STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335778	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Highlands at Brighton	5901 LAC DE Ville Boulevard Rochester, NY 14618

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility did not ensure alleged violations involving resident-to-resident physical aggression were reported immediately to the Administrator and the New York State Department of Health for two (2) of four (4) residents reviewed (Resident #4 and Resident #5). Specifically, on 11/24/2025 at 6:00 PM, Resident #4 threw a cup containing ice at Resident #5 during a verbal altercation, striking Resident #5. The facility did not notify the Administrator until 11/28/2025 at 3:00 PM and did not report the incident to the New York State Department of Health until 12/02/2025 at 3:45 PM.The findings include:The facility policy Abuse, Neglect and Mistreatment, last reviewed in October 2024, included all staff were required to report any potential or actual incidents of abuse, mistreatment, or neglect involving a resident to the Director of Nursing, Administrator, or the New York State Department of Health. In compliance with Section 2803-d of the Public Health Law, potential or actual incidents of abuse, mistreatment, or neglect involving a resident would be reported by the Administrator or facility designee to the New York State Department of Health.Resident #4 had diagnoses including anxiety (a mental health disorder causing excessive worry or fear), bipolar disorder (a mental health disorder causing changes in mood and behavior), and failure to thrive (decline in physical health, weight, or functioning). The Minimum Data Set (a resident assessment tool) dated 12/29/2025 documented Resident #4 was cognitively intact.Resident #5 had diagnoses including psychosis (a mental health disorder causing loss of contact with reality), cerebrovascular accident (a stroke caused by interrupted blood flow to the brain), and adjustment disorder (difficulty coping with stressful events). The Minimum Data Set, dated [DATE] documented Resident #5 was cognitively intact.Review of the Nursing Home Incident Intake documented the incident occurred on 11/24/2025 at 6:00 PM, staff became aware of the incident on 11/24/2025 at 6:00 PM, and the Administrator was first notified on 11/28/2025 at 3:00 PM. The record documented the incident was not reported to the New York State Department of Health until 12/02/2025 at 3:45 PM. The investigation report was submitted to the New York State Department of Health on 12/03/2025 at 10:18 AM.Review of the facility incident report dated 11/24/2025 classified the incident as Physical Aggression. The report documented Resident #4 and Resident #5 were involved in a verbal altercation in the dining room which escalated when Resident #4 threw a cup containing ice at Resident #5, striking Resident #5 on the arm. The report documented Resident #4 stated, I do not care, I do not feel bad, I do not like Resident #5 and I will do it again. The facility's immediate response documented Resident #4 and Resident #5 were separated for safety and monitored by staff the remainder of the shift. Both residents were encouraged to refrain from aggressive behaviors and instructed to report aggressive incidents to staff immediately. The record documented the residents were placed in rooms away from each other and were not seated near each other in the dining room. Review of witness statements revealed statements were obtained on 11/24/2025 immediately following the incident. Resident #5 was assessed following the incident and had no observed injuries or signs of emotional distress. The record documented Resident #5 remained pleasant and in good spirits following the incident.Review of notification records documented (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #4's family member was notified on 11/26/2025 at 3:15 PM and Resident #5's family member was notified on 11/26/2025 at 4:24 PM. The record documented Resident #4's medical provider was notified through the Provider Communication Book on 11/26/2025 at 3:14 PM and Resident #5's medical provider was notified through the Provider Communication Book on 11/26/2025 at 4:24 PM.During an interview on 03/06/2026 at 9:45 AM, the Director of Nursing stated reportable incidents should be reported within two (2) hours if serious bodily injury occurred and within 24 hours if serious bodily injury did not occur. The Director of Nursing stated the incident involving Resident #4 and Resident #5 should have been reported to the New York State Department of Health within 24 hours but was not. The Director of Nursing stated staff delayed reporting while completing the investigation and acknowledged the practice was incorrect.During a telephone interview on 03/06/2026 at 10:55 AM, the Administrator stated reportable incidents were submitted to the New York State Department of Health by the Director of Nursing or the Administrator within 48 hours of the incident occurring. The Administrator stated the incident involving Resident #4 and Resident #5 was not reported timely.Title 10 New York Codes, Rules and Regulations Section 415.4(b)(2),(4)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure a resident's environment remained as free from accident hazards as possible for one (1) of five (5) residents reviewed (Resident #6). Specifically, the facility did not ensure consistent monitoring and documentation of Resident #6's self-administration of medications as ordered by the medical provider. The facility also did not ensure accurate accountability of medications available to Resident #6 after the resident reported ingesting multiple days' worth of medications.The findings include:The facility policy Medication Administration: Self-Administration of Medication, last reviewed on 10/04/2018, included if the attending physician and interdisciplinary team approved self-administration of medications, the Nurse Manager or Charge Nurse would obtain a physician order for self-administration of medications. The medication nurse would determine daily the correct amount of medications self-administered and would initial the Medication Administration Record (MAR - a medication documentation record) for the daily check and accuracy. Any discrepancy in medication counts should be reported immediately to the Nurse Manager or Charge Nurse.Resident #6 had diagnoses including diabetes (a disease causing high blood sugar), obesity (excess body weight increasing health risks), and psychotic disorder with delusions (a mental health disorder causing false beliefs). The Minimum Data Set (a resident assessment tool) dated 07/07/2025 documented Resident #6 was cognitively intact.Review of the Comprehensive Care Plan dated 09/09/2024 revealed Resident #6 was able to self-administer medications using a medi-set (a weekly medication organization system). Interventions included nurses would check the medi-set every shift, refill the medi-set weekly per provider orders, and notify the medical team if Resident #6 was noncompliant with medications.Review of physician orders active as of 08/19/2025 included the following: Ziprasidone (Geodon) 60 milligrams two (2) times daily for psychosis, ordered 05/24/2024. Divalproex (Depakote Extended Release) 1,500 milligrams daily for psychosis and dementia with behaviors, ordered 09/20/2023. Bictegravir-emtricitabine-tenofovir (Biktarvy) one (1) tablet daily, ordered 09/15/2022. Medi-set training ordered 05/08/2024. The provider order included nursing staff were to check the medi-set after each scheduled medication administration, document in the Medication Administration Record Resident #6 self-administered medications, document every shift compliance with the medi-set and whether prompting was needed, and refill the medi-set every Thursday on day shift.Review of progress notes from 08/01/2025 through 08/19/2025 revealed Resident #6 was noncompliant with medications on 08/02/2025 at 2:00 PM, 08/02/2025 at 10:00 PM, and 08/11/2025 at 4:20 AM. The record did not include evidence a medical provider was notified regarding the medication noncompliance. The record also did not include documentation identifying dates and times the medi-set was refilled.Review of the historical Medication Administration Record for medications administered from 08/01/2025 through 08/19/2025 revealed inconsistent nursing documentation. Some licensed nurses documented medications as given, while other licensed nurses documented medications as given by other.Review of a nursing progress note dated 08/19/2025 (Tuesday) at 8:00 PM documented Resident #6 stated they had taken all medications for the week with the intention to harm themselves because they felt lonely and had no one to talk to. The on-call provider was notified immediately and Resident #6 was transferred to the hospital for further evaluation and treatment.Review of a facility investigative report dated 08/25/2025 revealed staff found Resident #6 lying on the floor on 08/19/2025 at 8:00 PM. Resident #6 stated, I took extra pills and got dizzy. The medi-set was checked and staff observed six (6) days' worth of medications were missing. Vital signs were stable and Resident #6 was alert and responsive during the assessment. Emergency Medical Services transported Resident #6 to the hospital for further evaluation and treatment. The provider, Director of Nursing, and responsible parties were notified.Review of an Emergency (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Department provider note dated 08/19/2025 at 8:39 PM revealed Resident #6 was evaluated after intentionally ingesting four (4) days' worth of medications, including Biktarvy and Depakote.Review of hospital records documented Resident #6 remained hospitalized from [DATE] through 08/26/2025 and was followed by toxicology services for medication monitoring.Review of a psychiatric evaluation dated 08/22/2025 documented Resident #6 remained at chronically elevated risk for suicide related to chronic medical conditions and trauma history. The psychiatric evaluation documented Resident #6 was also at elevated acute risk following the intentional ingestion of medications. The psychiatric evaluation documented the safety plan included facility staff assisting Resident #6 with medications.During an interview on 02/23/2026 at 2:27 PM, Licensed Practical Nurse #2 stated if a resident was care planned to self-administer medications, nursing staff would check at the end of the shift to ensure the resident took the medications. Licensed Practical Nurse #2 stated staff would document medication administration in a progress note and check ?completed' on Medication Administration Record.During an interview on 02/23/2026 at 2:36 PM, Licensed Practical Nurse Manager #1 stated staff would know a resident could self-administer medications because there would be a provider order identifying refill instructions. Licensed Practical Nurse Manager #1 stated the assigned nurse would refill the medi-set and document the refill in a progress note. Licensed Practical Nurse Manager #1 stated staff found Resident #6 on the floor and found the medi-set empty.During an interview on 02/24/2026 at 12:17 PM, the Director of Nursing stated investigations involving resident events would include resident interviews, staff interviews, and medical record review. The Director of Nursing stated the purpose of the investigation process was to ensure resident safety and determine whether policy or practice failures occurred. The Director of Nursing stated during the investigation involving Resident #6, staff reviewed the Medication Administration Record to determine possible medications ingested. The Director of Nursing stated six (6) days of medications were missing from the medi-set. The Director of Nursing stated they expected documentation identifying when the medi-set was refilled, but staff could not determine when the medi-set was last filled prior to the incident.During an interview on 03/04/2026 at 12:43 PM, Licensed Practical Nurse Manager #1 stated nurses were expected to document every shift whether Resident #6 complied with self-administration of medications and whether prompting was required. Licensed Practical Nurse Manager #1 stated nurses would review the Medication Administration Record, speak with the resident regarding medication administration, and document given by other if the resident self-administered medications.During an interview on 03/06/2026 at 8:50 AM, Licensed Practical Nurse Manager #1 stated staff could not determine when the medi-set was last filled before 08/19/2025. Licensed Practical Nurse Manager #1 stated nurses documenting given may have meant the resident took the medications, but staff should have documented given by other if Resident #6 self-administered the medications. Licensed Practical Nurse Manager #1 stated nurses were expected to complete behavior notes every shift documenting medication compliance, but some nurses completed the documentation and others did not.During an interview on 03/06/2026 at 9:46 AM, the Director of Nursing stated the provider order required nurses to specifically document how Resident #6 performed self-administration of medications and whether prompting was needed. The Director of Nursing stated nursing documentation left opportunities for unanswered questions regarding medication accountability and monitoring. The Director of Nursing stated the investigation relied on the nursing supervisor's findings regarding missing medications and staff did not review documentation to determine when the medi-set was last refilled.Title 10 New York Codes, Rules and Regulations 415.12(h)(1)-(2)