STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335620	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Unity Living Center	89 Genesee Street Rochester, NY 14611

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 46880 Based on interviews, observations, and record reviews conducted during a Recertification Survey from 7/19/24-7/25/24, for two (Residents #20 and #93) of three residents reviewed for medication administration, the facility did not ensure that each resident was free from significant medication errors. Specifically, several significant medications were not administered to both Resident #20 and Resident #93 due to not being available. This is evidenced by the following: The facility's policy Medication Administration dated August 2021, documented the facility shall properly administer and store all medications. Medications are administered following a valid order entered in the Electronic Medical Record which links to the Medication Administration Record. 1. Resident #20 had diagnoses that included chronic obstructive pulmonary disease, seizure disorder, and hypertension (high blood pressure). Resident #20's current physician orders included Lasix (diuretic or water pill) 20 milligrams once daily and Topamax (anti-seizure medication) 250 milligrams every 12 hours. Review of the July 2024 Medication Administration Record revealed that Resident #20's Lasix and Topamax were scheduled to be given at 9:00 AM. During an observation and interview of medication pass on 7/22/24 at 11:38 AM, Licensed Practical Nurse #1 did not administer Resident #20's scheduled Lasix because it was not available in their medication cart. Additionally, Licensed Practical Nurse #1 said they could not administer the resident's Topamax because the ordered dose was 250 milligrams and they only had 200 milligram tablets available. 2. Resident #93 had diagnoses that included a history of recurrent pulmonary thromboembolism (arteries in the lungs blocked by blood clots), chronic pain, and megacolon (disease of the large intestine). Resident #93's current physician orders included Eliquis (anticoagulant medication used to prevent blood clots) 5 milligrams twice daily. Review of the July 2024 Medication Administration Record revealed Resident #93's Eliquis was scheduled to be given at 9:00 AM. (continued on next page)

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

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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 7/22/24 at 12:07 PM, Resident #93's Eliquis was not administered. Licensed Practical Nurse #1 stated that they could not administer Resident #93's Eliquis because it was not available. During an interview on 7/24/24 at 10:51 AM, Licensed Practical Nurse #1 said they were told by the nurse whom they relieved (on 7/22/24) that all the medications that were unavailable during their medication pass on 7/22/24 had already been ordered prior to their shift, but had not been delivered in time, so they were not able to administer the medications. During an interview on 7/24/24 at 3:18 PM with Registered Nurse Manager #1 and the Director of Nursing, Registered Nurse Manager #1 said there was an emergency medication box and a Pyxis (automated medication dispensing machine) available that contained frequently used medications, including Lasix and Eliquis to avoid the residents missing their medications. Registered Nurse Manager #1 and the Director of Nursing both stated that Lasix and Eliquis were significant medications and that the Licensed Practical Nurses should notify leadership and pharmacy, and document that the medication had not been available. During an interview on 7/25/24 at 11:26 AM, Licensed Practical Nurse #1 said they had not received training on the medication protocol and did not know the facility had a Pyxis machine until the previous day. Licensed Practical Nurse #1 said they were trained to notify the unit nurse manager if a medication was not available along with calling the pharmacy and faxing over a medication request sheet but that they had not seen Registered Nurse Manager #1 the day their medications were not administered because they were behind on their medication pass and just wanted to get it done. Licensed Practical Nurse #1 said they did not call the provider to let them know the medications were significantly late or that some of the medications were not given because they were not trained to call the provider, but that the unit manager would call the provider instead. 10 NYCRR 415.12(m)(2)

