STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335825	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Brook at High Falls Nursing Home and Rehab Ctr	2150 St Paul Street Rochester, NY 14621

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45200 Based on observations and interviews conducted during a Recertification Survey completed 11/07/2024 to 11/14/2024, the facility did not provide maintenance services necessary to maintain a sanitary, orderly, and comfortable homelike environment. Specifically, kitchen lighting was not protected or operable, a residential kitchen freezer and a staff bathroom were inoperable, bathrooms exhaust ventilation was not installed or was inoperable, there was no soap in resident bathrooms, a call bell was not installed in a resident bathroom, and a corridor exit sign was not affixed to the ceiling. The findings are: Observations on 11/07/24 from 9:05 AM to 11:08 AM included the following: 1. A Frigidaire residential stand-up freezer by the back kitchen entrance was empty and not operational. During an interview at this time, the cook stated that it did not work and had been out of order for a while. 2. Two glass fluorescent light fixtures above the cook line in the main kitchen were uncovered and unprotected from shattering. Another similar light fixture near the back kitchen door had no bulbs or cover. During an interview at this time, the Kitchen Manager stated the fixture did not work. 3. A staff bathroom outside the Director of Nursing office was inoperable with the water shut off. During an interview at this time, the Director of Maintenance stated they did not have time to fix it; the residents come first. 4. The Dirty Utility room hand wash sink had a sign across the basin marked: Do not use. During an interview at this time, the Director of Maintenance stated someone hit the drainpipe with the mop bucket so it leaks, and that they had not had time to fix it. 5. The exhaust ventilation in the housekeeping closet next to the kitchen was not pulling any air when tested with a paper towel. 6. There was a foul odor in the staff restroom across from the kitchen door and the ceiling exhaust grate was not pulling any air when tested with a paper towel. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/07/2024 at 12:27 PM, Anonymous Staff Member #1 stated they needed soap dispensers in all the resident rooms and when they finish care, they cannot wash their hands after taking off their gloves. Observations on 11/07/2024 beginning at 1:05 PM included a bathroom in resident room [ROOM NUMBER] with no exhaust ventilation. The exhaust vent was closed in the bathroom of resident room [ROOM NUMBER], and the exhaust vents in the bathrooms in resident rooms #9 and #22 were inoperable when tested with a piece of paper. Observations on 11/07/2024 beginning at 1:29 PM included resident rooms #1, 3, 5, 6, 7, 8, 9, 10, 11, 12, 21, 22 and 23 lacked soap or hand sanitizer for residents and staff to wash their hands in the rooms or bathrooms. During an interview on 11/08/2024 at 10:28 AM, the Administrator stated they were aware (of the missing ventilation in resident room [ROOM NUMBER]) and that the construction workers were not done. Observations on 11/12/2024 from 8:42 AM to 8:45 AM included the bathrooms in rooms #9, 15, and 16 did not have soap or hand sanitizer for residents and staff to wash their hands. Observations on 11/12/2024 beginning at 8:53 AM included a bathroom in resident room [ROOM NUMBER] had no exhaust ventilation. Observations on 11/12/2024 at 8:57 AM included there was no nurse call button in resident room [ROOM NUMBER]. During an interview on 11/12/2024 at 12:57 PM, Certified Nursing Assistant #2 stated there was no soap or hand sanitizer in the resident rooms and they must go to a staff bathroom or shower room to wash their hands. During an interview on 11/12/2024 at 2:20 PM, the Director of Maintenance stated a service vendor was in the building fixing the air handler, and a belt had come off, causing the vents to not work earlier in the day. During an interview on 11/13/2024 at 9:22 AM, the Director of Maintenance stated they checked the ventilation in the rooms that had newly constructed bathrooms and noticed resident room [ROOM NUMBER] did not have a vent installed. The Director of Maintenance stated a senior maintenance person had showed them what to look for with the ventilation back in August, but they do not check the ventilation on a regular basis. During an interview on 11/13/2024 at 9:43 AM, the Administrator stated the renovations will be hopefully be done by the end of the year. Observations on 11/13/2024 at 12:09 PM included an exit sign in the corridor between rooms #11 and #12 that was not affixed to the ceiling and was hanging by the electrical cord. During an interview on 11/14/2024 at 10:18 AM, the Kitchen Manager stated the inoperable freezer needs to be replaced and they had tried to get it fixed, but by the next morning it was not working again. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/14/2024 at 10:33 AM, Director of Nursing #2 stated they were aware of the resident bathrooms not having soap dispensers and were concerned about the limited amount of hand sanitization areas and the staff's ability to wash their hands in the resident's room. 10 NYCRR: 415.29, 415.29(b), 415.29(d), 415.29(h)(1), 415.29(j)(1), 415.14(h), 10 NYCRR: Subpart 14-1.88(c), 14-1.174

