STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335668	A. Building B. Wing	12/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kirkhaven	254 Alexander Street 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 0550 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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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(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 Note: The nursing home is disputing this citation.	Based on observations, interviews, and record review conducted during an Abbreviated Survey (NY00370316/443765, NY00372543/443769) completed on 12/08/2025, the facility failed to ensure one (1) of seven (7) residents reviewed (Resident #8) was treated with respect and dignity and cared for in a manner that promoted quality of life. Specifically, the facility failed to honor Resident #8's expressed preferences and repeated requests for assistance with grooming and hygiene and the resident stated it made them feel dirty and grubby. This resulted in actual psychosocial harm that was not Immediate Jeopardy.The findings include:The undated facility document provided to residents upon admission, Your Rights as a Nursing Home Resident in New York State, included but was not limited to: As a resident in this facility, you have rights guaranteed to you by state and federal laws. This facility is required to protect and promote your rights. Your rights strongly emphasize individual dignity and self-determination, promoting your independence and enhancing your quality of life. You have the right to be cared for in a manner that enhances your quality of life and free from humiliation. You have the right to be offered choices, allowed to make decisions important to you, and to receive adequate and appropriate care. Resident #8 had diagnoses including chronic pain syndrome, major depressive disorder, and anxiety disorder. The Minimum Data Set (a resident assessment tool) dated 10/29/2025, documented the resident was cognitively intact, did not reject care during this time, and required staff assistance with personal hygiene.Review of Resident #8's Comprehensive Care Plan, revised 11/12/2025, revealed the resident required assistance with their activities of daily living (ADLs, self-care tasks like bathing and grooming) and had non-compliance/refusal of care related to medications, treatments, the preference not to go out on appointments, and the resident was on comfort care. Interventions included, but were not limited to, limited assistance of one (1) staff for personal hygiene, to document discussions regarding refusals, and to reapproach as needed.Review of the Kardex (care plan used by certified nursing assistants to direct care) current as of 12/08/2025, revealed Resident #8 required the limited assistance of one (1) staff for personal hygiene, staff were to encourage the resident to use their call light for assistance as needed and to respond promptly to all requests for assistance. Review of the Household Bath List, last updated on 11/12/2025, revealed Resident #8 was scheduled to receive a bed bath on Thursday evenings and nursing staff should enter a skin note in the electronic health record on the resident's bath day. The Household Bath List did not include documented evidence Resident #8 received bed baths from 11/08/2025 to 12/07/2025. Review of nursing progress notes from 11/08/2025 to 12/07/2025 did not include documented evidence Resident #8 was offered assistance with shaving or hair washing, or any refusals of personal hygiene services. During an observation and interview on 12/02/2025 at 10:57 AM, Resident #8 was sitting up in bed with oily, uncombed hair, and a significant amount of overgrown facial hair. When interviewed at that time, Resident #8 appeared frustrated and spoke hurriedly stating they did not like their overgrown beard and had asked staff for assistance with shaving and the use of a shampoo cap (an alternative method used to clean a person's hair and scalp without water) to wash their hair but had not received assistance.During an interview on 12/03/2025 at 11:21 AM, Certified Nursing Assistant #1 stated there were days when they were unable to assist residents with scheduled showers and bed baths or assist residents who asked for assistance with shaving because they did not have time due to staffing challenges. During an observation and interview on 12/05/2025 at 10:18 AM, Resident #8 continued with an overgrown beard and oily, uncombed hair. When interviewed at that time, Resident #8 stated they did not like having an overgrown beard and they had asked more than once to be shaved, including asking a supervisor (name unknown). Resident #8 stated they had asked for a shampoo cap to wash their hair, and no one provided it. Resident #8 stated they felt dirty and grubby, and their care was horrible. During an interview on 12/05/2025 at 10:45 AM, Licensed Practical Nurse Manager #1 stated shower/bed bath day consisted of hair washing, shaving, nail care, and bed linen changes. Licensed Practical Nurse Manager #1 stated Resident #8 preferred bed baths and required assistance with their activities of daily living, as the resident could not complete them independently, and there was no documentation of Resident #8 refusing shaving or hair washing. Licensed Practical Nurse Manager #1 stated Resident #8 had not reported to them directly about wanting a bed bath or shave, but staff should still offer. If the resident refused, the staff should reattempt care and document and report further refusals to Licensed Practical Nurse Manager #1 and the Director of Nursing. During an interview on 12/05/2025 at 1:45 PM with the Administrator and Director of Nursing, the Administrator stated they were not aware residents were not receiving assistance with shaving and hair

