

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335668	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/18/2026
NAME OF PROVIDER OR SUPPLIER Kirkhaven		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility did not ensure residents were treated in a dignified manner for two (2) of seven (7) residents reviewed (Residents #97 and #151). Specifically, Resident #97 was observed with fecal matter on their hands, clothing, and assistive device and was later observed eating without hand hygiene while fecal debris remained present under their fingernails. Resident #151 was observed eating meals while wearing feces-soiled clothing and had a strong odor of feces and was observed in an unclean and improperly prepared bed environment. The finding include: The undated facility policy, Your Rights as a Nursing Home Resident in New York State, provided to residents upon admission, documented in part, 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 which enhances your quality of life, free from humiliation and to be offered choices and allowed to make decisions important to you. 1. Resident #97 had diagnoses including Alzheimer's dementia with agitation, anxiety disorder, and gastro-esophageal reflux disease (GERD). The Minimum Data Set (a resident assessment tool) dated 01/18/2026 documented the resident had severe cognitive impairment, required assistance with toileting and personal hygiene, and did not exhibit behaviors related to rejection of care. Review of nursing progress notes from 02/13/2026 to 03/12/2026 documented the last nail care provided occurred on 02/13/2026. No additional documentation related to nail care or refusals of care was identified. During an observation on 03/10/2026 at 10:12 AM, Resident #97 was sitting in bed with a meal tray present. A golf-sized amount of feces was on the resident's rolling walker. The resident's left hand had visible fecal matter beneath the fingernails. Fecal matter was smeared on the front of the resident's gown, and the gown was undone and hanging off the right shoulder. Certified Nursing Assistant #1 entered the room, applied a glove, removed the feces from the rolling walker, leaving a visible smear on the surface, and exited the room without providing hygiene care to the resident. During an observation and interview on 03/10/2026 at 10:27 AM, Certified Nursing Assistant #2 entered the room, identified themselves as assigned to the resident, removed the meal tray, exited the room, and did not return to provide care. During an observation on 03/10/2026 at 10:32 AM, Licensed Practical Nurse #3 entered the room, stated they would return with topical cream, exited the room, and did not return. During an observation on 03/10/2026 at 10:35 AM, Registered Nurse Manager #1 entered the room with disinfectant wipes and closed the door. During an observation on 03/10/2026 at 12:23 PM, Resident #97 was seated in the dining room with visible dark brown debris beneath the fingernails on both hands. At 12:27 PM, a meal tray was placed in front of the resident with no hand hygiene performed. The resident began eating and was observed retrieving dropped food from their lap with their hands and consuming it. During an interview on 03/11/2026 at 11:01 AM, Certified Nursing Assistant #1 stated they notified Certified Nursing Assistant #2 and Registered Nurse Manager #1 of the condition of Resident #97 and left to assist other assigned residents. Certified Nursing Assistant #1 stated the (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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>resident should not have been allowed to eat with dirty fingernails and hygiene should have been provided prior to the meal. During an interview on 03/17/2026 at 12:00 PM, the Director of Nursing stated staff were expected to complete nail care during showers and were expected to provide or offer hand hygiene to residents prior to meals. 2. Resident #151 had diagnoses which included vascular dementia, history of falling, and cerebral infarction (stroke). The Minimum Data Set, dated [DATE] documented the resident had moderately impaired cognition, required assistance with toileting, was frequently incontinent of bowel and bladder, and did not exhibit behaviors related to rejection of care. Review of the comprehensive care plan dated 04/04/2025 documented the resident required extensive assistance with toileting, personal hygiene, and dressing. The care plan included the resident may be non-compliant with care at times and staff were to reapproach as needed. Review of nursing progress notes from 02/09/2026 to 03/12/2026 did not document refusals of care. During an observation on 03/09/2026 at 12:49 PM, Resident #151 was seated in the dining room eating lunch while wearing pajama pants and a white shirt visibly soiled on the front. A strong odor of feces was present. During an interview on 03/12/2026 at 11:23 AM, Certified Nursing Assistant #1 stated Resident #151 was soiled prior to lunch and required care. Certified Nursing Assistant #1 stated care was not provided prior to the meal due to short staffing and the resident was taken to the room after lunch where a significant amount of stool was present extending up the resident's back. During an observation and interview on 03/16/2026 at 9:23 AM, Resident #151 was lying in bed on a pillow without a pillowcase. The fitted sheet was partially removed and hanging off the bed. The room had a urine odor, and the floor was sticky and unclean. The call light was observed on the floor next to the bed. Resident #151 stated they did not have a pillowcase when they laid