medication cart. The medications were not stored in a permanently fixed compartment per the regulations. When interviewed at this time Licensed Practical Nurse #2 stated all controlled medications are stored in the medication cart and they do not use the double locked cabinet in the medication room. Licensed Practical Nurse #2 stated the medication carts are not affixed to the wall and the carts have wheels that you can unlock and roll the cart around. There was no chain or lock that could be used to affix the medication cart to the wall. Multiple observations on 01/23/2025 on the second floor resident unit hallways during the day shift revealed the medication carts were left in the hallways not affixed to anything and with no nurse in sight. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/30/2025 at 1:20 PM the Director of Nursing stated controlled medications should always be stored behind two locks in the secured double door cabinet in the medication room, unless they are being used during the shift and then only the medications being used should be kept in the medication cart. If the controlled medications are being kept in the medication carts all the time, there is an increased risk for diversion (theft). 10 NYCRR 415.18(e)(1-4)

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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** 46526 Based on observations, record review, and interviews conducted during the Extended Recertification Survey and complaints investigations 01/21/2025 to 01/31/2025, facility did not ensure it was administered in a manner that enabled it to use it's resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body is responsible and accountable for the Quality Assurance and Performance Improvement program. Specifically, the administration did not ensure residents were free from neglect, there was sufficient nurse staffing to provide nursing services based on residents' assessments, residents were treated with respect and dignity, the nurse call bell system functioned as intended, and that grievances were thoroughly investigated and a follow-up provided to the resident and/or their representative. The is evidenced by the following: The facility's 2025 Quality Assurance and Performance Improvement Plan included that the facility shall develop, implement, and maintain an ongoing, facility-wide Quality Assurance and Performance Improvement Plan designed to monitor and evaluate the quality and safety of resident care, pursue methods to improve care quality, and resolve identified problems. The Administrator was responsible for assuring that the facility's Quality Assurance and Performance Improvement Program complied with federal, state, and local regulatory agency requirements. The Administrator was the chairperson of the Quality Assurance and Performance Improvement Committee, and the role of the Administrator consisted of (but not limited to): -Planning, developing, organizing, implementing, coordinating and directing the Quality Assurance and Performance Improvement Program, in accordance with current rules, regulations, and guidelines that govern the facility. -Helping to identify quality areas that are appropriate for performance improvement projects. -Implementing recommendations from the Quality Assurance and Performance Improvement Committee as they relate to the Quality Assurance and Performance Improvement Program. The Facility assessment dated [DATE], included (but not limited to) services provided by the facility were skilled nursing, subacute services, physical therapy, occupational therapy, and speech therapy. The average daily census was 94 residents. Care and services offered by the facility based on resident's needs included activities of daily living, bowel/bladder care, skin integrity, mental health, medications, infection prevention and control, and other special care needs. Free from Abuse and Neglect - Refer to citation F600. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #8 and Resident #48 did not receive timely incontinence care. Resident #65 did not receive wound care as ordered by the physician for multiple days and was not assisted with toileting or provided incontinence care for approximately six hours. Resident #73 was left sitting in their wheelchair for approximately 14 hours without care. Resident #76 waited approximately 21 hours for incontinence care. Resident #350 did not receive wound care as ordered by the physician for multiple days. In addition, multiple grievances were filed by the residents related to the issues which were not followed up by the Administration team. These issues resulted in the likelihood of serious injury, serious harm or death for all of the residents in the facility (current census 95), which resulted in Immediate Jeopardy. Resident Rights - Refer to citation F550. Residents #8 and #350 did not receive timely emptying of their urinal (container used to urinate in) causing urine to spill on the resident or having to empty the contents out a window in order to urinate. Resident #28 did not receive timely incontinence care and had not received a shower in four weeks. Resident #48 was observed on multiple occasions soaked through their incontinence brief, pad, and sheets. This resulted in psychosocial harm to Resident #8, #28, and #48 that is not Immediate Jeopardy. Sufficient Nursing Staffing - Refer to citation F725. There were multiple observations of residents incontinent of bladder or bowel for extended periods of time, several residents