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interviews, and record review conducted during an Abbreviated Survey (Intake ID: NY00368335/443768 and NY00372367/443775) completed on 12/08/2025, the facility failed to provide services that met professional standards of quality for one (1) of three (3) residents reviewed (Resident #4). Specifically, for Resident #4 there was missing administration documentation for several medications, including but not limited to significant medications used to treat hypertension and cardiac related conditions, and no documented evidence the resident received the medications or notifications of missed medications to a medical provider. The findings include:The facility policy, Medication Administration/ Documentation dated 07/15/2025 included, but was not limited to, medications will be dispensed only by registered nurses/licensed nurses and prepared, administered, and charted by the same nurse. Each nurse passing medication on the unit is to document each medication as given in the electronic medication administration record and notify the Registered Nurse or Licensed Practical Nurse Supervisor of a medication omission and the Registered Nurse/ Licensed Practical Nurse Supervisor will determine the next step; for example, to notify the doctor, or obtain a missing medication or its substitute. Each nurse is to check the electronic medication administration record at the end of the shift to ensure all medications and treatments are signed off. Resident #4 had diagnoses including diabetes, congestive heart failure, and atrial fibrillation (heart rhythm disorder leading to a fast, irregular pulse). The Minimum Data Set (a resident assessment tool) dated 11/21/2024, documented the resident was cognitively intact, had no rejection of care, including taking medications, and was taking high-risk medications including an antidepressant (medications used to improve mood), anticoagulant (medications that stop blood from clotting too easily), and hypoglycemic (medications used to lower high blood sugars). Review of Resident #4's Comprehensive Care Plan last revised on 10/22/2025 revealed the resident had diabetes, chronic pain, and used psychotropic medications. Interventions included, but were not limited to, administer medications as ordered by the doctor and to monitor and document side effects and effectiveness. Review of Resident #4's medical orders included, but was not limited to, the following: Acetaminophen 650 milligrams three (3) times daily for pain (ordered 11/20/2024). Check blood sugar every day, notify Medical Doctor if blood sugar is greater than 400 and less than 70 before meals for diabetes (dated 02/12/2025). Eliquis 5 milligrams two (2) times daily for atrial fibrillation (dated 01/15/2025). Gabapentin 200 milligrams three (3) times daily for diabetic neuropathy (dated 11/21/2024). Hydralazine 25 milligrams three (3) times daily for hypertension (dated 01/16/2025). Metformin 500 milligrams two (2) times daily for diabetes (dated 10/31/2024). Trazodone 50 milligrams at bedtime for depression and insomnia (dated 08/16/2024). Vital signs every day shift starting on the first and ending on the sixth of every month (dated 10/31/2024).Review of Resident #4's February 2025 Medication Administration Record revealed missing administration documentation (blank boxes) on the following dates/times for each medical order:- Acetaminophen 650 milligrams three (3) times daily: 02/03/2025 at 9:00 PM.- Check blood sugar every day: 02/04/2025 at 6:00 AM.- Eliquis 5 milligrams two (2) times daily: 02/03/2025 at 8:00 PM- Gabapentin 200 milligrams three (3) times daily: 02/03/2025 at 9:00 PM- Hydralazine 25 milligrams three (3) times daily: 02/03/2025 at 10:00 PM and 02/04/2025 at 6:00 AM.- Metformin 500 milligrams two (2) times daily: 02/03/2025 at 9:00 PM and 02/17/2025 at 5:00 PM.