down. During an observation and interview on 03/16/2026 at 9:29 AM, Certified Nursing Assistant #2 entered the room with the resident's meal tray, assisted the resident to a seated position, and set up the meal. No hand hygiene was performed prior to the meal. Certified Nursing Assistant #2 stated training included anticipating resident needs and performing hand hygiene. They acknowledged hand hygiene was not provided. During an interview on 03/16/2026 at 9:57 AM, Registered Nurse Manager #1 stated beds were expected to be properly made with pillowcases in place. During an interview on 03/17/2026 at 12:17 PM, the Director of Nursing stated staff were expected to provide care prior to meals so residents were not eating while soiled and were expected to ensure residents were clean and in clean clothing. The Director of Nursing stated hand hygiene was expected prior to meals regardless of dining location and residents' beds were expected to be properly made to promote a homelike environment. 10 New York Codes Rules and Regulations 415.5</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p>Based on observations, interviews, and record review, the facility did not ensure allegations of abuse were responded to timely, thoroughly investigated, and residents were protected from potential abuse for two (2) of three (3) residents reviewed (Resident #1 and Resident #2). Specifically, staff failed to initiate a timely response following allegations or observations of potential abuse, failed to immediately remove involved staff from resident care, and failed to conduct a thorough investigation, as available video surveillance was not reviewed as part of the initial investigation and was only reviewed after surveyor inquiry. The findings include: The facility policy, Abuse Policy, last reviewed 09/05/2024, defined an alleged abuse violation as a situation or occurrence observed or reported by staff, resident, or other individual which has not yet been investigated and, if verified, could demonstrate noncompliance related to mistreatment, neglect, or abuse. The facility will immediately address all incidents of staff-to-resident altercation or assault and provide a safe environment for residents, staff, and visitors. If an employee is suspected of abuse, he or she must be sent off duty until an investigation is complete. 1. Resident #2 had diagnoses including anxiety, hypertension, and chronic pain. The Brief Interview for Mental Status (cognitive assessment tool) dated 02/20/2026 documented Resident #2 was cognitively intact. Review of the facility investigation dated 02/20/2026 documented an allegation Resident #2 reported Licensed Practical Nurse #2 placed hands in their face, pushed their head into a pillow, and cut their hair. Review of additional investigation records included: A statement from Resident #2 dated 02/20/2026 documented a staff member placed hands in front of their face and pushed their face and head into a pillow. Resident #2 reported the incident to Licensed Practical Nurse #3, who stated the staff member would not return to the room; however, the staff member re-entered the room and continued to provide care. Resident #2 identified the staff member as Licensed Practical Nurse #2 using photographs and was observed to be upset and anxious during the identification. A statement from Licensed Practical Nurse #3 documented Resident #2 reported concerns during the night shift at 2:30 AM on 02/20/2026. The allegation was not reported to leadership at that time. Review of facility timecards dated 02/19/2026 to 02/20/2026 revealed Licensed Practical Nurse #2 started their shift on 02/19/2026 at 06:56 PM and ended their shift on 02/20/2026 at 07:35 AM. During an interview on 02/25/2026 at 9:58 AM, Resident #2 stated approximately one (1) week prior, a nurse had put their hands in their face, cut their hair in the shower, and they reported the incident. During a telephone interview on 03/02/2026 at 3:49 PM, Licensed Practical Nurse #3 stated Resident #2 reported Licensed Practical Nurse #2 had placed hands in their face and spoke in a derogatory manner. Licensed Practical Nurse #3 stated Resident #2 did not say they were hit, the allegation was not reported to a supervisor and acknowledged it should have been reported. Licensed Practical Nurse #3 stated Licensed Practical Nurse #2 gave Resident #2 a shower after the allegation was voiced and observed Resident #2's hair appeared shorter after the shower. During an interview on 03/18/2026 at 12:02 PM, the Director of Nursing stated when a staff member is made aware of potential abuse, the allegation should be reported immediately and the staff member should be removed from resident care pending investigation. Review of investigative materials revealed video surveillance was available for review at the time of the incident; however, the video was not reviewed as part of the initial investigation and was only reviewed on 02/25/2026 after surveyor inquiry, approximately five (5) days after the incident. During an interview on 02/25/2026 at 1:25 PM, the Administrator stated video footage was reviewed at an accelerated speed and acknowledged not all footage was reviewed. During an interview on 02/26/2026 at 9:29 AM, the Director of Nursing stated video surveillance is not always reviewed if there is a witness account. 