who reported going weeks without showers and were observed unkept with unclean hair. Interviews with multiple staff including the Director of Nursing stated they did not have enough staff to provide timely incontinence care, showers, or treatments and that they have asked the Administrator for more staff. Activities of Daily Living Care Provided for Dependent Residents - Refer to citation F677. Residents #28 and #48 did not receive incontinence care for extended periods of time (up to 13 hours) and Resident #65 was not assisted to the bathroom for hours causing the resident to be left incontinent for an extended period of time. Grievances - Refer to citation F585. Residents #88 and #350 did not have thorough investigations of their grievances and in some cases no follow up was provided. There was no evidence that the facility ruled out abuse or neglect. Resident Call System - Refer to citation text under F919 For three of three residential floors, the facility did not properly maintain the nurse call system. Specifically, central nurse call system panels were not present or functioning properly, the audible component for the call system was not working properly, and there was no documented testing of nurse call devices on the first floor. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 01/22/2025 at 3:30 PM with the Administrator and the Corporate Administrator, the Corporate Administrator stated the call bell system was installed in 2018 and that the overhead lights should light up and audibly tone. The Corporate Administrator said staff should be trained during orientation on the call bell system, and they saw no issue with the panels not being in place as the system still functioned. During an interview on 01/27/2025 at 1:47 PM the Administrator stated they had received grievances related to wound care, toileting assist, and incontinence care not being provided and the Director of Nursing should be following up on these concerns. The Corporate Administrator stated approximately one to two weeks ago they had identified issues with residents' grievances at the facility and a Quality Assurance and Performance Improvement meeting was held with the interdisciplinary team. Discussions were conducted related to the grievance policy and what grievances entailed. The Corporate Administrator said they set up a weekly call to make sure grievances were identified and everything completed but had not yet had the ability to check if the suggestions/recommendations had been done. During an interview on 01/31/2025 at 2:25 PM, the Administrator stated the facility's Quality Assurance and Performance Improvement committee were aware of concerns related to care not being provided (incontinence care, showers, and grooming), dressing changes not being done, and sufficient staffing. 10 NYCRR 415.26

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47642 Based on observation, interviews and record review conducted during the Extended Recertification Survey from 01/21/2025-01/31/2025, the facility did not ensure an Infection Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections was maintained for 3 (Residents' #65, #350 and #351) of 24 residents reviewed. Specifically, appropriate Personal Protective Equipment (PPE) was not worn by nursing staff in residents' room that were identified by the facility as requiring Enhanced Barrier Precautions while preforming high contact care to residents. Additionally, observations of multiple facility staff who had declined the influenza vaccine were not wearing face masks while in resident care areas during the current influenza season as determined by the Department of Health. The facility policy Enhanced Barrier Precautions dated 05/30/2024, documented Enhanced Barrier Precautions would be initiated and implemented for residents as applicable in accordance with federal and/or state regulations and/or in accordance with Centers for Disease Control guidance to reduce the risks of transmission of Multiple Drug-Resistant Organisms. Enhanced Barrier Precautions is applicable for resident with any of the following: a. Infection or colonization with a Multiple Drug-Resistant Organisms. b. Wounds (e.g. any type of wound requiring a dressing) c. Indwelling medical devises (e.g., central line, urinary catheter, feeding tube, tracheostomy/ ventilator, etc.) Issue 1 1. Resident #350 had diagnoses that included diabetes (high blood sugars), peripheral vascular disease (arteries and/or veins become narrowed or blocked reducing blood flow to the limbs), and chronic venous ulcers (wounds caused by reduced blood flow in the limbs). The Minimum Data Set Resident assessment dated [DATE] included Resident #350 was cognitively intact and had seven venous and/or arterial ulcers (wounds). The Comprehensive Care Plan dated 01/08/2025 included Resident #350 had venous wounds to both legs and was on Enhanced Barrier Precautions. During an observation of wound care on 01/21/2025 at 10:54 AM Resident #350 had an Enhanced Barrier Precautions sign posted outside their door which included for staff to wear a gown and gloves with hands on care. Nurse Practitioner #1 wearing gloves, but no gown, removed Resident #350's wound dressings on both legs. