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	08/13/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, interviews, and record review conducted during the Recertification Survey from 08/6/2025 to 08/13/2025, for four (4) (Medication Carts on Residential Units A, B, D, and E) of five (5) medication carts reviewed, the facility did not ensure that all drugs and biologicals were stored and/or labeled in accordance with currently accepted professional principles and regulations. Specifically, on the Residential E Unit, there were pre-poured medications for multiple residents and multiple loose medications in the medication cart. On the Residential A Unit, there were multiple loose pills in a medication cart, and an unlocked, unattended medication cart was observed. On the Residential D Unit, medication carts were left unlocked and unattended with medications sitting on top. On the Residential B Unit, a medication cart was left unlocked and unattended. The findings include:The facility policy Medication Administration, dated July 2024, included, but was not limited to, medication carts are secured or controlled by nursing personnel at all times and nursing staff will observe the eight (8) Rights of Medication Administration (a set of principles for nurses to ensure the safe and accurate delivery of medication to patients): right patient, right medication, right dose, right time, right record, right reason, right response, and right route.During an observation on the Residential B Unit on 08/08/2025 at 12:32 PM, a medication cart was observed unlocked and unattended.During an observation on the Residential D Unit on 08/11/2025 at 9:35 AM, a medication cart was observed unlocked and unattended with three (3) bottles of omeprazole (a medication that treats excess stomach acid) on the top of the medication cart.During an observation on the Residential A Unit on 08/11/2025 at 10:33 AM, a medication cart was observed unlocked and unattended.During an observation and interview on the Residential E Unit on 08/11/2025 at 4:33 PM, there were 16 cups labeled with resident names with multiple pre-poured (prepared prior to the scheduled medication pass) medications found on the top of the medication cart, and multiple loose pills were found in the drawers. During an interview at this time, Licensed Practical Nurse #9 stated the entire 08/11/2025 medication pass for 5:00 PM and 8:00 PM were in the medication cups observed on the cart. Licensed Practical Nurse #9 was unable to identify all medications contained in the cups, including but not limited to, levetiracetam (an anti-seizure medication), ziprasidone (an anti-psychotic medication), buspirone (an anti-anxiety medication), and lisinopril (a medication to control high blood pressure). Licensed Practical Nurse #9 stated they did not know the policies or procedures for when a medication cart is to be inspected for expired medications or loose pills. They stated it was unsafe to have loose in the medication cart and to administer medications to a resident they could not identify. Licensed Practical Nurse #9 did not give a response when asked why the medications were pre-poured.During an interview on 8/12/2025 at 2:24 PM, Registered Nurse Manager #1 stated medication carts should be checked weekly for expired medications or loose pills and both should be sent back to pharmacy for disposal. Registered Nurse Manager #1 stated the expectation for a medication pass is to pull medications for one resident at a time, and to administer the medications at the time they were pulled. Registered Nurse Manager #1 stated it is not a safe practice to pre-pour medications. During an interview on 8/13/2025 at 9:49 AM, the Director of Nursing stated (continued on next page)

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

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	08/13/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the expectation for a medication pass is to monitor and observe the Rights of Medication Administration, assess the resident for appropriate response to medications, and to document in real-time. The Director of Nursing stated it was never appropriate to pull medications prior to the scheduled medication administration time and it was an unsafe practice. 10 NYCRR 415.18 (d), (e)(1-4)