2. Resident #1 had diagnoses including dementia, cerebral infarct (stroke), and chronic obstructive pulmonary disease (COPD). The Minimum Data Set (a resident assessment tool) dated 01/02/2026 documented Resident #1 had severe cognitive impairment. Review of an Incident Report dated 02/23/2026 at 2:15 AM documented Certified Nursing (continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Assistant #1 grabbed Resident #1 and pushed the resident backward into a chair, resulting in an approximately three (3) centimeter laceration to the left forearm. Additional review of investigative records and interviews revealed the incident occurred between approximately 1:30 AM and 1:45 AM on 02/23/2026; however, Certified Nursing Assistant #1 was not immediately removed from resident care following the witnessed allegation of abuse. Review of facility timecards dated 02/22/2026 to 02/23/2026 revealed Certified Nursing Assistant #1 started their shift on 02/22/2026 at 11:19 PM and punched out on 02/23/2026 at 3:22 AM. During an observation and interview on 02/25/2026 at 9:23 AM, Resident #1 was in bed and stated staff took good care of them and no one had ever physically hurt or pushed them. During a telephone interview on 02/25/2026 at 4:23 PM, Registered Nurse Manager #1 stated they observed Certified Nursing Assistant #1 grab Resident #1 by the arms and push the resident into a chair, resulting in injury. Registered Nurse Manager #1 stated the staff member remained on the unit and continued to provide care after the incident until the Director of Nursing arrived at approximately 3:00 AM, found Certified Nursing Assistant #1 providing care in another resident's room, and sent them home. Registered Nurse Manager #1 acknowledged Certified Nursing Assistant #1 should have been removed immediately. During a telephone interview on 02/26/2026 at 10:29 AM, Certified Nursing Assistant #1 stated after the incident they remained in the same area and provided care to another resident. During an interview on 02/26/2026 at 9:29 AM, the Director of Nursing stated staff involved in potential abuse should be removed from resident care immediately and acknowledged Certified Nursing Assistant #1 should have been sent home at the time of the incident. Review of investigative materials revealed video surveillance was not reviewed as part of the initial investigation. Documentation indicated video playback was not completed until 02/27/2026 due to reported technical issues, which was after surveyor inquiry. Video review findings indicated Certified Nursing Assistant #1 assisted Resident #1 to a chair; however, the initial investigation did not include review of available video evidence. During an interview on 02/26/2026 at 10:22 AM, the Administrator stated staff involved in potential abuse should be removed immediately and acknowledged the expectation Certified Nursing Assistant #1 would have been removed at the time of the incident. 10 New York State Code Rules and Regulations 415.4(b)(1)(i), (3)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>Based on observations, interviews, and record review, the facility did not ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good grooming and personal hygiene for one (1) of eight (8) residents reviewed (Resident #112). Specifically, Resident #112 did not receive scheduled hygiene care, including shaving and showering, on multiple occasions, and the facility did not ensure care was completed, documented, or reattempted when missed. The findings include: The facility policy Standards of Care at Kirkhaven, updated 08/20/2020, included baths or showers are given per resident preference and the Certified Nursing Assistant is responsible for informing the nurse the resident is receiving a bath or shower per the schedule. Documentation included the use of POC (Point of Care, the software used by Certified Nursing Assistants to show what work the Certified Nursing Assistants have completed). Refusals of care which included 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. Resident #112 had diagnoses including vascular dementia (dementia caused by reduced blood flow to the brain), heart disease, and diabetes. The Minimum Data Set (a resident assessment tool) dated 12/15/2025 documented the resident had moderately impaired cognition, required staff assistance with showering and personal hygiene, and had no rejection of care. During an observation and interview on 03/10/2026 at 10:07 AM, Resident #112 had several days of beard growth and stated they were due for a shave and shower on Mondays. Review of Resident #112's Comprehensive Care Plan, revised 01/06/2026, revealed the resident had refusal of treatment related to cognitive impairment and lack of knowledge, was at risk for decline in activities of daily living due to muscle weakness, and preferred weekly showers on the evening shift with removal of facial hair weekly with an electric razor. Interventions included, but were not limited to, documenting discussions regarding refusals and providing showers and personal hygiene with the assistance of one (1) staff member. Review of Resident #112's Kardex (care plan used by certified nursing assistants to guide daily care) effective as of 03/12/2026 included preference for weekly showers on Monday evenings and removal of facial hair weekly with an electric razor requiring the assistance of one (1) staff member. Review of a Personal Hygiene Support Provided report (a Point of Care documentation report used to record hygiene care including combing hair, brushing teeth, shaving, applying makeup, washing and drying face and hands, excluding baths and showers) for the period 02/07/2026 through 03/17/2026 revealed no documentation of hygiene care on 03/02/2026, 03/09/2026, or 03/16/2026. Review of the Treatment Administration Record on 03/17/2026 revealed no documentation of showers provided