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	12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kirkhaven	254 Alexander Street Rochester, NY 14607

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46526 Based on observation, interview, and record review conducted during a Recertification Survey from [DATE] to [DATE], for one (Resident #127) of 36 residents reviewed, the facility did not ensure that all residents had the right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive (a resident's wishes to be or not to be resuscitated in the event of an acute cardiac or pulmonary arrest) that would be honored. Specifically, the facility did not ensure Residents #127's advance directive identifiers were consistent with the resident's wishes. This is evidenced by the following: The facility policy Advanced Directives and Code Blue, dated [DATE], included an advanced directive should be maintained in the resident's medical record and should the resident wish to review or revise their advanced directive, the Social Service/Nursing/Designee would be contacted to assist the resident if necessary. All follow-up education and interaction with the resident/significant other should be documented in the medical record by the individual designated to interact with the resident/significant other regarding their concerns surrounding advanced directives. Resident #127 had diagnoses that included a stroke, anxiety, and depression. Review of an Acute Visit Progress Note, dated [DATE] and signed by Nurse Practitioner #1, revealed Resident #127 was alert and oriented to person, place, and time. Review of Resident #127's Medical Orders for Life Sustaining Treatment (MOLST) form, dated [DATE], revealed the resident's advanced directive wishes were for Do Not Resuscitate (allow natural death). The Medical Orders for Life Sustaining Treatment form included Resident #127 was the individual making the decision and verbal consent had been obtained. Review of current Physician orders, dated [DATE], revealed Resident #127's advanced directive wishes were for full cardiopulmonary resuscitation ([CPR] meaning to initiate cardiopulmonary resuscitation in the event of acute cardiac or respiratory arrest). The order was entered into the electronic medical record by the Director of Nursing. Review of Resident #127's current Comprehensive Care Plan on [DATE] revealed the resident's advanced directive wishes were for Do Not Resuscitate. In an admission note (readmission from the hospital), dated [DATE], Nurse Practitioner #2 documented that Resident #127's advanced directive wishes were for Full Code. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a Nursing Progress Note, dated [DATE], Nurse Manager #1 documented that Resident #127 was readmitted from the hospital and a Do Not Resuscitate (Medical Orders for Life Sustaining Treatment) form was completed at the resident's bedside. Review of Interdisciplinary Progress Notes from [DATE] through [DATE] did not reveal any documentation related to a change of advanced directives since Resident #127's [DATE] Medical Orders for Life Sustaining Treatment form was filled out. During an interview on [DATE] at 9:18 AM, Licensed Practical Nurse #13 stated to determine a resident's advanced directive wishes, they would look in the computer (resident's electronic medical record) or the resident's Medical Orders for Life Sustaining Treatment form. During an interview on [DATE] at 1:47 PM, the Director of Nursing stated a resident's advanced directive wishes are determined on admission and the resident's Medical Orders for Life Sustaining Treatment form if they came in with one was reviewed (to ensure current wishes). The Director of Nursing stated nursing staff should refer to the Medical Orders for Life Sustaining Treatment form as primary place or refer to the resident's electronic medical record. The Director of Nursing stated Resident #127 was a Do Not Resuscitate per their Medical Orders for Life Sustaining Treatment form. During a review at this time with the surveyor, Resident #127's physician's orders included the resident was a Full Code. The Director of Nursing stated they entered the Full Code order on [DATE] as they may have received an email from the Social Worker that there was change, but could not recall. In a follow-up interview at 2:56 PM, the Director of Nursing stated they spoke with Resident #127 who verbalized their advanced directive wishes at this time were for Full Code. 10 NYCRR 415.3(f)(1)(ii)

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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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 40803 Based on interviews and record review conducted during the Recertification Survey conducted from 12/02/2024 to 12/09/2024, the facility did not refer the resident who had an intellectual disability to the appropriate state-designated authority for a Level II Pre-Admission Screening and Resident Review (PASARR) for recommendations for one (Resident #115) of two residents reviewed. Specifically, the resident had a letter from the admitting hospital documentation that the resident required a full Level II assessment (referral process for individuals who were known or suspected of having serious mental illness for care planning recommendations) prior to admission or when a significant change occurred. Consequently, Resident #115 received no Level II referrals or services if needed. Findings include: The facility's revised SCREEN/ PASRR policy, dated 12/13/2018, documented for prospective residents a Level II assessment, based on screen indicators completed by the referring hospital or agency, admissions would request results of the assessment, and once obtained from the hospital or referring agency, the applicant's eligibility for admission would be determined. Level II reports and recommendations would be kept in the resident's chart and Level II recommendations would be incorporated into the resident's care plan. The policy included that a new SCREEN and Level II was required if a previously identified resident with a diagnosis of a serious mental illness or intellectual/developmental disability experienced a significant change in physical and/or mental condition. Resident #115 was admitted with diagnoses including Down Syndrome and acute respiratory failure with hypoxia (low oxygen level). The 09/13/2024 Minimum Data Set Resident Assessment documented the resident had severely impaired cognition, had no behaviors, required substantial/maximum assistance with most activities of daily living, and was receiving hospice care (effective 06/24/2024). The 07/17/2023 (prior to admission) New York State Department of Health Pre-Admission Screening and Resident Review form documented that Resident #115 had a diagnosis or documented history of developmental disability before the age of 22 and is likely to continue indefinitely, has received or is eligible for services for the developmental disability, and does have evidence of cognitive deficits and/or adaptive skills which indicate the presence of a developmental disability. The Screening form documented that Level II services were not warranted at the time. Review of an undated New York State Department of Health Office of Persons with Developmental Disabilities response letter from the admitting hospital on admission to the facility documented that Resident #115 required a full Level II Assessment, parts 1-4 and eligibility needs were to be determined. The form documented the Level II process would stop and proceed once eligibility was established. There was no documented evidence a Level II Assessment had ever been completed. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Comprehensive Care Plan, dated revised 11/18/2024, documented the resident had impaired cognitive function or impaired thought process related to developmentally delayed Down Syndrome. Interventions included to ask yes/no questions to determine their needs, communicate with the resident/family/caregivers regarding resident's capabilities, and cue, reorient, and supervise as needed. The plan included the resident had a terminal prognosis (initiated 06/24/2024) related to end stage dementia and received hospice care. Interventions included to encourage support system of family and friends and observe closely for signs/symptoms of pain. During an interview on 12/09/2024 at 8:52 AM, the Administrator stated they were a Qualified SCREENER for New York State and Resident #115 had been admitted prior to them starting at the facility. The Administrator stated due to the resident's diagnosis, they should have had a Level II Pre-Admission Screening and Resident Review Assessment completed to ensure the resident was appropriate to be placed at the facility and that they received the necessary services needed related to their diagnosis. During an interview on 12/9/2024 at 11:16 AM, the Director of Social Work stated the admission office reviews all documentation prior to admission. The Pre-Admission Screening and Resident Review information would then be passed along to the Director of Social Work for review. The Director of Social Work also stated the previous Director of Social Work should have reviewed Resident #115's paperwork and it was important to ensure residents who were determined to require Level II services had a Level II Assessment completed to ensure they were appropriate to be admitted to the facility and ensure they received the services they needed. The Director of Social Work stated the social work department is responsible for updating the resident's care plan of any Level II services required. 10 NYCRR 415.11(e)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46880 Based on observations, interviews, and record review conducted during the Recertification Survey from 12/02/2024 to 12/09/2024, for two (Residents #4 and #53) of six residents reviewed, the facility did not develop and implement a comprehensive person-centered care plan that included measurable objectives and timeframes to meet the resident's medical, nursing, mental and psychosocial needs including resident goals, desired outcomes and preferences related to their ongoing smoking habits. Specifically, the facility was aware that Residents' #4 and #53 continued to smoke against facility policy and there was no care plan in place to ensure the residents remained safe. This is evidenced by the following: 1. Resident #4 had diagnoses that included chronic respiratory failure, anxiety, and a tracheostomy (surgically created hole in the windpipe that provides alternative airway for breathing). The Minimum Data Set Resident Assessment, dated 09/23/2024, revealed Resident #4 was cognitively intact and used a wheelchair. Review of the Smoking Assessment Policy and Assessment form, dated 07/08/2024, and signed by Resident #4 revealed that the resident did smoke cigarettes daily, was on oxygen, was considered safe to smoke by themselves, and was educated that the facility was a non-smoking facility. Review of Resident #4's current Comprehensive Care Plan did not include any information related to the resident's non-compliance with the facility's smoking policy, safety concerns related to continuing to smoke, care of smoking materials, ongoing education, or cessation efforts if desired. During an interview on 12/04/2024 at 1:05 PM, Licensed Practical Nurse #5 stated Resident #4 had a pass to go outside to smoke independently. Licensed Practical Nurse #5 stated the nurses do not assist the resident to smoke and they thought they saw the resident locking their smoking materials in their room. During an interview on 12/06/2024 at 4:30 PM, Registered Nurse Manager #1 stated Resident #4 was noncompliant (with the facility's non-smoking policy), smoked off facility grounds, and this noncompliance with smoking should be on their care plan. 2. Resident #53 had diagnoses that included a below the knee amputation, pulmonary disease, and congestive heart failure. The Minimum Data Set Resident Assessment, dated 10/23/2024, documented the resident was cognitively intact and current tobacco use was indicated at the time. Review of the Smoking Assessment Policy and Assessment form, dated 02/27/2024 and signed by Resident #53, revealed the resident smoked for the past [AGE] years, declined smoking cessation support, and the resident acknowledged the facility's no smoking policy and does not comply with it. Review of Resident #53's current Comprehensive Care Plan did not include any information related to the resident's non-compliance with the facility's smoking policy, safety concerns related to continuing to smoke, care of smoking materials, ongoing education, or cessation efforts if desired. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/05/2024 at 11:39 AM, Resident #53 stated they went outside to smoke a cigar twice weekly despite being told that smoking was not allowed at the facility and had had their smoking supplies taken away by the Social Worker. The resident also stated they were also told by the Administrator where they could go if they insisted on smoking. Resident #53 stated they kept a lighter hidden in their dresser drawer to avoid having it stolen or confiscated. During an interview on 12/06/2024 at 9:55 AM, Certified Nurse Assistant #1 stated they had seen Resident #53 outside smoking while they were taking a break and the resident wore a pass around their neck to indicate they could leave the unit and building unsupervised. During an interview on 12/06/2024 at 11:01 AM, the Administrator stated they discouraged smoking at the facility and if they see on admission that a resident smokes, they encourage their admission planner to enforce that there was no smoking at the facility. The Administrator also stated they had spoken to Resident #53 in the past after the resident went out to smoke and was out of their eyesight and they were worried about the resident's safety. The Administrator stated that smoking assessments were conducted by their therapy department and if residents insisted on smoking, it should be documented on their care plan. During an interview on 12/09/2024 at 10:50 AM, the Director of Nursing stated the purpose of care plans were to inform the staff how to care for the residents. The Director of Nursing also stated as soon as they learn a resident smokes and is noncompliant, it should be put on their care plan. The Director of Nursing stated Resident #4 was not a smoker when they were first admitted , which is perhaps why the resident's care plan did not include any information related to smoking. 10 NYCRR 415.11(c)(1)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 40803 Based on observations, interviews, and record review conducted during a Recertification Survey from 12/02/2024 to 12/09/2024, the facility did not ensure that residents received care in accordance with professional standards of practice, their person-centered care plan, and resident's choice for 2 (Residents #53 and #81) of 29 residents reviewed for quality of care. Specifically, Resident #53 was not wearing a physician ordered compression wrap following a recent amputation of their right lower extremity on multiple observations. Resident #81 had multiple falls, one resulting in a major injury, and there was no documented evidence that the resident had been assessed by a Registered Nurse or that neurological checks had been completed following a fall with a potential head injury. This is evidenced by the following: The facility's undated Resident Fall Policy documented that prior to moving a resident after a fall, the Registered Nurse/Licensed Practical Nurse must assess/evaluate the resident for physical injury. Care and transfer will be provided as determined by the Registered Nurse/Licensed Practical Nurse based upon the post fall assessment. Vital signs are obtained as allowed and documented. If a fracture is suspected, the resident should not be moved and made as comfortable as possible at the site of the fall or found on the floor. If a head injury is suspected, the protocol for possible head injury and neurological checks are initiated and a neuro check flow sheet utilized for documentation and the physician notified. 1. Resident #81 had diagnoses that included a cognitive communication deficit and Huntington's disease (disease of the nervous system that affects a person's movements, thinking ability, and mental health). The 09/05/2024 Minimum Data Set Resident Assessment documented the resident had moderately impaired cognition, did not have upper or lower extremity impairments, did not use any mobility devices, and required supervision or touching assistance with most activities of daily living. The resident had two falls with no injury and one fall with major injury since the previous assessment. Resident #81's Comprehensive Care Plan, dated as last revised 09/18/2024, and the current Bedside Kardex (care plan used by the Certified Nursing Assistants for daily care) documented the resident had limited physical mobility, was at risk for falls, had a history of falls, impulsive behaviors, and had at times sat themselves on the floor. Interventions included, but were not limited to, the resident required supervision with transfers, did not use assistive devices, required supervision with ambulation, housekeeping should keep floors clean after meals as possible, and to follow facility fall protocol. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an Unwitnessed Fall Report, dated 08/05/2024 at 9:04 AM, Licensed Practical Nurse Manager #1 documented Resident #81 was found on their knees at 9:04 AM and that seconds prior to the incident, staff observed the resident seated in the dining room. The resident was unable to give a description of the event and the incident was unwitnessed. Immediate action taken included that vital signs were normal and range of motion of extremities was within normal limits. The resident denied hitting their head and it appeared they slid to the floor from how they were positioned. They had blanchable redness (redness that goes away and then comes back) on both knees, but the resident denied discomfort or pain. There were no observed injuries at the time of incident, the resident was alert and oriented, and had nonskid footwear on at the time. Predisposing physiological factors included impaired cognition and impaired judgment. The report notes, completed on 08/07/2024 (two days after the fall), by the facility's Administrator documented the resident had fallen with no injuries sustained and had been placed on 15-minute safety checks until bedtime. The Administrator documented that per the nursing supervisor, there were no care plan violations, mistreatment, neglect, or abuse identified. There was no documented evidence that a Registered Nurse has assessed Resident #81 either on-site or remotely following the fall. In an Unwitnessed Fall Report, dated 08/20/2024 at 12:39 PM, Licensed Practical Nurse Manager #1 documented Resident #81 was found sitting on their buttocks on the floor in the dining room with their legs extended. Staff had informed them that the resident may have bumped their head. Immediate action taken included that vital signs were normal and range of motion was normal. Neuro checks were initiated and predisposing environmental factors included a wet floor. The section titled 'injuries observed at time of incident' included fracture of right elbow and the section titled 'injuries report post incident' included no injuries observed post incident. The fall report did not include any follow-up related to a possible elbow fracture. Review of the Head Injury Flow Sheet, dated 08/20/2024, revealed the resident was to be monitored 12 times post incident for changes in neurological status and 6 of the 12 checks were not signed off as completed. In a nursing progress note, dated 08/21/2024 at 10:39 AM, Licensed Practical Nurse #10 documented Resident #81 complained of arm pain. Physician #1 was in for a follow-up visit and ordered an X-ray. At 2:49 PM, Licensed Practical Nurse Manager #4 documented the X-ray results showed a probable elbow fracture with soft tissue swelling and an orthopedic evaluation was recommended. Review of Resident #81's electronic medical record from 08/05/2024 to present revealed no documented evidence that a Registered Nurse had assessed the resident after either of the two unwitnessed falls. During an interview on 12/06/2024 at 4:18 PM, the Director of Nursing stated when a resident had an unwitnessed fall, staff should notify the nursing supervisor who should ensure the safety of the resident and start the incident report. Licensed Practical Nurses could only gather information and present it to the Registered Nurse as a Registered Nurse should assess the resident either physically or virtually if they were not present in the building. The Director of Nursing stated they do not see documentation that a Registered Nurse saw the resident on 08/05/2024 or 08/20/2024. The Director of Nursing stated residents should be assessed by a Registered Nurse after each incident and the Registered Nurse should document their findings in the resident's medical record. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow-up interview on 12/09/2024 at 9:03 AM, the Director of Nursing stated they thought a Registered Nurse did assess the resident after the 08/05/2024 and 08/20/2024 fall, but there was no documentation in the medical record, and it could not be assumed and that it was important for a Registered Nurse to assess the resident to rule out injury. They stated nursing staff should have completed the neurological checks after the unwitnessed fall to rule out any neurological changes. During an interview on 12/09/2024 at 10:57 AM Licensed Practical Nurse Unit Manager #1 stated sometimes they were the building supervisor (was not scheduled as such for the two incidents). If a resident had a fall, they would see the resident, gather information, look for any environmental factors or care plan violations, complete the incident report, and place a note in the medical book. If a resident was unable to describe what happened and it was an unwitnessed incident, they would check the resident's range of motion and skin. If they noticed any pain with range of motion or bruising, they would stop and notify the Registered Nurse, but if they did not observe any issues, they just document the incident and notify medical team via the communication book. They recalled the 08/20/2024 incident and recalled the nurse on the unit told them the resident had no new noted skin issues and was able to move their arms and legs without issues. In this case, they do not always call the Registered Nurse (on call). 2. Resident #53 had diagnoses that included a recent right below the knee amputation, arthritis, and diabetes. The Minimum Data Set Resident Assessment, dated 10/23/2024, documented the resident was cognitively intact and received scheduled and as needed pain medications. Review of a physician's orders, dated 11/19/2024, revealed Resident #53 required an ace wrap compression at all times to the right below the knee amputation to reduce swelling. Resident #53's Comprehensive Care Plan, revised on 10/31/2024, documented the resident had acute and chronic pain related to a surgical amputation of their right lower extremity, but did not include that the resident should wear an ace wrap compression. Review of the nursing progress notes for December 2024 did not reveal any documentation that Resident #53 had refused to wear the ace wrap compression to their right lower extremity. During an observation and interview on 12/04/2024 at 9:27 AM, Resident #53 was seated in their wheelchair in their room, wearing a sweatshirt and brief. There was no compression wrap to the right lower extremity. The resident stated their right leg was recently amputated and their stump should be wrapped, but no one wraps it because they were too busy. Resident #53 stated staff often say they would be right back, but then they do not return. During an observation on 12/04/2024 at 11:21 AM, Resident #53 was in the dining room playing BINGO. There was no ace wrap compression applied to their right lower extremity. During an observation and interview on 12/06/2024 at 9:41 AM, Resident #53 was lying in bed with complaints of pain and stated the severity was eight out of ten. There was no ace wrap compression to their right lower extremity. Resident #53 stated their ace wrap compression had been on, but it had come off during the night. The resident stated around 5:00 AM, the nurse came into their room with their morning medications, they asked if the nurse could reapply the ace wrap compression, they were told by the nurse they would come back to reapply it once they were done passing medications, but never returned. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/06/2024 at 9:55 AM, Certified Nurse Assistant #1 stated that Resident #53 often complained of pain due to their recent amputation and the resident is often without their compression wrap in place, but they could not apply it because it was the nurse's responsibility. During an interview on 12/06/2024 at 1:17 PM, the Director of Nursing stated the nurses should apply Resident #53's ace wrap compression as ordered and if the wrap needed to be reapplied, they would expect the nurse to do so as soon as possible but the resident should never have to wait hours. During an interview on 12/06/2024 at 1:55 PM, Licensed Practical Nurse Manager #1 stated that Resident #53 often complained of pain and they have instructed all nurses to look at the medical orders after their medication pass to see what orders needed to be completed, but due to the unit being acute, the orders did not always get completed promptly. 10 NYCRR 415.12