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	08/13/2025

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interviews, and record review conducted during a Recertification Survey from 08/06/2025 to 08/13/2025, for one (1) (Resident #1) of one (1) resident reviewed, the facility did not ensure the resident's right to privacy and confidentiality of their personal and medical records was maintained. Specifically, a computer stationed in a hallway on Residential Unit D was observed open, exposing Resident #1's personal and medical information; there were no staff members present to secure the information for nine (9) minutes. This is evidenced by the following:Resident #1 had diagnoses including chronic respiratory failure, diabetes, and methicillin resistant staphylococcus aureus infection (a bacteria that is resistant to a wide range of antibiotics). The Minimum Data Set (a resident assessment tool), dated 05/30/2025, documented the resident was in a persistent vegetative state (lacking any meaningful interaction with themselves and the environment) and cognition was undetermined. During an observation and interview on 08/11/2025 at 4:35 PM, a computer was stationed in the middle of the hallway approximately five (5) feet from the nurse's station on Residential Unit D. There was no staff present in the area. The computer screen was open, exposing Resident #1's picture, name, date of birth , vital signs, and code status. Additionally, a yellow banner across the top of the computer screen included diagnoses of Extended-Spectrum Beta-Lactamase (ESBL) (enzymes produced by bacteria causing resistance to common antibiotics), Carbapenem-Resistant Enterobacterales (CRE) (a group of bacteria resistant to antibiotics), and Multidrug-Resistant Organism (MDRO) (an infection that occurs when bacteria/fungi becomes resistant to multiple types of antibiotics). At 4:44 PM, the computer screen timed out and went back to the original home screen; the staff person assigned to the computer had not returned. At 4:48 PM, Respiratory Therapist #1 exited a resident room and stated they had been busy on the unit, but they usually closed their computer screen before walking away. Respiratory Therapist #1 stated they received Health Insurance Portability Accountability Act (HIPAA) training in the past which covered maintaining residents' privacy and protecting their medical records. During an interview on 08/12/2025 at 10:46 AM, the Director of Respiratory stated they considered an open computer screen that exposed a resident's medical record a breach of confidentiality because anyone could access their information, and even during busy times, staff should secure their computers before walking away. The Director of Respiratory stated the facility had sent out modules reminding staff about Health Insurance Portability Accountability Act (HIPAA) and they would expect staff to position their computers so the resident's information was only visible to them. During an interview on 08/12/2025 at 12:07 PM, the Director of Nursing stated they would expect staff to follow their training, and when they are not with their computer, to secure their screen to protect the resident's information. Not doing so was a Health Insurance Portability Accountability Act (HIPAA) violation. 10 NYCRR 415.3 (e)(1)(ii)

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	08/13/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interviews and record review conducted during a Recertification Survey from 08/06/2025 to 08/13/2025, for one (1) (Resident #90) of one (1) resident reviewed, the facility did not ensure an incident was thoroughly investigated to rule out abuse, neglect, or mistreatment. Specifically, Resident #90 reported being touched on their leg and foot by a staff member, and the facility could not provide documented evidence that potential abuse, neglect, or mistreatment were ruled out. This is evidenced by the following:The facility policy Abuse, Neglect & Mistreatment, dated October 2024, included the residents shall be free from verbal, mental, sexual and physical abuse, corporal punishment and involuntary seclusion, mistreatment or neglect. Alleged violations involving abuse, mistreatment or neglect will be thoroughly investigated, and investigative outcomes will be documented, and measures will be taken to prevent further potential abuse, mistreatment, or neglect while the investigation is in progress. The facility policy Abuse, Neglect and Mistreatment: Protection of Residents, dated June 2024, included in the event abuse, neglect, mistreatment, or misappropriation of resident property is alleged or has occurred, the facility will take timely and appropriate steps to protect the residents of the facility and to prevent further potential for abuse during the course of the investigation and as the situation subsequently warrants. Resident #90 had diagnoses including Wernicke's encephalopathy (a brain disorder caused by a vitamin deficiency), transverse myelitis (a neurological disorder causing damage to the spinal cord), and muscle weakness. The Minimum Data Set (a resident assessment tool), dated 06/20/2025, revealed Resident #90 was cognitively intact. Resident #90's Comprehensive Care Plan, initiated on 05/13/2025, included the resident had a personality disorder, schizoaffective disorder, and persecutory delusions. Interventions included to assess the resident's coping skills and support systems, and to analyze and document key times, places, circumstances, triggers, and what de-escalates behaviors. During an interview on 08/13/2025 at 10:43 AM, Resident #90 stated earlier in the year, Certified Nursing Assistant #3 touched their leg and two (2) weeks later wiggled the resident's big toe and stated they were checking to see if the resident was breathing. Resident #90 stated Certified Nursing Assistant #3 also touched the back of their calf during the overnight shift on 01/25/2025 when the staff member was by themself. Resident #90 stated they told the nurse, but it was investigated and swept under the rug.Review of a progress note, dated 01/25/2025, Licensed Practical Nurse #7 documented at 7:00 PM Resident #90 informed the writer Certified Nursing Assistant #3 had touched the resident's foot or leg on three (3) occasions, they felt uncomfortable with Certified Nursing Assistant #3, and it made the resident feel weird. Licensed Practical Nurse #7 documented Certified Nursing Assistant #3 was told to swap, if they were assigned to Resident #90's care, until management could address the issue. Review of a progress note, dated 01/28/2025, Licensed Practical Nurse #8 documented they spoke with the resident about their concerns, and Resident #90 stated the certified nursing assistant touched their leg and grabbed their toes, which was done on two (2) occasions to see if the resident was breathing. Resident #90 stated they did not feel unsafe or that it was sexual in nature, but felt it was inappropriate. Review of the facility's investigation revealed a three (3) page file which included Licensed Practical Nurse #7's progress note, Licensed Practical Nurse #8's progress note, and a typed, unsigned statement, dated 01/25/2025, with Certified Nursing Assistant #3's typed name. The facility's investigation did not include additional investigative findings, a statement from Licensed Practical Nurse #7, additional staff/witness statements, or a determination if abuse was ruled out. During an interview on 08/13/2025 at 2:33 PM, the Director of Nursing stated investigations of alleged abuse, neglect, or mistreatment would include the creation of an Accident/Incident report, speaking with the resident, and obtaining additional statements to then determine if immediate action needed to be taken. The Director of Nursing stated if a complaint did not rise to the level of abuse, the immediate course of action would be to notify a supervisor. The Director of Nursing stated Resident #90's statement to Licensed Practical Nurse #7 would not have risen to the level requiring immediate (continued on next page)