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation of wound care on 01/27/2025 at 10:53 AM Registered Nurse #1 wearing gloves, but no gown, provided wound care to Resident #350's multiple leg wounds. Wound care orders included cleansing each wound, drying, applying Aquacell AG (medicated dressing material) to the wound bed and cover with a dressing. During an immediate interview Registered Nurse #1 stated they did not believe Resident #350 was on precautions, and that the Enhanced Barrier Precaution sign was for the roommate. Registered Nurse #1 stated they did not recall receiving education on Enhanced Barrier Precautions at this facility. During a follow up interview on 01/30/2025 at 10:59 AM Registered Nurse #1 stated Enhanced Barrier Precautions signs were posted outside of the doors to residents' room and when providing hands on care (wound care, catheter care, incontinence care) for those residents' staff should wear appropriate personal protective equipment, including gowns and gloves, to prevent cross contamination. 2.Resident #65 had diagnoses that included a right leg fracture (broken bone), Parkinson's disease (a progressive movement disorder), and malnutrition. The Minimum Data Set Resident assessment dated [DATE] included Resident #65 was cognitively intact, incontinent of bladder and bowel, and required assistance from staff for transfers and toileting hygiene. The Comprehensive Care Plan initiated 12/24/2024 included Resident #65 had an actual skin impairment to the right shin and right thigh and was on Enhanced Barrier Precautions. During an observation of wound care on 01/25/2025 at 1:58 PM Resident #65 had an Enhanced Barrier Precaution sign posted outside their door. Licensed Practical Nurse #2 wearing gloves, but no gown, removed the resident's wound dressings and applied two new wound dressings. During an interview on 01/31/2025 at 9:52 AM Licensed Practical Nurse #2 stated precautions are posted outside the resident's door and include the type of precautions. Enhanced Barrier Precautions should be used with residents who had wounds. Licensed Practical Nurse #2 stated they did not wear a gown while providing wound care and should have. 3.Resident #351 had diagnoses that included neurogenic bladder (impaired bladder function due to damaged nerves), a leg fracture, and depression. The Minimum Data Set Resident assessment dated [DATE] included Resident #351 had severe cognitive impairment and had an indwelling urinary catheter. During an observation on 01/25/2025 at 1:58 PM Resident #351 had a sign for Enhanced Barrier Precautions posted outside their door. Licensed Practical Nurse #2, wearing gloves, but no gown, unhooked the resident's urinary catheter drainage bag, emptied the drainage bag of urine into a urinal and emptied the urinal into the toilet. During an interview on 01/31/2025 at 9:52 AM Licensed Practical Nurse #2 stated Enhanced Barrier Precautions were used with residents who had indwelling medical devices such as urinary catheters. Licensed Practical Nurse #2 stated they should have worn a gown while providing care to the resident's urinary catheter drainage bag. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/30/2025 at 11:17 AM with the Assistant Director of Nursing (newly hired Infection Preventionist) and the Registered Nurse/Regional Director of Clinical Services and covering Infection Preventionist stated residents on Enhanced Barrier Precautions are those with open wounds, catheters and residents who have positive multidrug resistant organism cultures. Any staff providing direct hands-on care should be wearing appropriate personal protective equipment of gowns, gloves, goggles (if appropriate) and masks (if appropriate) and all staff received education at orientation and annual in-servicing. Issue 2 The facility policy Influenza Vaccine dated 08/22/2024, documented that staff will provide consent or declination for the influenza (flu) vaccine each year. Individuals refusing the vaccination may be required to wear a standard face mask in resident care areas throughout flu season, as defined and required by the state Department of Health. During an interview on 01/31/2025 at 10:37 AM the Corporate Licensed Practical Nurse stated staff that received the flu vaccine this year have a purple sticker on their ID badges. If staff do not have the purple sticker on their badge this would reflect not receiving the flu vaccine and should be wearing a surgical mask in resident care areas. During an observation and interview on 01/31/2025 at 10:45 AM Licensed Practical Nurse #6 was on the 2nd floor residential unit preparing and administering medications and was not wearing a mask. Licensed Practical Nurse #6 stated they did not receive the flu vaccine this year, did not have a purple sticker on their ID badge, and should be wearing a mask. During an interview and observation on 01/31/2025 at 10:50 AM on the 2nd floor the Director of Maintenance was standing at nurses' station not wearing a mask. The Director of Maintenance stated they did not receive the flu vaccine this year and should be wearing one. During an interview on 01/31/2025 at 2:25 PM the Administrator stated they were aware that facility staff who had not received the current flu season vaccination were not appropriately masking as defined and required by the state Department of Health. 10 NYCRR 415.19(a)(b)(1-3)