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 46880 Based on interviews and record review conducted during a Recertification Survey from 11/07/2024 to 11/14/2024, for one (Resident #3) of twelve residents reviewed for care planning, the facility did not ensure a comprehensive person-centered care plan meeting was held at least quarterly and that the resident and/or their representative had been invited to attend. Specifically, Resident #3 had been in the facility for approximately 22 months, and there was no evidence that the resident and/or their representative had been invited to any care plan meetings. This is evidenced by the following: The facility policy Care Plans-Comprehensive, revised December 2010, documented the facility's interdisciplinary team in coordination with the resident and their representative develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain, and the interdisciplinary team is responsible for the review and updating of care plans at least quarterly. The policy did not include if the resident and/or their representative would be invited to attend the care plan meetings. Resident #3 had diagnoses that included unintentional poisoning by unspecified drugs, diabetes, and chronic pain. The Minimum Data Set Resident Assessment, dated 09/01/2024, documented the resident was cognitively intact. During an interview on 11/08/2024 at 10:23 AM, Resident #3 stated since their admission (approximately 22 months ago), they had never been invited to a care plan meeting and they did have questions pertaining to their care. The resident stated they had requested a meeting with a member of the interdisciplinary team (specific name or department unknown) previously, but had not heard anything back. The resident stated they felt a meeting would be important. Review of all nursing and social services interdisciplinary team progress notes since admission revealed no documentation that a care plan meeting had been held or if Resident #3 and/or their representative had been invited to any care plan meeting to review their care and get their input. During an interview on 11/13/2024 at 9:35 AM, the Director of Social Work stated care plan meetings should be held quarterly and they invited Resident #3 and their family to a meeting in April, but the family did not return their call and they did not follow up. The Director of Social Work stated the family was involved in the resident's care, and although the family had not returned their call, no additional care plan meeting invitations had been extended. Additioanlly, the Director of Social Work stated they started at the facility in February 2024, and during that time, the resident should have had a care plan meeting. The facility had been trying to develop a schedule for care plan meetings but there was no system currently in place. During an interview on 11/13/2024 at 1:41 PM, Resident #3 stated their family visited often and would want to be included in any care plan meetings. They also stated even if their family could not attend, they would still want to have a care plan meeting to discuss their money, pain management, and the food. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/13/2024 at 2:05 PM, Director of Nursing #2 stated they were new to the facility and were unaware that care plan meetings were not being held for all residents. They also stated care plan meetings should be held quarterly and with any significant changes, and families should be invited, with a progress note be entered after each meeting. 10 NYCRR 415.11(c)(2) (i-iii)

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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. 49368 Based on observations, interviews, and record review conducted during the Recertification Survey from 11/07/2024 to 11/14/2024, the facility did not ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good grooming and personal hygiene for one (Resident #9) of one resident reviewed for activities of daily living. Specifically, Resident #9 was observed over several days with debris underneath their fingernails, including while eating with their hands. This is evidenced by the following: The undated facility policy Activities of Daily Living, Supporting Policy Statement documented residents will be provided with care, treatments, and services appropriate to maintain or improve their ability to carry out activities of daily living, including that refusals of care and treatments would be documented