for Resident #112 from 03/01/2026 through 03/17/2026. Additional record review included no documented evidence nursing staff identified missed hygiene care or implemented follow-up to ensure completion. There was no documentation in the electronic health record, including Point of Care documentation or nursing progress notes, indicating hygiene care was provided, refused, or reattempted on the identified dates. No documentation was provided upon request indicating Resident #112 refused showers, shaving, or other hygiene care from 02/07/2026 through 03/17/2026. During an observation and interview on 03/11/2026 at 10:07 AM, Resident #112 had one-quarter inch to one-third inch length facial hair across the entire face and stated they had not received a shower. During an interview on 03/18/2026 at 11:53 AM, Certified Nursing Assistant #7 stated a resident's care needs were determined by checking the Kardex and if they were busy and unable to offer a shower, they would offer a bed bath and shave and stay past their shift to provide care if the resident did not receive care. Certified Nursing Assistant #7 stated they did not know where in the health record shaving care was documented. During an interview on 03/18/2026 at 11:38 AM, Licensed Practical Nurse #8 stated a resident's care needs were determined by checking the care plan, Kardex, Medication Administration Record, and discharge summaries from the hospital. Licensed Practical Nurse #8 stated the expectation from Certified Nursing Assistants was to reattempt care if unable to provide it and to notify the nurse if a resident refused care.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Licensed Practical Nurse #8 stated if they had time, they would attempt to shave the resident. During an interview on 03/18/2026 at 12:06 PM, Registered Nurse Manager #2 stated a resident's care needs were determined by checking Plan of Care (software used by Certified Nursing Assistants to document care provided to residents) and Plan of Care allowed nursing staff to view care needs. Registered Nurse Manager #2 stated the expectation for nursing staff was to notify the Nurse Manager if care could not be provided and to document in a progress note. Registered Nurse Manager #2 stated they would provide care if time allowed or ask the next shift to provide care. During an interview on 03/18/2026 at 12:57 PM, the Director of Nursing stated the expectation for a resident who did not receive a shave was for nursing staff to reattempt on the next shift or offer and reattempt the next day. 10 New York Codes Rules and Regulations 415.12(a)(3)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility did not ensure the resident environment remained as free of accident hazards as possible and did not ensure adequate supervision and implementation of individualized interventions to prevent accidents for one (1) of eight (8) residents reviewed for accidents (Resident #149) and across three (3) of five (5) resident use floors (third (3rd), fourth (4th), and fifth (5th) floors). Specifically, (1) hot liquids at temperatures capable of causing burns were accessible to residents, including residents with cognitive impairment requiring supervision, and (2) Resident #149, who had severely impaired cognition and was identified as high risk for falls, was not provided supervision and sustained a fall with a head injury requiring hospital evaluation. The findings include: Issue One (1): Resident #149 had diagnoses including Alzheimer's disease, epilepsy, and hypertension. The Minimum Data Set (a resident assessment tool) dated 12/24/2025 revealed Resident #149 had severely impaired cognition and required supervision or touching assistance for walking. The Comprehensive Care Plan last revised 02/17/2026 included Resident #149 was at high risk for falls related to dementia and impaired mobility with interventions including follow facility fall protocol, staff awareness of resident location in common areas, assist to the floor if out of bed to prevent injury, supervision with a four (4) wheeled walker, anticipate and meet needs, and ensure call bell was within reach when in room. The Kardex (care instructions used by certified nursing assistants) effective as of 03/18/2026 included follow facility fall protocol. Review of an Incident and Accident Report and Incident Report Note dated 01/02/2026, Registered Nurse #1 documented Resident #149 was found sitting on the floor in the doorway between the front and back lounge at approximately 11:00 PM. The resident was sitting upright leaning against the edge of the open lounge door. Assessment included a large purple hematoma (pooling of blood due to larger blood vessel leakage) on the left forehead measuring approximately four (4) centimeters by two (2) centimeters by two (2) centimeters raised area with a small one (1) centimeter abrasion in the center. The left kneecap was reddened with complaints of soreness. The on-call provider was notified and ordered transfer to the emergency department for further evaluation and possible imaging. In a Witness Account of Accident/Incident dated 01/02/2026, Licensed Practical Nurse #14 documented they came out of the nurse office and found Resident #149 sitting on their bottom with their back against the door frame and had a large hematoma on the left side of their forehead. Licensed Practical Nurse #14 documented the only care they provided to Resident #149 prior to the incident was medication assistance and they did not provide toileting or ambulation assistance prior to the fall. The Incident and Accident Report identified predisposing