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. 49447 Based on observations, interviews, and record review conducted during the Recertification Survey from 12/02/2024 to 12/09/2024, for one (Resident #11) of two residents reviewed for communication, the facility did not ensure the resident received treatment and/or assistive devices to maintain their hearing. Specifically, the facility did not ensure the resident's hearing aids were repaired in a timely manner. This is evidenced by the following: Resident #11 had diagnoses that included auditory hallucinations, high blood pressure, and depression. The Minimum Data Set Resident Assessment documented Resident #11 was cognitively intact, was hard of hearing, and wore hearing aids. During an observation and interview on 12/02/2024 at 10:00 AM, Resident #11 was not wearing either hearing aid. Resident #11 stated at this time they could not hear unless voices were raised as they normally wore hearing aids, but had not had them for the last two months because they were broken. The Comprehensive Care Plan, dated 11/01/2024, and the Kardex (a care plan used by the Certified Nursing Assistants to provide daily care), dated 12/09/2024, documented Resident #11 had hearing aids to assist with communication. Review of the current physician's orders included an order, dated 04/03/2024, for hearing aids to be placed in the morning and removed at night. Review of the Treatment Administration Record and notes, dated 10/03/2024 to 12/02/2024, revealed multiple entries that the hearing aid(s) were broken and awaiting repair. In an email, dated 10/09/2024, to Long Term Care Management Provider #1, Quality Assurance and Performance Improvement Coordinator #1 documented Resident #11's hearing aid was broken and needed to be fixed. In an email, dated 10/15/2024, to Quality Assurance and Performance Improvement Coordinator #1, Long Term Care Management Provider #1 documented they were waiting to hear back from them to coordinate picking up Resident #11's hearing aid(s). During an interview on 12/05/2024 at 11:35 AM, Licensed Practical Nurse Manager #4 stated Resident #11 had a broken hearing aid and they had notified Quality Assurance and Performance Improvement Coordinator #1 to coordinate with Long Term Care Management Provider #1 to get the hearing aid(s) fixed. During an interview on 12/05/2024 at 11:45 AM, Quality Assurance and Performance Improvement Coordinator #1 stated they are responsible for coordinating with Long Term Care Management Provider #1 to have the hearing aids picked up to be sent out for repair, but they had not had any communication with them since 10/15/2024, and the broken hearing aid(s) was still in the facility (unrepaired). Quality Assurance and Performance Improvement Coordinator #1 stated Resident #11's hearing aids should have been picked up for repair sooner, but they were the only one handling appointments and transportation for the rest of the facility, and the hearing aids got lost in the shuffle. (continued on next page)

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	335668	A. Building B. Wing	12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kirkhaven	254 Alexander Street Rochester, NY 14607

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/06/2024 at 5:06 PM, the Director of Nursing stated coordination with Long Term Care Management Provider #1 should have been done sooner and two months was too long of a time period for hearing aids to get fixed. 10 NYCRR 415.12(3)(b)(1-3)

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46526 Based on observations, interviews, and record review conducted during the Recertification Survey and complaint investigation (NY00361034) from 12/02/2024 to 12/09/2024, the facility did not ensure acceptable parameters of nutritional status for one (Residents #127) of five residents reviewed. Specifically, nutritional assessments by a registered dietician were not performed during Resident #127's initial and readmission to the facility and documented weight losses were not identified timely. This is evidenced by the following: The undated facility policy Nutrition Assessment included that a registered dietician would perform a comprehensive nutrition assessment on residents to determine their risk for malnutrition or nutrition-related problems. A nutrition assessment would be completed on all residents on admission, annually, quarterly, and as needed. The assessment would include (but not limited to) review of documented weights, weight histories as available, clinical factors, and interviews with the resident as appropriate and available. Documentation would be provided in the electronic medical record. Resident #127 had diagnoses that included a stroke, dysphagia (difficulty swallowing), and adult failure to thrive. The Minimum Data Set Resident Assessment, dated 09/11/2024, revealed Resident #127 had a feeding tube, a documented weight of 152 pounds, and any weight loss had not occurred or was unknown. In an Acute Visit Progress Note, dated 11/15/2024, Nurse Practitioner #1 documented Resident #127 was alert and oriented to person, place, and time. Resident #127's current Physician orders, reviewed on 12/05/2024, included a regular diet, one carton of Very High Calorie Boost (nutrition supplemental drink) daily, and monthly weights between the first and third of every month. The current Comprehensive Care Plan, reviewed on 12/05/2024, included Resident #127 was independent with eating, required set-up assist, and was at risk for altered nutrition with interventions that included monthly and as needed weights. Review of a Hospital Nutritionist Note, dated 07/31/2024 (prior to Resident #127's admission to the facility), revealed Resident #127's weight of 113.5 pounds. Review of Resident #127's electronic medical record revealed a 26.6% weight loss over approximately three months (09/05/2024 to 12/02/2024) based on the following documented weights at the facility: - 08/11/2024: 157 pounds - 09/05/2024: 152 pounds - No weight documented after a readmission from the hospital on 09/19/2024. - No weight documented for October 2024. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 11/01/2024: 104.8 pounds - 12/02/2024: 111.6 pounds Review of a Hospital Nutritionist Note, dated 09/17/2024, revealed Resident #127 presented to the hospital on 09/11/2024 and weighed 111.2 pounds on 09/12/2024. In a Readmission Note, dated 09/22/2024, Physician #2 documented that prior to Resident #127's transfer to the hospital, their weight had declined and the resident's readmission weight was pending. Review of Nutrition Assessments revealed a comprehensive Nutrition Assessment had not been completed by a registered dietician on Resident #127's admission to the facility in August 2024 or on their readmission to the facility in September 2024. A Mini Nutrition Assessment (screening tool used to identify residents who are malnourished or at risk for malnutrition) was conducted on 08/12/2024, which identified Resident #127 at risk for malnutrition. A Comprehensive Nutrition Assessment was subsequently completed on 11/14/2024 (by Registered Dietician #1), which included unknown weight loss or gain in the past one, three, and six months. During an interview on 12/05/2024 at 3:01 PM, Registered Dietician #1 stated nutrition assessments were done on admission, quarterly, and if significant changes and were based on the Minimum Data Set Resident Assessments (schedule). Nutrition assessments included review of the resident's electronic health record, visiting the resident, and observing them at meals. Dietician #1 stated a resident's readmission to the facility from the hospital should trigger a Minimum Data Set Resident Assessment, which would show up on their list (to do a nutrition assessment). Registered Dietician #1 stated weights were done monthly or on a weekly basis if needed for tracking, and residents should be re-weighed if something was awry. Registered Dietician #1 stated significant weight loss is the standard for one (5%), three (7.5%), and six (10%) months. Registered Dietician #1 stated the first time they saw Resident #127 was in November 2024 (only works one day a week), and a Comprehensive Nutrition Assessment was done then. Review of the Comprehensive Nutrition Assessment with Registered Dietician #1 at the time revealed that the 11/14/2024 Nutrition Assessment included that Resident #127's (meal) intake was greater than 75%, was receiving Boost supplements to promote weight gain, and they would monitor the resident's weight trends. Registered Dietician #1 stated a Nutrition Assessment should have been done after Resident #127 was readmitted on [DATE], but they were not in the facility that week. Registered Dietician #1 stated Resident #127's weights from September to November met the criteria for significant weight loss, but because the resident had gone to the hospital and had a feeding tube (not in use for nutrition), they chose to use the resident's status in November 2024 as their baseline to work with going forward. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/06/2024 at approximately 3:15 PM, Food Service Director/Registered Dietician #2 stated if a resident was a full readmission (not just a visit to the emergency room), a Comprehensive Nutrition Assessment was required. Food Service Director/Registered Dietician #2 stated significant weight loss or gain is a five percent difference over 30 days and ten percent difference over 180 days. They did not see a Comprehensive Nutrition Assessment following Resident #127's August 2024 admission, were not sure why one was not done, and that they should also have had one when they were readmitted on [DATE], but did not. Food Service Director/Registered Dietician #2 stated they suspected Resident #127's initial weights (in August obtained by the facility) were inaccurate because the hospital notes listed the resident weighing 113 pounds and the Comprehensive Nutrition Assessment (if completed) would have picked up on the weight discrepancies. Food Service Director/Registered Dietician #2 stated they could not recall notifying the medical provider about Resident #127 potential weight loss. During an interview on 12/09/2024 at 10:57 AM, with the facility Administrator and the [NAME] President of Human Resources, the Administrator stated the facility had a performance improvement project related to timely identification of weight losses. 10 NYCRR 415.12(i)(1)

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. 46526 Based on observations, interviews, and record review conducted during the Recertification Survey from 12/02/2024 to 12/09/2024, for one (Resident #4) of two residents reviewed, the facility did not provide specialized care needs for the provision of respiratory care in accordance with professional standard of practice, and the resident's care plan, goals, and preferences. Specifically, Resident #4 was observed intermittently wearing oxygen via a tracheostomy (a surgically created opening in the neck and into the windpipe to breathe through) collar (a soft plastic mask used to deliver oxygen to a person with a tracheostomy tube). There was no physician's order in place for supplemental oxygen use or documentation in the resident's medical record that reflected the use and care of the oxygen. Additionally, the facility was unable to provide evidence that nursing staff had been educated or trained to care for Resident #4's Airvo machine (machine that provides humidified high flow oxygen). This is evidenced by the following: The facility Airvo 2 policy, dated June 2024, included (but not limited to) instructions for use, the step-by-step process for cleaning, and noted that the circuit and water chamber should be changed every 60 days by respiratory therapy. Resident #4 had diagnoses that included chronic respiratory failure, a tracheostomy, and anxiety. The Minimum Data Set Resident Assessment, dated 09/23/2024, documented Resident #4 was cognitively intact, required suctioning and tracheostomy care, and was not receiving continuous or intermittent oxygen therapy. During an observation on 12/02/2024 at 10:34 AM, Resident #4 was observed coming out of their room via motorized wheelchair with an oxygen tank on the back of their wheelchair. An Oxygen in Use sign was on Resident #4's door frame. Review of Resident #4's current physician's orders revealed the resident should use the Airvo machine at all times when in their room with the designated settings (initiated 09/30/2024) and to fill the Airvo water bag with distilled water every four hours (initiated 06/17/2024). The orders did not include the additional use of oxygen via the tracheostomy. Resident #4's current Comprehensive Care Plan reviewed on 12/04/2024, included that Resident #4 had impaired breathing and removed their oxygen at times. The care plan did not include instructions for use of Resident #4's Airvo machine, that the resident was independent with use of the machine, or wore supplemental oxygen via a tracheostomy collar when out of their room. Review of the Medication Administration and Treatment Administration Records from 11/01/2024 to 12/06/2024 did not include any documentation of Resident #4's continuous use of oxygen. Review of a Speech Therapy Evaluation and Plan of Treatment note, dated 06/19/2024, revealed Resident #4 was on three liters of oxygen via their tracheostomy. In an Interdisciplinary Progress Note, dated 11/07/2024, Respiratory Therapist #1 documented they checked Resident #4's Airvo machine and the resident was on three liters per minute of oxygen via a tracheostomy collar. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an Acute Visit Progress Note, dated 11/21/2024, Physician Assistant #1 documented Resident #4 used a tracheostomy collar with oxygen and the treatment plan noted to continue with oxygen via tracheostomy collar. Review of completed Tracheostomy Set-up and Skills Competency Checklists (to be checked as skills were either met or unmet) for Licensed Practical Nurses #11 and #12 (night shift nurses assigned to Resident #4 during the survey), revealed skills related to the Airvo machine were documented as N/A (not applicable). During interviews on 12/02/2024 at 1:12 PM and on 12/03/2024 at 11:40 AM, Resident #4 stated they do not spend a lot of time in their room. The resident stated they wear three liters of oxygen via their tracheostomy collar at all the times (except when smoking). Resident #4 stated the facility's Respiratory Therapist quit three weeks prior and they were nervous that no one else could help them because no one else was trained to care for their tracheostomy. During an observation on 12/04/2024 at 9:58 AM, Resident #4 was wearing three liters of oxygen via their tracheostomy collar. During an interview on 12/04/2024 at 1:05 PM, Licensed Practical Nurse #5 stated Resident #4 wore three liters of oxygen via their tracheostomy collar and Resident #4 was responsible for changing their own inner cannula (tube inserted through main tracheostomy tube, which can be removed for cleaning or replacement) and self-suctioning with staff present. During an interview on 12/05/2024 at 11:19 AM, the Director of Nursing stated Respiratory Therapist #1 last worked on 11/09/2024, and while they were looking to replace the respiratory therapist, no one was currently covering (the position). During an observation in Resident #4's room on 12/05/2024 at 12:40 PM, the Airvo machine's water bag was empty. During an observation on 12/05/2024 at 1:11 PM, Resident #4's oxygen mask was hanging from their wheelchair armrest and the oxygen tank gauge was at empty. During an interview on 12/06/2024 at 4:04 PM, Licensed Practical Nurse #5 stated if a resident required oxygen, it should be on the Medication/Treatment Administration Records so nurses know how much the resident should be on and to monitor it. Licensed Practical Nurse #5 stated Resident #4 did not have a current order for oxygen and should have. Licensed Practical Nurse #5 stated Resident #4 used their Airvo machine overnight when they were in bed and connected it themselves. Licensed Practical Nurse #5 stated they could not explain exactly what the Airvo machine did. During an interview on 12/06/2024 at 4:30 PM, Registered Nurse Manager #1 stated oxygen use should be listed on a resident's care plan and there should be an order. Registered Nurse Manager #1 stated Resident #4 wore oxygen continuously, and believed it was three liters, but would have to check the order. During an observation and interview on 12/06/2024 at 4:45 PM, Resident #4 stated they (staff) would not change their oxygen tank (which was empty at the time) because the resident did not have a current order for the oxygen (via their tracheostomy collar). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/09/2024 at 10:50 AM, the Director of Nursing stated supplemental oxygen required an order. The Director of Nursing stated Respiratory Therapy was responsible for the resident's Airvo machine, and if the resident was independent with use of the machine, they should be care planned for this. 10 NYCRR 415.12(k)(6)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40803 Based on observation, interviews and record review conducted during the Recertification Survey and complaint investigation the facility did not ensure a resident who displays or is diagnosed with dementia, received the appropriate services to maintain their highest practicable mental and psychosocial well-being for two (Residents #34 and #89) of five residents reviewed for dementia care. Specifically, Resident #34 had a diagnosis of dementia and did not have individualized interventions in place to guide direct care staff in managing behavioral symptoms. Resident #89 who had a history of dementia and behaviors sexual in nature was not appropriately care planned to include interventions to prevent further occurrences. Findings include: 1. Resident #34 had diagnoses that included dementia, repeated falls, and muscle weakness. The 07/30/2024 Minimum Data Set Resident Assessment documented the resident had severely impaired cognition, wandered daily, ambulated with a walker, and required supervision/ touching assistance with most activities of daily living. Resident #34's Comprehensive Care Plan dated 09/16/2024 and the current Bedside Kardex (care plan used the Certified Nursing Assistants for daily care) documented the resident was at risk for behavior problems related to impaired cognition and impaired thought process. On 11/11/2024 the care plan documented the resident had the potential to be physically aggressive related to dementia as well as being a victim in an altercation. Current interventions included (but not limited to) to analyze triggers for behaviors and what de-escalates behaviors, assess and address contributing sensory deficits, anticipate needs and monitor/document/report any signs/symptoms of resident posing danger to self and others. If the resident became agitated intervene before agitation escalates, guide away from the source of distress, calmly engage in conversation, and if response is aggressive, approach later. Review of the facility's investigation related to an incident on 08/08/2024 revealed the resident had a resident-to-resident interaction with another resident. The incident summary dated 08/18/2024 and signed by the Director of Nursing included there was no care plan violation and no evidence of mistreatment or neglect. Physical contact was made between the two residents that met the definition of abuse. The residents were assessed for injuries, none were noted for the residents and there was no indication that contact had occurred. Interventions included Resident #34 was placed on 15-minute checks until bedtime. On 08/08/2024 at 3:32 PM, the Director of Social Worker documented Resident #34 denied issues with their mood, remained pleasant and social towards other residents, had no observed changes in mood or behavior and that they would continue to monitor the resident as needed. On 08/09/2024 at 1:41 PM, the Director of Social Work documented another altercation with Resident #34 and the same resident as prior altercation where Resident #34 was both the victim and the aggressor. They would continue to monitor and support the resident. (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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's investigation related to another incident on 8/13/2024 revealed Resident #34 was physically aggressive with another resident (not the same as previous). Immediate interventions included the residents were separated and placed on 15-minute checks. The incident summary completed on 8/15/2024 by the Director of Nursing documented no care plan violation, no evidence of mistreatment or neglect, but that physical contact was made between the residents that met the definition of abuse. Intervention included 15-minute checks until bedtime. On 8/14/2024 at 4:23 PM, the Director of Social Work documented they followed up with Resident #34 regarding the altercation the previous day. The resident denied any concerns, touching, or harming anyone and their mood appeared stable and unchanged, and they would continue to provide support as needed. Review of the facility's investigation related to an incident on 10/09/2024 revealed Resident #34 was observed by a staff member punching another resident in the face. The incident summary completed by the Director Nursing on 10/9/2024 documented the residents were eating prior to the incident and after the meal crossed paths and started to argue. Resident #34 punched the other resident in the face and staff intervened immediately. Interventions included Resident #34 was placed on 15-minute checks until bedtime. The interdisciplinary team reviewed the incident and no changes in care recommended. In a progress note dated 10/14/2024 the Director of Social Worker documented that the interdisciplinary team reviewed the 10/09/2024 incident and determined no safety concerns. Staff would continue to monitor in common areas and offer activities as distraction as the resident tolerated. During an interview on 12/6/2024 at 2:32 PM the Director of Social Work stated the interdisciplinary team reviewed all incidents and usually entered a note with interventions added but there were no new interventions added to the care plan after the first several incidents for Resident #34 except for an activity that was added for distraction following the 10/09/2024 incident. During an interview on 12/06/2024 at 3:39 PM and again on 12/09/2024 at 10:50 AM the Director of Nursing stated the nurse supervisor who responded to an incident should review the care plans and interventions to determine if there has been a care plan violation and add new interventions as needed. The Director of Nursing stated Resident #34 had two resident-resident altercations where they were both the victim and aggressor and that they had written up Registered Nurse Supervisor #3 for using the same interventions (without success). The Director of Nursing stated it was important to try new interventions if the ones already in place were not working because it could lead to potentially more resident to resident incidents. 2) Resident #89 had diagnoses that included dementia, muscle weakness, and depression. The Minimum Data Set Resident assessment dated [DATE] revealed Resident #89 was severely impaired cognitively and wandering behaviors occurred daily. Review of Resident #89's Comprehensive Care Plan revealed behaviors that included (but not limited to) removing their clothes and undergarments, being resistive to re-dressing and remaining in a naked state, had potential to be physically aggressive, and intrusive to other residents' space. Neither the Comprehensive Care Plan or Kardex (care plan used by the Certified Nursing Assistants for daily care) did not include that the resident had a history of sexual behaviors, any potential triggers for such behaviors, or interventions to be used to prevent further occurrences. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observations on 12/02/2024 at 11:38 AM, 11:39 AM and 11:40 AM, Resident #89 was wandering in and out of several other resident rooms talking loudly to other residents. Review of a facility investigation of an incident on 08/29/2024 revealed Resident #89 had contact with a second resident that was sexual in nature. Both residents were immediately separated, and frequent checks were conducted. Review of another facility investigation of an incident on 10/04/2024 revealed Resident #89 had pulled up their shirt in front of the same resident who was subsequently found to touching Resident #89 in a sexual manner. The residents were separated, frequent checks conducted, and the other resident was moved to another floor. An Interdisciplinary Progress Note dated 10/07/2024 at 12:05 PM Licensed Practical Nurse #6 documented Resident #89 had wandered into other residents' rooms and had been redirected out of male residents' rooms several times during the day. In an Interdisciplinary Progress Note dated 11/27/2024 at 7:31 PM, Licensed Practical Nurse #6 documented Resident #89 had been going into male residents' room attempting to pull up their gown requiring redirection by staff. Review of the monthly Treatment Administration Records from September 2024 through December 2024 revealed orders for nurses to document Resident #89's behaviors twice a shift which included such behaviors as inappropriate touching and/or sexual behaviors towards others. There were no documented sexual behaviors coded during this time frame. During an interview on 12/06/2024 at 9:39 AM and at 10:06 AM, Licensed Practical Nurse #7 said they did not know where Resident #89 was at the time but if they were not in their room, then they were probably in another resident's room in another resident's bed. Licensed Practical Nurse #7 said it was hard to get Resident #89 involved in activities and staff just try and keep an eye on the resident. During an interview on 12/06/2024 at 9:50 AM, Certified Nursing Assistant #6 said the Kardex should include if a resident had any specific behaviors, and that Resident #89 could be hypersexual, which usually occurred after spending time with their significant other. When Resident #89 returned from spending time with their significant other, staff just try to keep an eye on the resident. During an interview on 12/09/2024 at 9:07 AM, Licensed Practical Nurse Manager #4 said if a resident had specific behaviors, including sexual behaviors, they should have a behavior care plan which would include interventions (related to the behaviors). Licensed Practical Nurse Manager #4 said Resident #89 often wandered the unit and had some sexual behaviors in the past but not recently. Licensed Practical Nurse Manager #4 stated they did not see a history of sexual behaviors or interventions related to sexual behaviors in the resident's care plan. During an interview on 12/09/2024 at 10:50 AM, the Director of Nursing said care plans were used to inform staff on how to appropriately care for the residents. The Director of Nursing said Resident #89's history of sexual behaviors and interventions used to be on the resident's care plan but were no longer as they had been considered resolved. (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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10 NYCRR 415.12

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	335668	A. Building B. Wing	12/09/2024

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 49447 Based on observations, interviews, and record review conducted during the Recertification Survey from 12/02/2024 to 12/09/2024, for one (Resident #22) of five residents reviewed for nutrition, the facility did not ensure food was prepared in a consistency to meet the residents needs per speech-language pathologist recommendations and physician orders. Specifically, Resident #22 had a history of dysphagia (difficulty swallowing), was on a mechanical soft diet (a diet that consists of easy to chew and swallow foods), and received a food item that was not appropriate on a mechanical soft diet. Additionally, Resident #22 was not care planned for a risk of aspiration (chance of food or liquids accidently inhaled into the lungs requiring close supervision with eating). This is evidenced by the following: The facility policy Modified Textured Diets, last revised 01/15/2024, included modified texture diets are offered based on facility and speech-language pathologist preference. Consult with the speech-language pathologist for determination of swallowing abilities and the safest diet texture for swallowing. The undated facility policy Aspiration Precautions included the policy was to reduce the risk of aspiration in residents who are at risk of choking or aspiration due to swallowing difficulties, medical conditions, or cognitive impairment. Follow individualized dietary recommendations provided by a speech-language pathologist or dietitian, including prescribed food textures (e.g., pureed, mechanical soft), and liquid consistencies (e.g., thin, nectar-thick, honey-thick) per provider order. Resident #22 had diagnoses that included dysphagia, malnutrition, and schizophrenia. The Minimum Data Resident Assessment, dated 11/19/2024, documented Resident #22 had severely impaired cognition, required supervision or touching assistance with meals, and had a mechanically altered diet (foods that required a change in texture). Review of the active physician's orders revealed a mechanical soft texture diet, initiated 03/11/2022. The orders did not include Resident #22 was at risk for aspiration. The Comprehensive Care Plan, dated 11/26/2024, and the Kardex (care plan used by the Certified Nursing Assistant to provide daily care), dated 12/06/2024, did not include that Resident #22 was on aspiration precautions. Review of Resident #22's meal tickets (a specific menu that includes what each resident should receive for meals, texture of the meal, and any other resident specific interventions during mealtime) for 12/02/2024 through 12/06/2024 revealed Resident #22 was on a mechanical soft texture diet and was on aspiration precautions. The facility document Therapist Progress and Updated Plan of Care, dated 05/05/2021, documented Resident #22 was receiving a mechanical soft texture diet due to being at high risk for aspiration and did not recommend changing the diet type. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 12/04/2024 at 12:34 PM, Resident #22 was eating a lettuce and tomato salad, had difficulty swallowing, started coughing, and spit the food out into a napkin. Resident #22's meal ticket did not include a lettuce and tomato salad. During an interview on 12/05/2024 at 3:29 PM, Registered Dietician #1 stated lettuce salads are not on a mechanical soft diet, residents should only get what is on their ticket, and Resident #22 should not have gotten a salad because it was not on their meal ticket. During an interview on 12/06/2024 at 10:17 AM, Certified Nursing Assistant #4 stated they are responsible for delivering trays to residents during mealtime, reading the meal tickets, and checking to make sure everything on the tray matches the ticket. Certified Nursing Assistant #4 stated they should not give a resident something that is not on their ticket. During an interview on 12/06/2024 at 1:38 PM, Speech Language Pathologist #1 stated they coordinate with the dietician to make sure residents have recommendations for a safe diet. A mechanical soft diet would not include a lettuce and tomato salad as it is considered a solid. Diet consistencies are ordered to keep residents safe from choking or aspiration. Speech Language Pathologist #1 stated Resident #22 should not have received the salad as it puts them at a higher risk for aspiration. Speech Language Pathologist #1 stated being on aspiration precautions should be included in the resident's care plan. 10 NYCRR 415.14 (d)(3)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 40803 Based on observations, record review, and interviews during the Recertification Survey from 12/02/2024 to 12/09/2024, for one of one main kitchen, the facility did not store, prepare, distribute, and serve food in accordance with professional standards for food service safety. Specifically, there were multiple undated food items not in their original containers and a food item was stored uncovered. The findings are: The undated facility policy titled Prepared Foods and Leftovers documented the maximum storage time for refrigerated prepared food items and leftovers was 72 hours and any foods stored beyond that date were to be discarded. Observations in the main kitchen on 12/02/2024 at 8:50 AM, and in the presence of the Food Service Director/Registered Dietitian #2, included the following: - The breakfast preparation cooler contained one undated two-quart container of cooked pureed eggs, one undated pan of cooked bacon, and one undated pan of cooked pancakes. - The cold production cooler contained 8 undated dishes of pumpkin souffle and one uncovered metal bowl of undated vanilla pudding. During an interview on 12/2/2024 at 9:03 AM, the Food Service Director/Registered Dietitian #2 stated it was important for food to be dated to know when it should be discarded to prevent potential food borne illness, and if food items are taken out of the original container or were leftover from a previous meal, those food items should be discarded after three days. The Food Service Director/Registered Dietitian #2 also stated the coolers and freezers were checked daily by all staff for undated food items, and it was important for food items to be covered to prevent contamination. During the follow up visit to the main kitchen on 12/03/2024 at 4:38 PM, and in the presence of Food Service Director/Registered Dietitian #2, there was an undated two-quart plastic container of chicken salad in the cold production cooler. During an interview on 12/03/2024 at 4:57 PM, the Food Service Director/Registered Dietitian #2, stated food service staff should be labeling and dating all food items once they are opened or taken out of their original container to ensure food safety. 