in the resident's clinical record. Resident #9 had diagnoses including chronic obstructive pulmonary disease (lung disease), arthritis, and dementia. The Minimum Data Set Resident Assessment, dated 08/15/2024, documented that Resident #9 was severely impaired of cognitive function, required substantial/maximal assistance with personal hygiene, had no behaviors, and no rejection of care at the time of the assessment. Review of the current Comprehensive Care Plan, revised 06/06/2024, and the current Kardex (care plan used by Certified Nursing Assistants for daily care) documented Resident #9 had an activities of daily living self-care performance deficit related to activity intolerance and fatigue. Interventions included, but not limited to, supervision and set-up assistance with personal hygiene, to check nail length, and trim and clean nails on bath days and as necessary. The care plans included that Resident #9 could be resistive to care and for staff to reassure, leave, and return in 5 to 10 minutes to try again. Physician's orders, dated 05/15/2024, included for the Licensed Nurse to perform a head to toe skin check with shower every Wednesday evening, to check finger/toenails for cleanliness and length, and to summarize findings in a progress note. Review of nursing progress notes from 10/16/2024 to 11/06/2024 revealed no documentation that Resident #9's fingernails had been checked for cleanliness and length, had been cleaned and trimmed, or that the resident had refused to have their nails cleaned or trimmed for the prior three weeks. During an observation on 11/07/2024 at 8:59 AM, Resident #9 had completed their breakfast. The resident had multiple dirty fingernails on both hands with a dark brown substance underneath. During an observation on 11/12/2024 at 8:28 AM, Resident #9 continued to have multiple dirty fingernails on both hands with a dark brown substance underneath. The resident was eating toast with their hands at the time. There was no soap dispenser or hand sanitizer available in the resident's room. During an observation on 11/13/2024 at 9:31 AM, Resident #9 continued to have multiple dirty fingernails on both hands with a dark brown substance underneath. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/14/2024 at 10:22 PM, Director of Nursing #2 stated the Certified Nursing Assistants should be cleaning their nails as needed with morning and evening care if they are dirty. During an interview on 11/14/2024 at 10:45 AM, Certified Nursing Assistant #1 stated that Resident #9's fingernails were cleaned on their shower day (Wednesday evenings) and in between during regular care. Certified Nursing Assistant #1 said the resident can be mean at times and give the staff a hard time, and that the resident is known to put their hands in their bowel movement and spread it around, and that would be the brown debris underneath their nails. During an interview on 11/14/2024 at 10:50 AM, Licensed Practical Nurse Manager #1 stated the Certified Nursing Assistants were responsible for cleaning residents' nails. During a record review at this time with the surveyor, Licensed Practical Nurse Manager #1 was unable to show any documentation in the electronic health record for the summary of findings for fingernail cleanliness and length. Review of Resident #9's electronic medical record for the prior 2 weeks did not include any documented evidence that the resident had refused nail care. 10 NYCRR 415.12(a)(3)

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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. 47642 Based on observations, interviews, and record review conducted during the Recertification Survey from 11/07/2024 to 11/14/2024, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for one (Resident #178) of three residents reviewed for nutrition/hydration and one (Resident #178) of one resident for pressure injury. Specifically, the facility did not ensure the resident received the highest practical, physical, mental and psychosocial wellbeing, including maintaining adequate hydration status and ensuring interventions to promote pressure ulcer injury healing. This is evidenced by the following: Resident #178 was recently admitted with diagnoses that included a stroke and hemiparesis (weakness or the inability to move on one side of the body), a history of falls, and a compression fracture of the lower back. The Minimum Data Set Resident Assessment, dated 11/01/2024, documented the resident had moderately impaired cognition, clear speech, and was able to communicate their needs. The facility policy Pressure Injury Risk Assessment. revised March 2020, included that a resident's risk factors that increase a resident's susceptibility to pressure injury included, but were not limited to malnutrition, hydration deficits, impaired/decreased mobility, and the presence of existing pressure injury. In a document titled Calvado Care, dated 11/05/2024, Nurse