- Trazodone 50 milligrams at bedtime: 02/03/2025 at 9:00 PM- Vital signs every day shift: 02/03/2025, 02/04/2025, and 02/05/2025Review of nursing progress notes from 02/01/2025 to 02/28/2025 did not include documented evidence missed medications, vital signs, or blood sugar checks had been administered or a medical provider had been notified. During an interview on 12/05/2025 at 4:00 PM with the Director of Nursing and Administrator, the Administrator stated Resident #4 was in the building on 02/03/2025, 02/04/2025 and 02/17/2025, they did not know why the boxes were left blank on the Medication Administration Record and was unable to follow up with the nurses assigned on those shift because the nurses had been terminated. The Administrator stated they would expect all medications to be given as ordered. During an interview on 12/08/2025 at 9:51 AM, Registered Nurse Manager #1 stated if there were blank boxes on the Medication Administration Record, the medication was not given and if a resident refused their medications, the nurse should document the refusal, how many times the resident refused, and who the nurse notified about the refusal. Registered Nurse Manager #1 stated a pharmacy representative checked the medication carts and the Medication Administration Records monthly for missing documentation and reported their findings to the Director of Nursing. Registered Nurse Manager #1 stated the Director of Nursing then made the unit managers aware of the missed documentation

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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 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. (continued on next page)

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review conducted during an Abbreviated Survey (Incident ID: NY00368335/443768, NY00370316/443765, and NY00372367/443775) completed on 12/08/2025, the facility failed to ensure residents who were unable to carry out activities of daily living (ADLs, self-care tasks like bathing and grooming) received the necessary services to maintain good grooming and personal hygiene for eight (8) of eight (8) residents reviewed (Residents #8, #13, #14, #15, #17, #18, #19 and #20). Specifically, Resident #8 was observed on multiple occasions with overgrown facial hair and oily, uncombed hair and stated they had asked staff for assistance but did not receive it. Residents #13, #14 and #20 were observed on multiple occasions with overgrown facial hair and there was no documented evidence staff offered, provided, or the residents refused assistance. Residents #15, #17, #18, and #19 were observed in common areas with oily uncombed hair, overgrown facial hair and the residents were unable to request assistance. The findings include:The facility policy Standards of Care updated on 08/20/2020 included, but was not limited to, as a person-centered community for elders, facility staff will honor and respect individual choice. Elders residing at the facility are encouraged to express personal choice regarding daily living. Choices or preferences that are not consistent with the care card or care sheet will be communicated to the House Manager, primary nurse and/or Neighborhood Nurse for awareness and/or appropriate follow up. Bath/showers are given per resident preference. The certified nurse assistant is responsible for informing the nurse when the resident is receiving a bath/shower per the schedule. Refusals of care, which include showers, baths, and removal of facial hair are to be reported to the primary licensed practical nurse so it can be documented in the resident's medical record. 1. Resident #8 had diagnoses including chronic pain syndrome, major depressive disorder, and anxiety disorder. The Minimum Data Set (a resident assessment tool) dated 10/29/2025, documented the resident was cognitively intact, did not reject care during this time, and required staff assistance with personal hygiene.Review of Resident #8's Comprehensive Care Plan revised 11/12/2025, revealed the resident required assistance with their activities of daily living and had non-compliance/refusal of care related to medications, treatments, the preference not to go out on appointments, and the resident was on comfort care. Interventions included, but were not limited to, limited assistance of one (1) staff for personal hygiene, to document discussions regarding refusals, and to reapproach as needed.Review of the Kardex (care plan used by certified nursing assistants to direct care) current as of 12/08/2025 revealed Resident #8 required the limited assistance of one (1) staff for personal hygiene, staff were to encourage the resident to use their call light for assistance as needed and to respond promptly to all requests for assistance. Review of the Household Bath List last updated on 11/12/2025 revealed Resident #8 was scheduled to receive a bed bath on Thursday evenings and nursing staff should enter a skin note in the electronic health record on the resident's bath day. The Household Bath List did not include documented evidence Resident #8 received bed baths from 11/08/2025 to 12/07/2025. Review of nursing progress notes from 11/08/2025 to 12/07/2025 did not include documented evidence Resident #8 was offered assistance with shaving or hair washing, or any refusals of personal hygiene services. During an observation and interview on 12/02/2025 at 10:57 AM, Resident #8 was sitting up in bed with oily, uncombed hair, and a significant amount of overgrown facial hair. When interviewed at that time, Resident #8 appeared frustrated and spoke