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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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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47642 Based on interviews and record review conducted during the Extended Recertification Survey from 01/21/2025 to 01/31/2025, the facility did not ensure each resident was educated and offered the influenza and/or the pneumococcal immunizations (vaccine) for three (Resident #12, #53, #351) of five residents reviewed. Specifically, the facility was unable to provide evidence the residents or their representatives had been provided educational material and offered, received or declined the pneumococcal and/or influenza immunizations. The facility policies Infection Control-Influenza Vaccine dated 08/22/2024 and the Pneumococcal Vaccine dated 11/27/2024 included all residents and/or their resident representative will be offered and provided the influenza and pneumococcal vaccines. Residents have the opportunity to refuse the vaccine(s). A resident's refusal of the vaccine(s) shall be documented on the informed consent for influenza vaccine and pneumococcal vaccine and placed in the resident's medical record and will include the resident or resident's representative was provided education regarding the benefits and potential side effects of the vaccine. 1.Resident #12 had diagnoses that included dementia, delusional disorders, and blindness. The Minimum Data Set Resident Assessment, dated 12/12/2024, included Resident #12 had impaired cognition and listed their daughter as their Health Care Proxy. Review of Resident #12 electronic health record revealed no documented evidence any educational material regarding the benefits and potential side effects of the influenza or pneumococcal vaccines had been provided to the resident's Health Care Proxy or if the vaccines had been offered, received or declined with a signed declination form. 2.Resident #53 had diagnosis that included dementia, hypertension, and a stroke. The Minimum Data Set Resident Assessment, dated 12/11/2024, included Resident #53 was cognitively intact. Review of Resident #53 electronic health record revealed they last received the pneumococcal vaccine on 11/11/2015 and they were due for an update. 3.Resident #351 had diagnoses that included neurogenic bladder (impaired bladder function due to damaged nerves), a leg fracture (broken bone), and depression. The Minimum Data Set Resident assessment dated [DATE] included Resident #351 had severe cognitive impairment. Review of Resident #351 electronic health record revealed their last pneumococcal vaccine was received on 11/5/2014. There was no documentation that Resident #351 had received the influenza vaccine or their Health Care Proxy educated regarding the risks, benefits and side effects of both the influenza and updated pneumococcal vaccines or had declined. In an interview on 01/30/2025 at 1:27 PM the Assistant Director of Nursing (newly hired Infection Preventionist) stated the facility was unaware that Resident #53 was in need of an updated pneumococcal vaccine and they were unable to provide any written documentation that any of the residents or representatives had been educated, received or declined the vaccinations. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 01/31/2025 at 2:25 PM the Administrator stated the facility offers the residents immunizations and they and the Quality Assurance Committee were aware of gaps in resident vaccination documentation. 10 NYCRR 415.19(a)(3)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26883 Based on observations, interviews, and record review conducted during the Extended Recertification Survey from 01/22/2025 to 01/31/2025, for three (first, second, and third floors) of three resident use floors the facility did not properly maintain the nurse call system. Specifically, central nurse call system panels were not present or functioning properly, the audible component for the call system was not working properly, and there was no documented testing of nurse call devices on the first floor. The findings are: 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 time and after any repair or modification that might have compromised electrical safety. 3. Testing and maintenance of the PCREE will be based on the manufacturer's service manual recommendations but tested annually at a minimum. 4. Documentation including a record of PCREE tests, repairs and modifications, whether performed by facility staff or an outside vendor, will be maintained at the facility. When observed on 01/21/2025 at 9:43 AM, the nurse call panel/station was unplugged and not operational in the corner of the third-floor nurse station desk. Overhead lights were observed outside of all resident rooms and one for each hallway. Call lights were lit up outside resident rooms, but no audible tones were heard and there was no panel available to see exact locations where pull stations were activated. During an interview at this time the Director of Facilities stated the call system tablet gets unplugged and does not work at times, and they were not sure why the panel was off or how long it had been that way. The Director of Facilities also stated the system was old and they could not get parts anymore, and there was no panel on the second floor as it was no longer fixable and removed 5-months ago. The Director of Facilities also stated they were not sure what the different colored lights on the overhead call lights meant and were not sure why the system did not have an audible tone. When observed on 01/21/2025 at 10:00 AM, the nurse call button was tested at the bedside of resident room [ROOM NUMBER] and there was one initial tone heard and then stopped. The overhead light in the corridor outside room [ROOM NUMBER] came on and when the activation was cancelled, the overhead light stayed on. When observed on 