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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. 25744 Based on observations, interviews, and record review conducted during the Recertification Survey from 7/19/24-7/25/24, for one of four residential units (3300 unit), the facility did not provide for safe and secured medications in accordance with currently accepted professional standards. Specially, there were multiple loose unpackaged and unlabeled pills and expired medications observed in two medication carts on the 3300 Unit. The Medication Administration Policy, dated February 2020, included that the facility shall properly store all medications. All medications must remain in secure storage until administered to the patient. During an observation and interview on 7/22/24 at 12:22 PM on the 3300 resident care unit, the team one hall medication cart contained 25 loose unlabeled pills (different shapes and colors) in the medication drawers. Licensed Practical Nurse #1 stated they thought some of the pills were senna (stool softener) but was unable to identify any of the other loose pills. Licensed Practical Nurse #1 stated they did not know who was responsible for cleaning the medication carts. During an interview on 7/22/24 at 12:26 PM, Registered Nurse Manager#1 said that all non-narcotic loose and expired pills should be discarded in bins in medication storage room. During an observation and interview on 7/22/24 at 12:34 PM, the second medication cart on Unit 3300 contained multiple unpackaged, unlabeled loose pills. Licensed Practical Nurse #2 was unable to identify most of the loose pills. The medication cart also contained a bottle of vitamin D3 that expired on 6/30/24 and colace (stool softener) that had expired June 2024. During an interview at 12:47 PM, the Director of Nursing stated staff should complete monthly, if not weekly, cart audits and preferably on the night shift. The Director of Nursing stated that it was not acceptable for any medication cart to have 24 or 26 loose pills. The Director of Nursing stated that they have had recent turnover in unit staff as well as the Unit Manager, but that medication storage is covered in orientation, so they expected the carts to be free from loose pills. 415.18(d)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49447 Based on observations, interviews, and record reviews conducted during the Recertification Survey from 7/19/24-7/25/24, the facility did not ensure they established and maintained an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for six (Residents #6, #26, #66, #87, #92, and #100) of seven residents reviewed for infection control on the facility's ventilator unit. Specifically, the facility failed to ensure a blood glucose monitoring device (a device used to obtain a blood sample to check blood sugar levels) was cleaned and disinfected between each use for Residents #6, #26, and #87. Additionally, staff did not wear the posted and required personal protective equipment for Residents #6, #26, #66, #92, and #100. Additionally, a nursing staff member mixed medications for Resident #66 with their gloved finger. Subsequently, facility staff members did not follow the facilities infection control process. These issues resulted in the likelihood of serious injury, harm, and death for all the residents in the facility (census 119) that was Immediate Jeopardy. The findings are: The facility policy Glucose Meter, last revised 2/29/24, documented that the blood glucose monitoring devices were to be cleaned and disinfected after each patient use. The facility policy Infection Prevention - Transmission Based Precautions Policy, last revised May 2024, documented transmission-based precautions are used for patients who are known or suspected to be infected/colonized with infectious agents which require additional control measures beyond standard precautions to effectively prevent transmission. Contact precautions are intended to prevent transmission of infectious agents which are spread by direct contact with the patient (hand or skin-to-skin contact that occurs when performing patient care activities that require touching the patient) or indirect contact with an immediate person or object (e.g., environmental surfaces or items in the patient's environment). Contact precautions require the use of gown and gloves when entering the room regardless of patient contact. Enhanced contact precautions are intended to prevent the transmission of extremely drug resistant pathogens including CRE (carbapenem-resistant enterobacterales) and MDRE (multidrug-resistant enterobacterales) which are spread by direct contact with the patient. Enhanced contact precautions require the use of gown and gloves when entering the room regardless of patient contact, require the use of dedicated equipment, and limiting the number of staff members caring for the patient. When possible, dedicate noncritical patient care items, such as blood pressure cuffs, thermometers, and stethoscopes, to a single patient. Equipment must be cleaned and disinfected in-between resident use. The facility policy Enhanced Barrier Precautions, last revised April 2024, documented Enhanced Barrier Precautions are used in conjunction with standard precautions and expand the use of personal protective equipment to donning gowns and gloves during high contact resident care activities that provide opportunities for transfer of multidrug resistant organisms to staff hands and clothing. Enhanced Barrier Precautions are used for residents with the presence of wounds and/or indwelling medical devices regardless of multidrug-resistant organisms. Indwelling medical devices include, but are not limited to, urinary catheters, feeding tubes, and tracheostomies. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #92 had diagnoses that included traumatic brain injury, seizure disorder, and diabetes. The Minimum Data Set Resident assessment dated [DATE] documented the resident had severely impaired cognition, had a feeding tube (a surgically inserted tube directly into the stomach for medication administration and nutrition), and had a tracheostomy (and artificial airway surgically inserted in the neck). Resident #66 had diagnoses that included diabetes, high blood pressure, and depression. The Minimum Data Set Resident assessment dated [DATE] documented the resident was cognitively intact, had a tracheostomy, and a feeding tube. Resident #66's current physician orders included enhanced barrier precautions for care of the feeding tube and tracheostomy. Resident #26 had diagnoses that included diabetes, dementia, and heart failure. The Minimum Data Set Resident assessment dated [DATE] documented the resident was comatose (prolonged unconsciousness brought on by illness or injury), had a tracheostomy, and had a feeding tube. Resident #26's current physician orders included insulin lispro injection per sliding scale (the amount of insulin administered is based on the blood sugar reading) every four hours, and that the resident required contact precautions due to having Multi Drug Resistant Organisms (MDRO - microorganisms, mainly bacteria, that are resistant to one or more classes of antimicrobial agents). Resident #6 had diagnoses that included diabetes, high cholesterol, and heart failure. The Minimum Data Set Resident assessment dated [DATE] documented the resident was cognitively intact and had a tracheostomy. Resident #6's current physician orders included glargine insulin injection 18 units before meals and to check the resident's blood sugar level before meals and enhanced barrier precautions for tracheostomy care. Resident #100 had diagnoses that included a stroke, hemiplegia (muscle weakness or partial paralysis on one side of the body), and difficulty swallowing. The Minimum Data Set Resident assessment dated [DATE] documented the resident had severely impaired cognitive skills and had a tracheostomy. Resident 100's current physician orders included enhanced contact isolation for carbapenem-resistant enterobacterales (CRE-germs resistant to one or several antibiotics called carbapenems). During an observation on 7/19/24 at 10:00 AM, Licensed Practical Nurse #2 was providing care to Resident #92's feeding tube. A sign posted outside the door stated EBP (enhanced barrier precautions) with a picture of a gown and pair of gloves. Personal Protective Equipment (including gowns) were available at the entrance to the room. Licensed Practical Nurse #2 was not wearing a gown while providing care to Resident #92's feeding tube. Ongoing observations on 7/19/24 from 11:18 AM to 11:48 AM included the following: - At 11:18 AM, Licensed Practical Nurse #2 entered Resident #66's room with several medicine cups of medications. A sign posted outside Resident #66's door stated EBP with a picture of a gown and pair of gloves. Personal Protective Equipment (including gowns) were available at the entrance to the room. Licensed Practical Nurse #2, wearing gloves, mixed the medications in the medicine cup with a gloved finger and administered the medications via Resident #66's feeding tube. Licensed Practical Nurse #2 did not wear a gown while administering medications to Resident #66. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- At 11:26 AM, Licensed Practical Nurse #2 entered Resident #26's room with a portable vital signs machine. A sign posted outside Resident #26's door stated Contact Precautions and documented that hand hygiene was required to enter and exit, gown and gloves were to be worn to enter the room, and gown and gloves were to be removed before exiting the room. Licensed Practical Nurse #2 did not perform hand hygiene before entering the room, and put on gloves once inside the room but did not don a gown. Licensed Practical Nurse #2 performed vital signs on Resident #26, left the room removed their gloves and used hand sanitizer. The Licensed Practical Nurse #2 then reentered the resident's room, without any of the required personal protective equipment, brought the vital sign machine out of the resident's room, plugged it into the wall outlet, and returned to the medication cart without sanitizing the machine or performing additional hand hygiene. - At 11:33 AM, Licensed Practical Nurse #2 entered Resident #26's room with a blood glucose monitoring device and was wearing gloves but no gown. Licensed Practical Nurse #2 placed the blood glucose monitoring device on Resident #26's bed and performed a blood sugar check, removed their gloves, and left the room. Licensed Practical Nurse #2 placed the blood glucose monitoring device on top of the medication cart and did not clean or disinfect the blood glucose monitoring device. - At 11:38 AM, Licensed Practical Nurse #2 reentered Resident #26's room with medications for the feeding tube, insulin in a syringe, and a gauze dressing. Licensed Practical Nurse #2 administered the medications via the feeding tube, injected insulin via a syringe, and changed the gauze dressing around the feeding tube. Licensed Practical Nurse #2 was wearing gloves but no gown while performing the care for Resident #26. - At 11:43 AM, Unit Secretary #1 went in Resident #92's room and removed tube feeding bottles and tube feeding tubing from Resident #92's room and placed them on a cart in the hall. The sign outside of the resident's room indicated: Contact Precautions, hand hygiene to enter and exit, gown and gloves to enter, and to remove gown and gloves before