hurriedly stating they did not like their overgrown beard and had asked staff for assistance with shaving and the use of a shampoo cap (an alternative method used to clean a person's hair and scalp without water) to wash their hair but had not received assistance.During an interview on 12/03/2025 at 11:21 AM, Certified Nursing Assistant #1 stated there were days when they were unable to assist residents with scheduled showers and bed baths or assist residents who asked for assistance with shaving because they did not have time due to staffing challenges. During an observation and interview on 12/05/2025 at 10:18 AM, Resident #8 continued with an overgrown beard and oily, uncombed hair. When interviewed at that time, Resident #8 stated they did not like having an overgrown beard and they had asked more than once to be shaved, including asking a supervisor (name unknown). Resident #8 stated they had asked for a shampoo cap to wash their hair, and no one provided it. Resident #8 stated they felt dirty and grubby, and their care was horrible.During an interview on 12/05/2025 at 10:45 AM, Licensed Practical Nurse Manager #1 stated shower/bed bath day consisted of hair washing, shaving, nail care, and bed linen changes. Licensed Practical Nurse Manager #1 stated Resident #8 preferred bed baths and required

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observations, interviews and record review conducted during an Abbreviated Survey (NY00368335/443768 and NY00372367/443775) completed on 12/08/2025, the facility failed to ensure all drugs and biologicals used in the facility were stored in locked compartments and permit only authorized personnel to have access for one (1) of four (4) residential units reviewed (Unit Three). Specifically, four (4) bins filled with medication blister packs (a type of packaging that organizes medications into individual, sealed compartments) and medications stored in three (3) plastic bags were observed on an office desk, unsupervised with the door open, and accessible to unlicensed personnel. The findings include:The facility policy, Storage of Medications and Chemical Products last revised on 08/30/2016 included, but was not limited to, all medications and other substances will be stored according to New York State and the Occupational Safety and Health Administration (OSHA) regulations. All medications, including treatment items, will be stored in a locked room inaccessible to residents and visitors. All medications, excluding controlled drugs and cool temperature drugs, shall be stored in a locked medication cart. When the medication cart is not in use, it is to be locked at all times and returned to the medication room for prolonged periods of time when not in use.During an observation and interview on 12/05/2025 at 3:02 PM, three (3) bags containing various medications and four (4) bins of medication blister packs were setting on Registered Nurse Manager's #2's office desk. The office door was open and Certified Nursing Assistant #2, Certified Nursing Assistant #5, and Licensed Practical Nurse #2 were seated less than five (5) feet from the office door. Registered Nurse Manager #2 was standing in the hallway near the nurse's office. The medications inside the bins included, but were not limited to, blood pressure medications, pain medications, thyroid medications, psychotropic medications, diuretic medications, and bowel medications prescribed for several different residents. There were brown plastic bags on the desk and in the bins that contained injectable and glass vials of medications. When interviewed at that time, Registered Nurse Manager #2 stated the medications had been removed from the medication carts on the unit, were going to be returned to the pharmacy, and had been stored in their office for the last week. Registered Nurse Manager #2 stated they usually locked their office door when they were not in the building but there were times they left the door open with staff in the office while Registered Nurse Manager #2 was out on the unit. Registered Nurse Manager #2 stated they had never discarded medications before, but knew they were not supposed to have medications stored in their office. Registered Nurse Manager #2 stated the Director of Nursing was aware medications were being stored in the office as they had previously met there with the medications present. During an interview on 12/05/2025 at 4:00 PM with the Administrator and Director of Nursing, the Director of Nursing stated while they had gone to Registered Nurse Manager #2's office, they had not noticed any medications stored there. The Director of Nursing stated staff would sometimes remove medications prescribed for discharged residents from medication carts, but they should be sent back to pharmacy. They stated while waiting for pharmacy, the medications should be secured in a locked medication room. The Director of Nursing stated certified nursing assistants should not have access to medications and storing medications in places other than locked medication carts or rooms was improper. 10 NYCRR 415.18(e)(1-4)