Practitioner #1 documented that Resident #178 was at risk for malnutrition based on the resident's medical record and dietary assessment. Review of Resident #178's current Comprehensive Care Plan revealed the following: -Initiated on 11/02/2024, the resident required extensive assist of staff for bed mobility and, initiated on 11/04/2024, the resident required limited assist of staff for eating. -Initiated on 11/04/2026 and 11/06/2024, the resident was at risk for fluid deficit and malnutrition with a goal to be free of dehydration and to maintain weight. Interventions included to monitor intake and record every meal. -Initiated 11/01/2024 and 11/05/2024, the resident had a stage 3 (full thickness tissue loss) pressure injury to the coccyx (buttock) region related to immobility. Interventions included to turn and position every 2 hours while in bed, and to off-load from surface with use of pillows (relieve pressure from the coccyx pressure injury). Review of the Kardex (a care plan used by Certified Nursing Assistants to provide daily care) included that the resident needed 1 to 2 person assist with turning in bed, to turn and position every 2 hours while in bed, and to off load from surface with use of pillows. Additionally, if resident resists with activities of daily living, reassure resident, leave, and return 5 to 10 minutes later to try again. Review of Resident #178's Physician orders, dated 11/01/2024, revealed to turn and position every 2 hours while in bed, every 1 hour when in chair, and use pillows to off-load weight. On 11/04/2024, Glucerna (nutritional supplement) 237 millimeters with meals was ordered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observations on 11/12/2024, Resident #178 was eating breakfast in bed and stated they had difficulty swallowing. The resident took a few bites of yogurt and a few sips of ginger ale and Glucerna. At 1:36 PM, the resident was eating lunch and stated the food was making them nauseated and they could not eat. During observations on 11/13/2024 at 8:52 AM, Resident #178 was eating breakfast in bed and only a few bites of food had been consumed. At 9:27 AM, the resident's tray with only a few bits consumed was removed. Review of the fluids consumed task documentation in the resident electronic medical record, dated 11/03/2024 to 11/13/2024, revealed out of 32 meal opportunities, 18 meals had no fluid intakes documented, including five days with no fluid intake recorded for the entire day. Review of the 'nourishment' (Glucerna) consumed for the same time period included 18 of 32 meal opportunities were not documented as having received any of the supplement. During an interview on 11/13/2024 at 8:54 AM, the Registered Dietician stated the documentation (resident's intakes) was sparce. In a progress note, dated 11/06/2024, the Wound Physician documented all wounds (including the pressure injury on the coccyx area) showed signs of healing. In a progress note, dated 11/11/2024 ,Director of Nursing #2 documented the stage 3 pressure injury on the resident's coccyx had changed appearance and had a black wound bed (signs of dead tissue). During observations on 11/12/2024 at 8:52 AM, 1:09 PM, and 3:04 PM, Resident #178 remained in bed on their back with no off-loading of the coccyx wound. During observations on 11/13/2024 at 8:52 AM, 9:46 AM, and 1:29 PM, Resident #178 remained in bed on their back with no off-loading of the coccyx wound. During an interview on 11/13/2024 at 9:46 AM, Resident #178 stated it had been a long time since anyone had turned (repositioned) them. In Resident #178's Treatment Administration Record, dated 11/01/2024 to 11/14/2024, several Licensed Practical Nurses had documented that Resident #178 was turned and repositioned every two hours while in bed during their shift (including 11/12/24 day shift). On 11/13/2024, the day shift was left blank. No refusals were documented. During an interview on 11/13/2024 at 3:25 PM, Certified Nursing Assistant #2 stated Resident #178 did not like to be on their side, or to be off-loaded (pillow placed under hips). Certified Nursing Assistant #2 said that the resident refused breakfast that morning and only had a few bites of lunch. Certified Nursing Assistant #2 stated they usually let the nurse know when Resident #178 refused any care and would then document this in the electronic medical record under tasks. During an interview on 11/13/2024 at 3:37 PM, Licensed Practical Nurse #1 stated Resident #178's coccyx wound looked worse possibly from not eating enough and not moving. (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 11/13/2024 at 4:14 PM, License Practical Nurse Manager #1 stated Resident #178 was not eating and refused care, and the nurses and Certified Nursing Assistants should document all refusals. During an interview on 11/13/2024 at 10:18 AM, Director of Nursing #2 stated Resident #178's coccyx wound looks worse and now has eschar (dead tissue) that was not present last week. Director of Nursing #2 stated intakes should be documented after every meal, including refusals, and the nurses should be made aware of refusals. Additionally, they stated turning and positioning should be done and documented every 2 hours as ordered, and refusals brought to the nurse for further follow-up. 10 NYCRR 415.12

