

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335620	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2025
NAME OF PROVIDER OR SUPPLIER Unity Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 89 Genesee Street Rochester, NY 14611	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews conducted during an Abbreviated Survey (NY00352620), the facility did not ensure resident records were complete, accurately documented, accessible, and systematically organized in accordance with professional standards of practice for three (3) (Residents #1, #2 and #4) of three (3) residents reviewed. Specifically, the facility could not provide documented evidence that wound treatments were administered as ordered, and documentation did not include who provided the treatments or when the treatments were completed. The findings include:</p> <p>The facility's policy Skin Inspection and Care, dated June 2024, documented that nursing staff were to perform and document weekly skin assessments for each resident. Nursing staff were to document changes in wound condition and new wounds under a lines, drains, and airways avatar as well as in a skin assessment flowsheet within the electronic medical record and were responsible for adding wound care to the daily work list in the electronic medical record.</p> <p>1. Resident #1 had diagnoses that included a cerebral vascular accident (stroke), paraplegia (form of paralysis that affects the lower body), and neurogenic bladder (loss of bladder control due to nerve, spinal cord, or brain issues). The Minimum Data Set (a resident assessment tool), dated 02/20/2025, revealed Resident #1 was cognitively intact.</p> <p>In a medical progress note, dated 03/03/2025, Physician Assistant #1 documented Resident #1 had a Stage II (partial loss of skin that presents as a shallow crater) pressure ulcer to the sacrum (area at the base of the spine above the tailbone).</p> <p>Resident #1's current physician's orders, dated 03/03/2025, included to cleanse the open area on the sacrum with saline, pat dry, and apply a dressing daily at 9:00 AM.</p> <p>Review of Resident #1's electronic medical record from 03/03/2025 to 05/02/2025 revealed no documented evidence that the wound treatments were administered as ordered on 38 of 61 days reviewed or any documentation that the resident refused the treatments.</p> <p>Review of Resident #1's Work List Tasks (work list used by the nurses in the electronic medical record), dated 04/25/2025 to 05/02/2025, revealed documentation that the wound care had been completed on seven (7) days but did not include what time or who completed the treatment.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Resident #2 had diagnoses that included a cerebral vascular accident, hemiplegia (paralysis on one side of the body), and chronic kidney disease. The Minimum Data Set, dated [DATE], revealed Resident #2 was cognitively intact.</p> <p>Review of Resident #2's current Comprehensive Care Plan revealed Resident #2 had a history of skin breakdown and was non-compliant with required interventions.</p> <p>Review of physician's orders included:</p> <p>a. Wound care to the sacrum (area at the base of the spine above the tailbone), to cleanse the wound, apply Santyl (topical ointment containing collagenase used to remove dead tissue), and cover with foam dressing daily at 9:00 AM and as needed (PRN); ordered 03/07/2025 and cancelled on 04/07/2025.</p> <p>b. Wound care daily to the right foot, cleanse the dried area with wound cleanser, apply xeroform (moist gauze used in wound care to promote healing), cover with dry dressing, and wrap with kling (gauze roll) daily at 9:00 AM until healed; ordered 03/20/2025.</p> <p>c. Wound care to right foot blisters, apply skin prep daily at 9:00 AM until healed; ordered 03/20/2025.</p> <p>Review of Resident #2's electronic medical records from 03/07/2025 to 05/02/2025, revealed no documented evidence that the ordered wound treatments were completed as ordered on 25 out of 57 days reviewed. There was no documented evidence that the treatments had been refused. Additionally, on multiple days when there was documentation that wound care was completed it did not include who the treatments were completed by.</p> <p>3. Resident #4 was admitted with diagnoses including tracheostomy (a surgically created opening in the neck and into the windpipe to help with breathing), ventilator dependence, and a sacral pressure ulcer. The Minimum Data Set, dated [DATE], documented the resident was unable to complete a cognitive assessment due to severe cognitive impairment.</p> <p>Current physician's orders, dated 08/08/2024, included to apply silver alginate ointment (wound treatment usually used for infected wounds) to the sacral wound bed, cover with an abdominal gauze pad, and affix with medical tape daily at 9:00 AM.</p> <p>Resident #4's current Comprehensive Care Plan, dated 01/09/2024, included to measure pressure ulcers weekly and record in the health record.</p> <p>Review of Resident #4's electronic medical record from 08/01/2024 to 08/02/2024 and from 08/08/2024 to 08/27/2024 (hospitalized from [DATE] to 08/07/2024) revealed no documentation that Resident #4 had received their wound care daily as ordered on 20 of 22 days reviewed or weekly skin assessments as care planned for.</p> <p>During an interview on 05/02/2025 at 10:00AM, Licensed Practical Nurse #1 stated either the bedside nurse or the clinical lead nurse was responsible for ensuring wound treatments were administered. Licensed Practical Nurse #1 stated wound care and wound assessments should be documented in the skin assessment flowsheet, in a progress note, or in the lines, drains, and airways avatar.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 05/02/2025 at 10:12 AM, Registered Nurse Manager #1 stated the licensed practical nurses and sometimes the clinical lead nurse was responsible for providing wound treatments and they were automatically added to the work list when a provider placed the order. Registered Nurse Manager #1 stated the treatments should be documented on the work list which should carry over into the flowsheets, which is where they look to make sure treatments were completed. Registered Nurse Manager #1 stated if wound care or wound assessments were not completed, it should be documented in a progress note.</p> <p>During an interview on 05/02/2025 at 10:40 AM, the Assistant Director of Nursing stated wound care and wound assessments should be documented each time they are performed by nursing staff in the skin assessment flowsheets or the lines, drains, and airways avatar, and a progress note written. When asked how they would know if wound care was performed as ordered, the Assistant Director of Nursing stated the actual dressing on a resident's dressing should have a date written on it and nurses should document when a dressing was completed. The Assistant Director of Nursing stated some of the older nurses charted by exception (wound care not done). After review of Resident #4's flowsheet at this time, Assistant Director of Nursing stated they did not see documentation for wound care for most of the dates reviewed and were not sure why. During a follow-up interview at 2:24 PM, the Assistant Director of Nursing stated work list items with a line through them meant they had been completed. Upon review of the Work List Tasks legend, the treatments that had a strikethrough (line through the item indicating it was either completed or discontinued) did not include who completed the treatment or at what time.</p> <p>10 NYCRR 415.22(a)(1-4)</p>		