factors including ambulating without assistance and non-compliance with safety recommendations. There was no documentation identifying staff supervision, monitoring, or resident location prior to the fall. The Incident Report Note included an intervention to complete routine safety checks. This intervention was not incorporated into the Comprehensive Care Plan and there was no documented evidence routine safety checks were implemented following the incident or upon return from the hospital. There were no additional staff/witness statements documented, including Certified Nursing Assistant staff, and no documented timeline of events identifying when Resident #149 was last observed prior to the fall. During an interview on 03/18/2026 at 12:02 PM, the Director of Nursing stated the facility completed their investigation, had not suspected abuse, and determined the care plan was followed. Issue Two (2): Observations on 03/09/2026 at 9:30 AM included the surveyor checking the [NAME] thermocouple for proper calibration in the main kitchen using the ice-point method (placing a thermometer into a container filled with a mix of crushed ice and clean water, waiting for stabilization, and adjusting the reading to 32 degrees Fahrenheit). After allowing the ice and water mixture to settle, the [NAME] thermocouple displayed 32.3 degrees Fahrenheit. Observations on (continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>03/09/2026 at 10:35 AM included a coffee and hot water dispensing machine on the counter near the kitchenette in the third (3rd) floor dining room. When the buttons for hot water and coffee were pressed, hot liquids were dispensed measuring 143.6 degrees Fahrenheit and 142.3 degrees Fahrenheit, respectively. The dispensing machine was located at a level and in an area accessible to any ambulatory resident. Observations on 03/09/2026 at 12:10 PM included a coffee and hot water dispensing machine on the counter near the kitchenette in the fifth (5th) floor dining room. When the buttons for hot water and coffee were pressed, hot liquids were dispensed measuring 167.4 degrees Fahrenheit and 161.7 degrees Fahrenheit, respectively. The dispensing machine was located at a level and in an area accessible to any ambulatory resident. There were ten (10) residents seated at tables in the dining room, one (1) resident approximately four (4) feet from the dispensing machine, and another resident walking nearby. The fifth (5th) floor is a secured unit where residents have cognitive impairment and wandering behaviors requiring supervision. Observations on 03/09/2026 at 12:15 PM included a coffee and hot water dispensing machine on the counter near the kitchenette in the fourth (4th) floor dining room. When the buttons for hot water and coffee were pressed, hot liquids were dispensed measuring 166 degrees Fahrenheit and 162 degrees Fahrenheit, respectively. The dispensing machine was located at a level and in an area accessible to any ambulatory resident. Observations on 03/09/2026 at 3:25 PM included a resident on the fifth (5th) floor was seated at a table directly adjacent to the coffee and hot water dispenser and there were no staff in the immediate area. During an interview on 03/09/2026 at 12:15 PM, a food service worker stated residents who are able can get their own coffee. During an interview on 03/09/2026 at 3:09 PM, the Administrator stated there were no incident and action reports within the last 6 months related to burns. During an interview on 03/09/2026 at 3:28 PM, Registered Nurse Manager #1 stated the fifth (5th) floor is a locked behavioral unit with most residents having dementia and at least half of the residents have wandering behaviors. Registered Nurse Manager #1 stated there may be a lockout feature on the coffee and hot water dispenser. During an interview on 03/12/2026 at 5:06 PM, Licensed Practical Nurse Manager #1 stated there are five (5) residents on the fourth (4th) floor with wandering behaviors. 10 New York Codes Rules and Regulations 415.12(h) 10 New York Codes Rules and Regulations 415.29(a)(1)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility did not ensure sufficient staffing to provide nursing services to attain or maintain the highest practical physical, mental, and psychosocial well-being of residents for four (4) of four (4) resident units reviewed. Specifically, staffing levels were insufficient to meet resident needs, resulting in delayed toileting assistance, missed or delayed bathing and grooming, failure to provide timely incontinence care, delayed response to resident call systems, and inability to complete required nursing tasks. The findings include: For additional information, see the Centers for Medicare/Medicaid Services Form 2567: F550 - Resident Rights/Exercise of Rights, F561 - Self-determination, F677 - Activities of Daily Living Care for Dependent Residents, F689 - Free from Accident Hazards/Supervision/Devices, F761 - Label/Store Drugs & Biologicals, F882 - Infection Preventionist Qualifications/Role. Review of the Facility assessment dated [DATE] documented the facility was licensed for 147 beds with an average daily census of 136 residents. The staffing plan included two (2) licensed practical medication nurses and four (4) certified nursing assistants on each unit during day and evening shifts, and one (1) licensed practical medication nurse and two (2) certified nursing assistants on each unit during the night shift. Additionally, an unspecified number of registered nurses and licensed practical nurse managers were noted, as well as an unspecified number of registered nurse