leaving the room. Unit Secretary #1 was not wearing a gown or gloves in Resident #92's room. - At 11:48 AM, Licensed Practical Nurse #2 retrieved the same (uncleaned) blood glucose monitoring device (as used on Resident #26) and supplies from the medication cart and entered Resident #6's room. A sign posted next to Resident #6's room stated Enhanced Contact Precautions and had a picture of a gown and gloves on the sign. Licensed Practical Nurse #2 did not put on a gown. Licensed Practical Nurse #2 placed the blood glucose monitoring device on Resident #6's bed and started the procedure to check the resident's blood sugar. During an immediate intervention and interview, Licensed Practical Nurse #2 was stopped from performing a blood sugar check on the resident. They stated they had not cleaned or disinfected the blood glucose monitoring device between Resident #26 and Resident #6, and had also used the same blood glucose monitoring device earlier in their shift to check Resident #6 and Resident #87's blood sugars and had not cleaned the device between each resident. Licensed Practical Nurse #2 stated they normally did not clean the blood glucose monitoring device until all blood sugar checks were completed for their assignment (7 residents on their assignment had blood sugar checks ordered). Licensed Practical Nurse #2 stated the blood glucose monitoring device should have been cleaned and disinfected between each use and each resident. Licensed Practical Nurse #2 stated they should have checked for signs regarding personal protective equipment prior to entering a resident's room but did not and should have worn the personal protective equipment listed on the signs for Residents #66, #26, and #6. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an observation on 7/19/24 at 11:56 AM, Physician #1 entered Resident #100's room without putting on any form of personal protective equipment. There was a sign posted on the resident's room door frame that stated Enhanced Contact Precautions. Physician #1 performed an assessment on Resident #100 that included listening to the resident's chest with a stethoscope and touched the resident's gown and their linens. Physician #1 then put the stethoscope around their neck and exited the room without performing hand hygiene or cleaning the stethoscope and entered a charting room to use the computer. During an immediate interview, Physician #1 stated they did not know Resident #100 was on precautions and had not seen the Enhanced Contact Precautions sign. Physician #1 stated they should have worn a gown and gloves in Resident #100's room and should always follow the posted signage and wear the instructed personal protective equipment. During an interview on 7/19/2024 at 1:31 PM, Registered Nurse Manager #2 stated blood glucose monitoring devices should be cleaned after every use and should never be used on multiple residents without cleaning and disinfecting. Registered Nurse Manager #2 stated that precaution signs are posted outside most of the residents' rooms because most residents are on either enhanced barrier precautions or contact precautions on this unit (ventilator unit). During an interview on 7/19/24 at 2:50 PM with the Administrator, the Director of Nursing and the Assistant Director of Nursing/Infection Preventionist, the Assistant Director of Nursing/Infection Preventionist stated all staff (including agency staff) received education on blood glucose monitoring devices and infection control practices prior to being able to use the devices and on precaution signs and the personal protective equipment that is to be worn for the different types of signs. The Assistant Director of Nursing/Infection Preventionist said blood glucose monitoring devices should never be used on multiple residents without being cleaned and disinfected and that all staff were expected to follow the posted precaution signs posted outside the resident rooms. On 7/19/24, the survey team identified and declared Immediate Jeopardy. The facility administrator was notified at 7:48 PM. On 7/20/24 at 11:51 AM, the survey team declared that the IJ was removed based on the following corrective actions taken by the facility: 1. 100% of staff working at the time of removal had received education on appropriate infection control practices, including posted signage Enhanced Barrier Precautions, Contact Precautions, use of Personal Protective Equipment, hand hygiene, appropriate cleaning of blood glucose monitoring devices (nursing staff), and the facility's policies on infection control practices prior to the start of their shift. 2. Interviews were completed with multiple staff, including direct care staff and environmental services staff, on four of four resident care units that revealed appropriate knowledge of the infection control processes and had that they had received education prior to starting their shift. 3.Approximately 47% of total licensed nurses (including Licensed Practical Nurse #2) were educated on appropriate infection control practices including posted signage, Enhanced Barrier Precautions, Contact Precautions, use of Personal Protective Equipment, hand hygiene, appropriate cleaning of the glucometers, and the facility's policies on infection control practices. (continued on next page)

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