01/21/2025 at 10:10 AM, the nurse call button was tested at bedside in resident room [ROOM NUMBER] and the corridor overhead light lit up and no audible tone was noted. Additionally, there was no nurse call system panel at the nurse station on the second floor. During an interview at this time the Director of Facilities stated the second-floor tablet had not been in use for about 5 months but there was the installation hardware in the communication room that was for use with the vendor to see what call bells have gone off. During an observation and interview on 01/21/2025 at 11:40 AM, Resident #90 stated they could not reach their tray table. Resident #90 pressed their call light button, which did not light up outside the resident's room and it did not make a sound. Certified Nursing Assistant #7 was in the hallway and came into the room of Resident #90 (after Surveyor intervention). Certified Nursing Assistant #7 pressed Resident #90's call light and observed that it did not light up or make a sound. Certified Nursing Assistant #7 stated the call light should make a noise, and they would tell someone. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation and interview on 01/21/2025 at 11:52 AM, the nurse call light in resident room [ROOM NUMBER] was pressed and did not activate an audible or visual signal. When notified by the surveyor at this time, Licensed Practical Nurse Manager #1 stated they would call maintenance to come fix it. During an interview on 01/22/2025 at 10:46 AM, Certified Nursing Assistant #8 stated they would know if a resident pressed their call button because they would look down the hall and see a light on over the resident's door. Certified Nursing Assistant #8 also stated the call button would only make a noise if the resident pressed it repeatedly. When observed on 01/22/2025 at 9:07 AM, the nurse call was activated for rooms [ROOM NUMBERS] and the overhead corridor lights outside the rooms came on but no audible tone was noted. When observed on 01/22/2025 at 9:17 AM, the nurse call was activated in the bathroom of resident room [ROOM NUMBER] and the corridor overhead light came on outside the room, one audible tone was noted the nothing further. Additionally, there was no panel operational or plugged in at the nurse station desk. When interviewed on 01/22/2025 at 3:30 PM, the Administrator and Corporate Administrator stated they found out the call bell system was installed in 2018 and there was only one call system for the building. The Corporate Administrator stated the overhead lights should light up and audibly tone, and the overhead light would go red if activated at the bathroom and green when cleared. The Administrator stated staff should be trained during orientation on the call bell system, and they saw no issue with the panels not being in place as the system still functioned. The Corporate Administrator stated that staff can look down the hallways to see if there are call lights on when they do not have a panel to look at and staff should note any issues with call bells not working. Record review on 01/23/2025 at 11:00 AM, revealed quarterly nurse call system logs for 2024 documented the call stations in resident rooms on the second and third floors were tested , only. The logs did not specify whether call stations were tested at the bed sides or at the resident room toilets. Additionally, the logs did not document testing/inspection of any areas on the first floor common bathrooms and shower areas on the second and third floors. Nurse call system annunciator panels were also not listed as tested or identified to need repairs in these logs. Record review of the nurse call system manufacturers specification manual on 01/23/2025 at 11:30 AM, revealed the intended use section listed: 'Use this product only for the purpose it was designed for.' The general purposes section listed: 'This document describes the implementation, programming and testing of the call station and auxiliary nurse station. The stations are a combination of hardware and software, a touchscreen PC with software that gives an overview of pending nurse calls.' Record review on 01/23/2025 at 11:45 AM revealed the hardware installation manual for the nurse call system listed the following: under the type of calls section, the chart listed the color lights for each light to correspond to the activation type/location. Call at bed would be a red light, call at toilet would be a white light, assistance toilet would be a green light, emergency would be a flashing red light, code blue would be a flashing blue light, and technical alarm would be a yellow light. The mounting instructions section for the tablet listed annunciators and visual display calls from the stations in the system, and the auxiliary PC (tablet) is a wall mounted staff console. The manual also listed that the tablet needs to have a power and network connection to operate. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 01/23/2025 at 12:49 PM, Registered Nurse #1 stated they would know if a resident pressed their call button because they are constantly looking and could see the red light and pointed to the light above a resident's room. Registered Nurse #1 stated they think there is a different alarm if a call button in the bathroom is pressed. Registered Nurse #1 stated they did not have a monitor (nurse call system central monitor) on the second floor, but the third floor did have something. 10NYCRR: 415.29, 415.29(b); 415.29(j)(1), 10NYCRR: 713-1.3(b), 713-3.25(g)