supervisors during evenings and weekends. Two (2) house managers were assigned to the day shift and would adjust to work open shifts as needed. The undated Emergency Staffing List included department heads and staff with phone numbers and instructed all department heads to call their staff in to assist and the Director of Nursing to call in unit managers to assist. During the entrance conference on 03/09/2026 at 9:21 AM, the Administrator stated the facility census was 131 residents. Review of resident information including Minimum Data Set assessments for residents on the Second (2nd), Third (3rd), Fourth (4th), and Fifth (5th) Floor units identified residents who required assistance with activities of daily living, including bathing, grooming, toileting, transfers requiring two (2) staff assist with a mechanical lift (a device used to transfer residents), and residents with cognitive impairment requiring supervision. Review of facility records, including nursing staffing sheets (dailies) and timecards from 02/01/2026 through 03/12/2026, revealed discrepancies between scheduled and actual staffing and staffing levels below the facility's stated plan to include (but not limited to) the following: On 02/02/2026 with a facility census of 136 residents, the day shift (7:00 AM to 3:00 PM) listed seven (7) certified nursing assistants, however two (2) did not have documented punches. On 03/02/2026 with a facility census of 135 residents, the day shift listed six (6) certified nursing assistants and one (1) additional until 1:27 PM, and the House Manager (a certified nursing assistant) assigned to the Fourth (4th) Floor unit did not have a documented punch. On 03/03/2026 with a facility census of 132 residents, the day shift listed six (6) certified nursing assistants and the House Manager assigned to the Fourth (4th) Floor unit did not have a documented punch. On 03/05/2026 with a unit census of 34 residents, day shift staffing on the Fifth (5th) Floor (designated dementia care unit) included two (2) certified nursing assistants and two (2) licensed nurses, including the registered nurse manager that was assigned to pass medications. On 03/08/2026 with a facility census of 131 residents, the night shift (11:00 PM to 7:00 AM) listed two (2) certified nursing assistants and one (1) licensed nurse without documented punches. On 03/09/2026 with a facility census of 131 residents, the day shift had five (5) certified nursing assistants and one (1) additional who arrived at 10:00 AM. On 03/12/2026 with a unit census of 34 residents, day shift staffing on the Fifth (5th) Floor included two (2) certified nursing assistants, two (2) licensed nurses, and one (1) licensed nurse manager. Review of a facility-provided list of nursing staff from 12/01/2025 through 03/13/2026 revealed 42 of 84 (equivalent to 50 percent) certified nursing assistants were no longer employed at the facility. During (continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Kirkhaven		STREET ADDRESS, CITY, STATE, ZIP CODE 254 Alexander Street Rochester, NY 14607	
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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>observations and interviews on 03/09/2026 on the Second (2nd) Floor unit with a census of 24 residents: During an interview at 9:45 AM, Registered Nurse Manager #3 stated day shift staffing included one (1) nurse manager, two (2) licensed practical nurses, and two (2) certified nursing assistants. During an interview on 03/09/2026 at 10:21 AM, Resident #106 stated on 03/08/2026 they waited four (4) hours for a bed pan after pressing the call button at 6:15 AM, defecated (had a bowel movement) on themselves, and were not assisted until 10:20 AM when physical therapy staff arrived. During an interview on 03/09/2026 at 11:26 AM, a visitor stated the unit was often staffed with one (1) certified nursing assistant and one (1) nurse, and Mondays and weekends were short staffed. During an interview on 03/09/2026 at 12:22 PM, Resident #75 stated staff told them they would have to wait to get out of bed due to lack of staff. During observations and interviews on 03/09/2026 and 03/10/2026 on the Third (3rd) Floor unit with a census of 37 residents: On 03/09/2026 at 10:02 AM, there was a strong urine odor in the hallway between rooms [ROOM NUMBERS]. During an interview on 03/09/2026 at 10:15 AM, Certified Nursing Assistant #13 stated there were two (2) nurses and two (2) certified nursing assistants on the day shift. During an observation on 03/09/2026 at 11:03 AM, Resident #76 was in bed in a hospital gown with a breakfast tray in front of them. During an interview on 03/09/2026 at 1:39 PM, Resident #70 stated nothing in the facility was on time, including meals and medications. During an observation and interview on 03/10/2026 at 10:07 AM, Resident #112 had several days of facial hair growth and stated they were due for a shower and shave. During an observation and interview on 03/10/2026 at 10:15 AM, Resident #94 had greasy and stringy hair and stated a certified nursing assistant told them on 03/09/2026 they could not shower due to only two (2) certified nursing assistants on the unit. Resident #94 stated the shower room was across the hall, and they did not hear it in use. During an interview on 03/10/2026 at 12:14 PM, Resident #41 stated they had not received a shower for two (2) months, and the facility was short staffed. During observations and interviews on 03/09/2026 on the Fourth (4th) Floor unit with a census of 36 residents: Day shift staffing included two (2) nurses and two (2) certified nursing assistants. During