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	08/13/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notification to a nursing supervisor and there was no suspicion of abuse. The Director of Nursing stated they did not think Licensed Practical Nurse #7 had a concern that abuse occurred. The resident stated they felt weird and Licensed Practical Nurse #7 reassigned the aide from the resident's care. The Director of Nursing stated the nurse manager could have been made aware by the 24-hour nursing report or a note placed under their door, and once notified, the nurse manager met with the resident, discussed the concern, and at that point it did not rise to the level of abuse. The resident's care plan was modified, and completion of an Accident/Incident report was not indicated. The Director of Nursing stated the facility did an ?unofficial' investigation of the concern. When reviewed at that time, the Director of Nursing stated the investigation provided by the facility was not a complete, thorough investigation and some of the nurse managers at the time of the incident were agency staff and it had been difficult to locate their investigation records.During an interview on 08/13/2025 at 2:34 PM, the Administrator stated during an investigation the facility would assess the resident, collect statements from staff and resident(s), gather as much data as possible, and go from there. The Administrator stated abuse would involve intent. They did not feel there was any intent or malice in this case, and they did not think the allegation rose to the level of abuse because on the night shift, staff must go in and check on the residents. 10 NYCRR 415.4(b)(3)

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	08/13/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review conducted during a Recertification Survey from 08/06/2025 to 08/13/2025, for two (2) (Residents #5 and #57) of four (4) residents reviewed, 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. Specifically, Resident #5 required staff assistance with shaving and was observed on multiple occasions with a significant amount of facial hair. Resident #57 required staff assistance with showering and hair washing, there was no documented evidence the resident received a shower or had their hair washed for two (2) weeks, and their hair was uncombed and oily with a dry, flaky scalp over multiple days. This is evidenced by the following:1. Resident #5 had diagnoses including end stage renal disease, low back pain, and depression. The Minimum Data Set (a resident assessment tool), dated 06/20/2025, documented the resident was cognitively intact and required supervision and hands on assistance with personal hygiene. Review of Resident #5's current Comprehensive Care Plan on 08/11/2025 did not include measurable goals or interventions related to personal grooming.Review of Resident #5's Personal Care Profile (used by certified nursing assistants to guide care), last revised on 07/30/2025, did not include instructions for personal grooming.During an observation and interview on 08/11/2025 at 10:42 AM, Resident #5 had a significant amount of facial hair around their chin and along their jawline and uncombed, oily hair. During an interview at that time, Resident #5 stated they did not like having facial hair, tried not to think about it, and avoided looking in the mirror. The resident stated there was a staff person who used to help with their care, but lately they seemed rushed. The resident stated they had received a bed bath in recent days, but no one offered to wash their hair or remove their facial hair at the time and they could not remember the last time it was done. Resident #5 stated they required staff assistance due to back and right arm pain with limited range of motion.During an observation and interview on 08/12/2025 at 9:50 AM, Resident #5 was seated in their wheelchair preparing to leave the facility for an appointment. The resident had a significant amount of facial hair measuring approximately 0.5 centimeter in length. During an interview at that time, Resident #5 stated a staff person had helped them get ready for their appointment, but did not offer to remove their facial hair. The resident stated they did not like going to their appointments with facial hair and would try not to think about it, but was reminded of it whenever they rested their face on their hands. During an interview on 08/12/2025 at 10:17 AM, Licensed Practical Charge Nurse #1 stated Resident #5 required assistance with washing their back and securing their corset, but they could wash up independently once set up was provided. Licensed Practical Charge Nurse #1 stated the resident did not have a history of refusing care and they noticed Resident #5 had a significant amount of facial hair. Upon review of the Personal Care Profile, Licensed Practical Charge Nurse #1 stated the resident required hands on assistance with personal grooming and facial hair removal. They stated they offered to remove the resident's facial hair a month and a half ago when they were in pain, but the resident refused at the time, and they had not offered or delegated anyone to assist the resident since then. Licensed Practical Charge Nurse #1 stated the Personal Care Profile was kept in the resident's room and the Certified Nursing Assistants should review and follow it. They stated they would expect staff to provide care and facial hair removal without the resident asking. During an interview on 08/12/2025 at 11:48 AM, the Director of Nursing stated Resident #5 needed to be re-evaluated by physical therapy to determine their level of care needs due to a discrepancy on their Personal Care Profile. The Director of Nursing stated various disciplines had seen the resident daily and someone should have assisted them with removing their facial hair.2. Resident #57 had diagnoses including hemiplegia/hemiparesis (muscle weakness and partial paralysis on one side of the body) affecting the left side, dysphagia (difficulty swallowing), and muscle weakness. The Minimum Data Set, dated [DATE], documented the resident was cognitively intact and dependent (continued on next page)