10 NYCRR 415.14(h), 10 NYCRR: Subpart 14-1, 14-1.42, 14-1.43(e)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 49686 Based on observations, interviews, and record review conducted during a Recertification Survey from 12/02/2024 to 12/09/2024, for three (Residents #36, #41, #42) of eight residents reviewed, the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections. Specifically, Resident #41 had their blood sugar checked by a nurse not wearing gloves. Resident #42 was on enhanced barrier precautions (a strategy used by nursing homes to decrease transmission of infectious disease) and received high-contact care from staff not wearing the required personal protective equipment, and infection control practices were not followed during the care of a cholecystostomy (a procedure that creates a surgical opening of the gallbladder to drain it) site. Resident #36 was on enhanced barrier precautions, had an indwelling urinary catheter, and received high-contact care from staff who were not wearing the required personal protective equipment. Additionally, the facility was unable to provide documented evidence that the infection surveillance plan included ongoing analysis of surveillance data and follow-up activity since August 2024. Additionally, the facility did not ensure the Infection Prevention and Control Program policies and procedure were reviewed at least annually as required. This is evidenced by the following: 1. Resident #41 had diagnoses that included diabetes, dementia, and depression. The Minimum Data Set Resident Assessment, dated 11/14/2024, documented Resident #41 was moderately impaired cognitively. Review of the active physician's orders revealed an order for blood sugar checks before meals and at bedtime. During an observation on 12/05/2024 at 12:34 PM, Licensed Practical Nurse #3 performed a blood sugar check with a glucometer (a machine used to check blood sugar levels via a drop of blood) without wearing gloves. During an interview at this time, Licensed Practical Nurse #3 stated it was important to wear gloves during a blood sugar check to prevent cross contamination and any blood contamination, and they should have worn gloves while checking the blood sugar, but forgot. 2. Resident #42 had diagnoses that included cholecystitis (inflammation of the gallbladder), a cholecystostomy tube (tube inserted into the gallbladder to drain fluid), and diabetes. The Minimum Data Set Resident Assessment, dated 10/01/2024, documented Resident #42 was cognitively intact and had a skin ulcer. Review of the active physician's orders revealed a dressing change and tube flush to the cholecystostomy site daily, a dressing change to the right ankle ulcer, and that Resident #42 was on enhanced barrier precautions. During an observation on 12/02/2024 at 11:00 AM, Licensed Practical Nurse #4 provided wound care to the ankle ulcer and the cholecystostomy site wearing gloves but no gown. An enhanced barrier precaution sign was posted in the room and a blue star (per staff interviews indicated enhanced barrier precautions required) was posted next to Resident #42's name outside their room. The enhanced barrier precautions sign included to wear a gown with high-contact resident care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 12/03/2024 at 9:50 AM, Certified Nursing Assistant #5 washed and dressed Resident #42 and changed their incontinence brief. Certified Nursing Assistant #5 wore gloves but no gown. During an observation on 12/05/2024 at 11:18 AM, Licensed Practical Nurse #3 flushed Resident #42's cholecystostomy tube. During the flush process, License Practical Nurse #3 removed the port cap from the cholecystostomy tube and attached a syringe to the tubing without cleaning the flush port and did not clean the cap prior to reattaching it to the flush port. During an interview at this time, Licensed Practical Nurse #3 stated they should have cleansed the flush port prior to flushing and the port cap prior to reattaching it to the tube. 3. Resident #36 had diagnoses that included neuromuscular dysfunction of the bladder (improper drainage of the bladder often resulting in incontinence or difficulty urinating completely), schizophrenia, and chronic pain syndrome. The Minimum Data Set Resident Assessment, dated 10/22/2024, documented Resident #36 had moderate impairment of cognitive function and an indwelling urinary catheter. Review of the active physician's orders revealed Resident #36 had an indwelling urinary catheter and was on enhanced barrier precautions. During an observation on 12/04/2024 at 9:59 AM, Certified Nursing Assistant #5 provided direct hands-on care to Resident #36 (changed their brief and assisted with dressing) and emptied their urinary catheter drainage bag. Resident #36 had a blue star next to their name outside their door and no enhanced barrier precaution sign in their room. Certified Nursing Assistant #5 was wearing gloves and no gown. During an interview at this time, Certified Nursing Assistant #5 stated they did not know what a blue star meant and would look for a sign to see if a resident was on precautions. Certified Nursing Assistant #5 stated they did not know they needed to wear a gown when providing hands on care for Resident #36. During an interview on 12/06/2024 at 5:06 PM, the Director of Nursing stated residents with wounds and indwelling urinary catheters should be on enhanced barrier precautions and all staff should wear a gown and gloves when providing high-contact care. The Director of Nursing also stated the Licensed Practical Nurse should have cleansed Resident #42's cholecystostomy tube's flush port before and after flushing and the port cap should have been cleansed prior to being reattached to the flush port. The Director of Nursing stated all nurses should wear gloves when checking blood sugars. 4. Review of multiple Infection Prevention and Control facility policies that included the Antibiotic Stewardship policy, Bloodborne Pathogen policy, Resident Influenza and Pneumococcal Vaccine policy, Personal Protective Equipment policy, and the Employee Influenza and Pneumococcal Vaccine policy revealed none were dated as to when they were last reviewed or revised. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility form titled Infection and Antibiotic Tracking Tool on 12/06/2024 at 10:19 AM with the Director of Nursing and the Infection Preventionist revealed that the previous Infection Preventionist completed the form for July 2024 and August 2024, but the documentation for September 2024, October 2024, and November 2024 did not include ongoing surveillance, analysis, and documentation of facility follow-up activity of infections and antibiotic use. During an interview at this time, the Director of Nursing stated the facility had no designated Infection Preventionist from mid-August 2024 until 10/31/2024, and the Director of Nursing and Administrator had maintained the tracking and surveillance for resident infections. The Director of Nursing stated facility policies were reviewed and updated on an as-needed basis. The facility policy titled Infection Prevention Plan, last reviewed and updated in March 2024, documented that facility policies are reviewed and approved every three years or as needed based on regulatory guidelines, and the bloodborne pathogen policy should be reviewed annually. 10 NYCRR 415.19(a) (1-3)