an interview on 03/09/2026 at 9:26 AM, Resident #161 stated they waited up to one (1) hour for assistance with toileting and staff expressed frustration when the resident was incontinent. During an observation on 03/09/2026 at 3:23 PM, a strong urine odor was present in the hallway. During an interview on 03/09/2026 at 10:17 AM, Resident #10 stated call light response times were hours due to short staffing and at times only one (1) certified nursing assistant was available for the entire floor. Resident #10 stated staff told them to wait until the next shift for care. During observations and interviews on 03/09/2026 and 03/10/2026 on the Fifth (5th) Floor unit with a census of 34 residents: During observations on 03/09/2026 at 9:04 AM, multiple residents were in the dining room wearing pajamas or a hospital gown and a strong urine odor was present throughout the unit. During an observation on 03/09/2026 at 9:46 AM, staffing included two (2) licensed practical nurses, one (1) certified nursing assistant, and one (1) registered nurse manager working as a certified nursing assistant. During an observation on 03/09/2026 at 9:55 AM, Resident #65 had uncombed hair, wore a hospital gown, and one sock, and at 11:37 AM their appearance remained unchanged. During an observation on 03/09/2026 at 12:49 PM, Resident #151 wore pajamas with a visible stain and had an odor of feces. During observations on 03/10/2026 at 10:12 AM and 12:23 PM, Resident #97 had visible fecal matter under their fingernails and was later observed eating without hand hygiene. During an observation on 03/09/2026 at 1:50 PM, signage in the elevator advertised attendance incentives for staff to reduce call offs. During an interview on 03/10/2026 at 11:30 AM during a special Resident Council meeting with four (4) residents, residents stated they waited two (2) to three (3) hours for care, staff had to work in multiple roles due to shortages, residents were not always assisted out of bed which resulted in them not being able to attend activities, and weekend staffing was the worst. During an interview on 03/12/2026 at 10:40 AM, Licensed Practical Nurse #4 stated they were called in and directed to assist in the kitchen, delaying medication administration, and stated there was usually only one (1) certified nursing assistant and medications were often given late due to (continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>staffing.During an interview on 03/12/2026 at 11:23 AM, Certified Nursing Assistant #1 stated they were unable to complete rounds and incontinent checks prior to meals due to staffing, resulting in Resident #151 being incontinent prior to lunch.During an interview on 03/12/2026 at 11:39 AM, Certified Nursing Assistant #4 and Licensed Practical Nurse #1 stated staffing shortages prevented completion of assigned tasks, including showers, toileting, transfers requiring two (2) staff assist, and timely medication administration.During an interview on 03/16/2026 at 10:15 AM, Certified Nursing Assistant #12 stated there was never enough staff, at times only one (1) certified nursing assistant was available, residents required full bed changes at the start of shift, showers were missed, and staff had to leave assignments to assist with two (2) person transfers.During an interview on 03/16/2026 at 1:32 PM, Licensed Practical Nurse #6 stated tasks such as checking medication carts for loose or unlabeled pills were not completed due to higher priority care needs related to staffing shortages.During an interview on 03/17/2026 at 12:16 PM, the Staffing Coordinator stated the facility frequently operated below target staffing levels, often with two (2) to three (3) certified nursing assistants per unit on day and evening shifts and one (1) certified nursing assistant on night shift, and acknowledged these levels were not sufficient to meet resident needs. The Staffing Coordinator stated they were unable to consistently meet staffing targets and did not know how to resolve the staffing issues.During an interview on 03/18/2026 at 11:20 AM with the Administrator and [NAME] President of Operations, the Administrator stated the leadership team was not aware of concerns related to insufficient staffing to meet resident needs, but staffing had not been a focus for the Quality Assurance and Performance Improvement committee. The [NAME] President of Operations stated the facility met frequently about staffing and all members of the interdisciplinary team assist with nurse staffing deficits. During an interview on 03/18/2026 at 12:02 PM, the Director of Nursing stated target staffing included four (4) certified nursing assistants and two (2) nurses per unit on day shift, four (4) certified nursing assistants and one (1) to two (2) nurses per unit and one (1) nursing supervisor on evening shift, and two (2) certified nursing assistants and one (1) nurse per unit and one (1) nursing supervisor on night shift. The Director of Nursing stated current staffing was not ideal, was affected by call offs, and required staff to work in multiple roles to meet resident needs.10 NYCRR 415.13 (a)(1)(i-iii)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility did not ensure its system for developing and implementing individualized meal service (use of meal tickets), including honoring resident preferences and available substitutions, was consistently followed for three (3) of thirteen (13) residents reviewed (Resident #10, Resident #77, and Resident #126). Specifically, residents were served food items which did not match their meal tickets and/or included items identified as