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	08/13/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with showering and personal hygiene. Review of Resident #57's current Comprehensive Care Plan, last revised on 06/26/2025, included the resident had an activities of daily living (basic daily care tasks) self-care performance deficit related to hemiplegia and staff were to provide a sponge bath when a full bath could not be tolerated. There were no documented interventions related to personal hygiene and grooming. Review of Resident #57's current Personal Care Profile included the resident had left-sided weakness, sensory deficits, and was dependent on staff for transfers, bed mobility, toileting, and dressing. There were no documented interventions related to personal hygiene and grooming. Review of a nursing progress note, dated 07/29/2025, a Licensed Practical Nurse documented Resident #57's last shower and hair wash was on 07/29/2025. During an observation and interview on 08/07/2025 at 9:39 AM, Resident #57 had long, oily hair and a significant amount of facial hair. During an interview at that time, Resident #57 stated they wanted a haircut and their shower day was on Tuesday, but had not received it because the unit was short-staffed. They were told by staff they would get a shower later, but the following day, no one offered. Resident #57 stated they had recently had a stroke and wanted a shave, but they could not do it alone. During an observation and interview on 08/11/2025 at 10:10 AM, Resident #57 was lying in bed with a gown on and their hair was uncombed and oily with a dry, flaky scalp. During an interview at that time, Resident #57 stated they had an appointment to get a haircut, but did not know when it would be because the barber was backed up. The resident stated they used to wash their own hair often, so having a dry, flaky scalp bothered them. They last had their hair washed a couple weeks ago, but they were afraid to ask for help due to the attitudes of staff. During an observation and interview on 08/11/2025 at 4:53 PM, Resident #57 was lying in bed with oily hair and a dry, flaky scalp. During an interview at that time, Resident #57 stated they did not get their hair washed and hoped the staff would wash it the following day. During an observation and interview on 08/12/2025 at 9:18 AM, Resident #57 was sitting up in bed wearing a gown and their hair was uncombed and oily with a dry, flaky scalp. Resident #57 stated they were supposed to get a shower and hair wash, but they were going to therapy and did not think the day shift staff would provide that care because their shower was scheduled for the night shift. During an interview on 08/12/2025 at 9:31 AM, Certified Nurse Assistant #4 stated when Resident #57 was on their assignment, they would wash them up and get them dressed. They stated the resident would not advocate for themself, so staff needed to check on them and anticipate their needs. During an interview on 08/12/2025 at 11:33 AM, the Director of Nursing stated they would expect the staff to anticipate Resident #57's care needs and assist them as needed. If the staff saw their hair soiled and disheveled, they would expect the staff to care for them since the resident could not express their own needs. 10 NYCRR 415.12(a)(3)

