| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 335668 | A. Building<br>B. Wing | 07/16/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Kirkhaven | 254 Alexander Street<br>Rochester, NY 14607 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>(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 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Based on observations, interviews, and record review conducted during an Abbreviated Survey (Intake ID: 2561610) from 07/15/2025 to 07/16/2025, for one (1) (Resident #1) of one (1) resident reviewed, the facility did not ensure a resident received treatment and care in accordance with professional standards of practice and the person-centered care plan. Specifically, Resident #1 refused several doses of haloperidol (an antipsychotic medication that is used to control severe agitation and aggression) in June 2025 and July 2025 and a medical provider was not notified. Additionally, on 07/11/2025 the resident had increased agitation, wandering behaviors, attempted to exit a bedroom window, and a medical provider was not notified of the incident. The findings include:The facility policy Medication Administration/Documentation, dated 12/06/2024 included, but was not limited to, if the resident does not take the medication, mark the electronic medication administration record (EMAR) as other and note why the medication was not given. Notify the Registered Nurse/Licensed Practical Nurse Supervisor of the medication omission and the Supervisor will determine the next step (i.e. to notify the doctor).Resident #1 had diagnoses including dementia, cerebral infarction, and diabetes. The Minimum Data Set (a resident assessment tool), dated 06/03/2025, documented the resident had moderately impaired cognition, daily wandering behaviors (a pattern of locomotion that can appear aimless or repetitive, and may involve leaving a safe environment), required supervision or touching assistance for walking, and was taking an antipsychotic medication. Review of the Comprehensive Care Plan, dated 06/16/2025, included Resident #1 had the potential to be physically aggressive and received a psychoactive medication for behavior management. Interventions included, but were not limited to, monitor, document, and report signs and symptoms of the resident posing a risk to themself or others and to administer psychotropic medications as ordered. Review of physician's orders, dated 06/03/2025, included (but were not limited to) haloperidol 0.5 milligrams by mouth two (2) times daily for dementia with agitation, to observe and document any side effects from the antipsychotic medication, and notify the medical provider. Review of Resident #1's Medication Administration Records revealed the following:From 06/03/2025 to 06/30/2025, the resident refused haloperidol on 29 of 55 opportunities.From 07/01/2025 to 07/14/2025, the resident refused haloperidol on 17 of 28 opportunities. Review of progress notes from 06/03/2025 to 07/13/2025 did not include documented evidence that a medical provider was notified regarding the frequency of Resident #1's medication refusals. In a medical progress note dated 07/07/2025, Physician #1 referenced nursing progress notes since Resident #1's last visit including on 06/22/2025 the resident was agitated, angry and refused his medications and on 06/26/2025, the resident refused all care, refused evening medications, and accepted morning medications. Physician #1 documented the care plan was reviewed with nursing staff and all medications and other orders were reviewed and approved. In a nursing progress note, dated 07/11/2025, Registered Nurse #2 documented Resident #1 was wandering into other resident rooms, refusing evening medications, becoming agitated, and wanted to leave the facility. The Director of Nursing was notified of the resident's behavior, and the resident was placed on every 15-minute checks. The staff would continue to monitor the resident's behaviors and elopement attempts. Review of a 24-Hour Nursing Report, dated 07/11/2025, included Resident #1 tried to climb out of a window and was put on 15-minute checks. Additional review of the electronic health record and facility documents did not include documented evidence a medical provider was notified of the incident. During an interview on 07/15/2025 at 1:33 PM, the Director of Nursing stated on 07/11/2025 Resident #1 was found in another resident's room with a foot and leg out of the window. When the electronic health record was reviewed at that time, the Director of Nursing revealed there was no progress note related to the incident and the comprehensive care plan had not been revised. They stated a progress note should have been entered and the care plan updated. The Director of Nursing stated they would expect that a medical provider was eventually notified of medication refusals although there was no set timeframe for notification. During an interview on 07/15/2025 at 2:00 PM, Licensed Practical Nurse Manager #1 stated if a resident refused medications they would attempt again, have another nurse attempt to administer the medications, and notify the medical provider of any refusals. During an interview on 07/15/2025 at 3:30 PM, Registered Nurse #1 stated if a resident refused medications they would notify the medical provider at that time. During an interview on 07/15/2025 at 3:40 PM, Nurse Practitioner #1 stated they would expect to be notified at the time medications are refused or the next day. If there are several refusals, the medical provider should be called. Nurse Practitioner #1 stated there was one entry in the provider communication book (used by the facility to communicate resident |