dislikes, and substitutions available on the meal tickets were not provided. The findings include: 1. Resident #10 had diagnoses including severe protein-calorie malnutrition, weight loss, and chronic pain. The Minimum Data Set (a resident assessment tool) dated 01/29/2026 documented Resident #10 was cognitively intact, required a mechanically altered diet, and had an active diagnosis of malnutrition or was at risk for malnutrition. Review of Resident #10's Comprehensive Care Plan last revised 09/05/2025 indicated Resident #10 was at risk for alteration in nutrition with a history of significant malnutrition and abnormal weight loss. Interventions included a regular diet, mechanical soft texture (foods blended, ground, or finely chopped to make chewing and swallowing easier), and thin liquid consistency. Review of Resident #10's medical orders on 03/17/2026 included an order dated 07/25/2025 for a regular diet, mechanical soft texture, and thin liquids. During an observation and interview on 03/12/2026 at 12:52 PM, Resident #10 had green beans on the meal tray. Review of the meal ticket at the time did not include green beans and indicated the resident disliked green beans. Resident #10 stated the meal tray frequently had incorrect items. 2. Resident #77 had diagnoses including severe protein-calorie malnutrition, adult failure to thrive, and muscle weakness. The Minimum Data Set, dated [DATE] documented Resident #77 had moderate cognitive impairment and was on a therapeutic diet. Review of Resident #77's Comprehensive Care Plan last revised 02/25/2026 indicated Resident #77 was at risk for alteration in nutrition and hydration status. Interventions included a consistent carbohydrate diet (a diet to help manage blood sugar levels in individuals with diabetes), mechanical soft texture, and thin liquid consistency. Review of Resident #77's medical orders on 03/17/2026 included an order dated 02/24/2026 for a consistent carbohydrate diet, mechanical soft texture, and thin liquids. During an observation and interview on 03/11/2026 at 12:45 PM, Resident #77 was seated at a dining room table with a lunch tray containing pasta, spinach, pie, and applesauce. At 12:47 PM, Resident #77 stated the resident did not eat pasta and requested tuna fish. Review of the meal ticket indicated a mechanical soft chicken salad sandwich on white bread, sauteed spinach, three (3) boiled eggs, a mechanical soft peanut butter and jelly sandwich, unsweetened applesauce (handwritten), and tomato soup. The meal ticket also indicated staff were to offer chicken salad, tuna salad, or a grilled cheese sandwich if the resident did not accept the meal. The meal tray did not include sandwiches, boiled eggs, or tomato soup. Substitutions listed on the meal ticket were not provided at the time of observation. At 12:51 PM, Quality Assurance Nurse #1 spoke with Resident #77 regarding meal preferences. 3. Resident #126 had diagnoses including hypertension, heart failure, and disease of the spinal cord. The Minimum Data Set, dated [DATE] indicated Resident #126 was cognitively intact and had an active diagnosis of malnutrition or was at risk for malnutrition. Review of Resident #126's Comprehensive Care Plan last revised 03/06/2026 indicated Resident #126 was at risk for alteration in nutrition with a history of malnutrition. Interventions included a regular diet, regular texture, and thin liquid consistency. Review of Resident #126's medical orders on 03/17/2026 included an order dated 08/05/2025 for a regular diet, regular texture, and thin liquid consistency. During an observation and interview on 03/09/2026 at 11:47 AM, Resident #126 had apple juice on the meal tray. Review of the meal ticket did not include apple juice. Resident #126 stated the meal usually did not match the meal ticket. During an observation on 03/11/2026 at 12:35 PM, Resident #126's meal ticket included salad, salad dressing, and cranberry (continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>juice. The meal tray included apple juice and did not include salad, salad dressing, or cranberry juice. During an interview on 03/17/2026 at 10:34 AM, Certified Nursing Assistant #5 stated if a resident's meal ticket indicated an item should not be served or was listed as a dislike, the item should not be on the tray. Certified Nursing Assistant #5 stated dietary staff (kitchen ambassadors) and nursing staff were responsible for checking meal tickets and ensuring meal trays were accurate. During an interview on 03/17/2026 at 11:13 AM, Certified Nursing Assistant #6 stated in the role of passing meal trays, the meal ticket and tray contents were reviewed to ensure the resident received all items. If an item was missing, staff would notify the individual preparing the tray. During an interview on 03/17/2026 at 11:12 AM, Licensed Practical Nurse Manager #1 stated the dietary team created meal tickets based on diet consistency, preferences, and allergies. Licensed Practical Nurse Manager #1 stated nursing staff delivering meal trays should verify accuracy and ensure items identified as dislikes were not served. During an interview on 03/17/2026 at 1:55 PM, Registered Dietitian #1 stated items identified as dislikes should not be served and emphasized honoring preferences to promote adequate intake and prevent weight loss or malnutrition. During an interview on 03/18/2026 at 10:04 AM, the Director of Nursing stated meal tickets should be checked for accuracy and items identified as dislikes should not be served and should be removed if present on the tray. 10 New York Codes Rules and Regulations 415.14(c)(1-3)</p>		