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	08/13/2025

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 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. Based on observations, interviews, and record review conducted during a Recertification Survey from 08/06/2025 to 08/13/2025, for one (1) (Resident #57) of one (1) resident reviewed, the facility did not ensure residents received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan. Specifically, Resident #57 had a medical order to wear a compression sleeve to their left arm and on multiple observations, did not have the compression sleeve in place. This is evidenced by the following:Review of the facility policy Splints/Braces, last revised October 2024, included, but was not limited to, nursing will add the device to the resident's care plan and Activities of Daily Living (ADL) Sheet/Care Card. The Certified Nursing Assistant will apply the device to the extremity as directed for the specified times as noted on the Activities of Daily Living Sheet/Care Card. The staff will apply and remove the device as directed per the Activities of Daily Living Sheet/Care Card.Resident #57 had diagnoses including hemiplegia/hemiparesis (muscle weakness and partial paralysis on one side of the body) affecting the left side, dysphagia (difficulty swallowing), and muscle weakness. The Minimum Data Set (a resident assessment tool), dated 07/29/2025, documented the resident was cognitively intact, and had limited range of motion in their left upper extremity.Review of the current Comprehensive Care Plan, last revised on 06/26/2025, included Resident #57 had left hemiparesis related to a stroke. Interventions included, but were not limited to, ensure the compression sleeve was applied in the morning and removed at bedtime. Review of the current Personal Care Profile (used by certified nursing assistants to guide care), last revised 08/12/2025, included Resident #57 had left-sided weakness and the resident was to wear a compression sleeve to the left arm during the day and removed at night. When reviewed on 08/11/2025, medical orders included to place a compression sleeve to the left arm in the morning and remove at bedtime. During an observations and interviews on 08/11/2025 at 10:10 AM and 4:53 PM, Resident #57 was lying in bed and was not wearing their compression sleeve. During interviews at these times, Resident #57 stated they had pain in their left arm. During an interview on 08/11/2025 at 4:57 PM, Licensed Practical Charge Nurse #2 stated Resident #57 should have their compression sleeve applied every morning and removed at night. Upon review of the electronic medical record at this time, Licensed Practical Charge Nurse #2 stated the nurse responsible for Resident #57's care on the day shift documented a pain score of 5 out of 10 (moderate pain) in their left arm, but there was no progress note indicating the resident refused to have their compression sleeve applied. Licensed Practical Charge Nurse #2 stated staff should always enter a progress note if the resident refused their compression sleeve. During an observation on 08/12/2025 at 9:18 AM, Resident #57 was sitting up in bed with their left arm resting on a pillow and they were not wearing the left compression sleeve. During an interview at this time, Resident #57 stated they were having pain in their arm.During an interview on 08/12/2025 at 9:31 AM with Social Worker #1 and Certified Nursing Assistant #4, Social Worker #1 stated through working with Resident #57 and from speaking with the family, they learned the resident did not advocate for themself and staff needed to check on them and anticipate their needs. Certified Nurse Assistant #4 stated Resident #57 would tell staff how they felt if staff checked in with them, but would not initiate reports. During an interview on 08/12/2025 at 11:33 AM, the Director of Nursing stated the task of applying the compression sleeve showed on the nurse's work list in the electronic health record and Resident #57 could not express their needs. They would expect staff to apply the resident's compression sleeve as ordered and certainly when the resident reported pain in their left arm. 10 NYCRR 415.12

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	08/13/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review conducted during a Recertification Survey from 08/06/2025 to 08/13/2025 for two (2) (Residents #69 and #81) of two (2) residents reviewed, the facility did not serve food in accordance with professional standards for food safety. Specifically, Resident Care Aide #1 was observed touching unwrapped pieces of graham crackers with their bare hands and the crackers were then consumed by Residents #69 and #81. This is evidenced by the following:The facility policy Hand Washing, dated June 2024, included hand washing was the most important component on infection prevention and should occur before and after contact with a resident or resident's environment. Hand washing with either commercially available hand sanitizer or soap and water was acceptable. The Resident Care Aide Job Description, revised January 2025, included, but was not limited to, passing water pitchers and nourishments, removing trash, and to demonstrate good customer service with residents, family, and other staff. Resident #69 had diagnoses including cerebral palsy (condition which affects a person's ability to move and maintain balance and posture), muscular dystrophy (genetic disease that causes progressive weakness and loss of muscle mass), and left hand contracture (a permanent tightening and shortening of muscles, tendons, or skin, causing limited movement). The Minimum Data Set (a resident assessment tool), dated 07/10/2025, revealed Resident #69 had severely impaired cognition. Resident #81 had diagnoses including Parkinsonism (a collection of neurological disorders that cause symptoms such as tremor, slow movement, and stiffness), dementia, and protein-calorie malnutrition (a condition caused by inadequate intake of protein and calories). The Minimum Data Set, dated [DATE], revealed Resident #81 had severely impaired cognition.During an observation on 08/06/2025 at 9:59 AM, Resident Care Aide #1 opened a package containing two graham crackers, and with their ungloved (bare) hand, they touched portions of the graham crackers and handed them to Resident #81. Resident Care Aide #1 then proceeded to an unknown resident, and took an empty bottle of Ensure (nutritional drink) from them to dispose. Resident Care Aide #1 did not perform hand hygiene or put on gloves between Resident #81 and the unknown resident. Resident Care Aide #1 then opened another package of graham crackers, and with their ungloved hand, touched portions of the graham crackers and handed them to Resident #69, which the resident consumed. Resident Care Aide #1 did not perform hand hygiene between the unknown resident and Resident #69. During an interview on 08/06/2025 at 10:03 AM, Resident Care Aide #1 stated in their role, they give residents water, snacks, and help them with their meal trays. Resident Care Aide #1 stated they usually wear gloves when assisting residents during meals and should have worn gloves when touching the graham crackers.During an interview on 08/06/2025 at 10:12 AM, Licensed Practical Nurse Manager #3 stated staff should perform hand hygiene anytime they come in contact with residents, including sanitizing their hands after passing out meal trays. Licensed Practical Nurse Manager #3 stated staff should not touch ready to eat food items with their bare hands. They stated Resident Care Aide #1 should not have touched the graham crackers without gloves. During an interview on 08/13/2025 at 12:33 PM with Administrator and Director of Nursing, the Administrator stated they were not aware staff were touching food with their bare hands. The Administrator stated Resident Care Aide #1 had worked in the kitchen and should have known better. 10 NYCRR 415.14(h), 10 NYCRR: Subpart 14-1.80(a)

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	08/13/2025

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 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. Based on observations, interviews, and record review conducted during the Recertification Survey from 08/06/2025 to 08/13/2025, the facility did not ensure the posted nurse staffing information included the required information daily, at the beginning of each shift, and was readily accessible to residents, staff, and visitors. Specifically, the posted nurse staffing information did not include the actual number of licensed (Registered Nurses and Licensed Practical Nurses) and unlicensed (Certified Nursing Assistants) nursing staff who were directly responsible for resident care during each shift. This is evidenced by the following:During observations on 08/06/2025 at 4:24 PM and 08/11/2025 at 10:16 AM, the facility's posted nurse staffing information listed numbers next to each nursing title, ranging from 8 to 56, and did not specify if those were the actual hours worked or the total number of licensed and unlicensed nursing staff assigned to each shift. Review of the daily nurse staffing information from 06/01/2025 to 08/11/2025 revealed all dates did not include the total number of Registered Nurses, Licensed Practical Nurses, and Certified Nursing Assistants for each shift.During an interview on 08/12/2025 at 11:26 AM, Staffing Coordinator #1 stated the posted daily nurse staffing information included the number of residents and how many nurses and certified nursing assistants were scheduled for each unit. Staffing Coordinator #1 stated if the posting listed a number eight (8) next to Registered Nurse (RN) on a shift, it meant there was one (1) Registered Nurse who worked eight (8) hours. If there was a number 16 next to Certified Nursing Assistant (CNA), it meant there were 2 Certified Nursing Assistants because they worked 8 hours each, which would account for the number 16. Staffing Coordinator #1 stated they were taught to only document the actual hours worked on the daily posted nurse staffing. During an interview on 08/13/2025 at 11:55 AM, the Director of Nursing stated the posted daily nurse staffing included the resident census for each unit and the actual hours for the registered nurses, licensed practical nurses, and certified nursing assistants scheduled each shift. The Director of Nursing stated the total number of nursing staff was reflected in the actual hours worked, and they were not aware both the total number of staff and the actual hours worked had to be listed on the daily postings. During an interview on 08/13/2025 at 12:33 PM with the Administrator and the Director of Nursing, the Administrator stated they were not aware the posted daily nurse staffing had to include both the total number and the actual hours worked by the nursing staff. 10 NYCRR 415.13