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. 49368 Based on observations, interviews, and record review conducted during the Recertification Survey from 11/07/2024 to 11/14/2024, the facility did ensure the nurse staffing information was posted on a daily basis. Specifically, the nurse staffing information was not posted at the beginning of each shift and was not posted on weekends per the regulations. This is evidenced by the following: During observations on 11/08/2024 at 9:02 AM, 9:58 AM, 11:38 AM, and 1:12 PM, the nurse staffing information sheet was dated 11/07/2024. During an interview on 11/08/2024 at 1:26 PM and on 11/14/2024 at 9:52 AM, Receptionist #1 stated they were responsible for completing and posting the nurse staffing sheets including the resident census and had been since 2022. Receptionist #1 stated they complete the staffing sheets for the weekend (Saturday and Sunday) on the following Monday morning by looking back to see who worked Saturday and Sunday. Receptionist #1 stated the nurse staffing sheet was posted late on 11/08/2024 because the facility was supposed to get a new admission that day and they wanted to wait to change the census, but the resident did not come into the facility. Receptionist #1 stated they were trained by the previous Receptionist (who was a Certified Nursing Assistant), not by nursing leadership or administration, and they were not aware of the process for the weekend staffing posting, and no one has checked to see if they were doing it correctly. During an interview on 11/14/2024 at 10:28 AM, Director of Nursing #2 stated they were not aware of the process for positing the nurse staffing information on the weekends as it was taken care of by the Receptionist. Director of Nursing #2 stated the nurse staffing should be posted at the beginning of the shift and updated with any changes throughout the day including Saturday and Sunday. 10 NYCRR 415.13

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 46880 Based on observations, interviews, and record review conducted during the Recertification Survey from 11/07/2024 to 11/14/2024, for one (Resident #13) of four residents reviewed, the facility did not ensure that the resident's menus items containing dietary recommendations were followed. Specifically, Resident #13 did not receive multiple food items as listed on their tray ticket during mealtime and refused 100% of their meal without staff intervention to assist and encourage them. This is evidenced by the following: Resident #13 had diagnoses that included vascular dementia, depression, and anxiety. The Minimum Data Set Resident Assessment, dated 08/03/2024, documented the resident was severely impaired cognitively, did not exhibit behaviors or rejection of care at the time, and required supervision or touching assistance with eating. The current Comprehensive Care Plan, revised on 07/11/2024, and the current Kardex (care plan used by the Certified Nursing Assistants for daily care) documented Resident #13 had a potential nutritional problem and was at risk for malnutrition related to adult failure to thrive, depression, dementia, and a history of weight loss. The goal for the resident was to consume more than or equal to 51% of meals. Staff interventions included set-up help for eating, providing the resident's diet as ordered, providing fortified pudding three times daily, encouraging resident to drink fluids of choice, and encouraging the resident to eat in the dining room with their peers as accepted. During an observation on 11/12/2024 at 8:17 AM, Resident #13 was observed sitting in a chair in their room with breakfast in front of them. Their meal was untouched and their tray card (description of therapeutic diet items the resident should receive and/or their preferences) indicated the resident should have received four ounces of fortified pudding and two (approximately four ounces) mighty shakes (nutritional supplements). There was no fortified pudding on their tray and there was only one mighty shake. Resident #13 reached for the one mighty shake to drink more but the container was empty. During an observation and interview on 11/12/2024 at 8:35 AM, Certified Nurse Assistant #3 collected Resident #13's meal tray. The resident had had not eaten any of their meal other than the one mighty shake and had not been encouraged or offered assist by staff to eat. During an interview at this time, Certified Nurse Assistant #3 stated that if a resident's tray card had two mighty shake drinks indicated and fortified pudding, the resident should have what was ordered. Certified Nurse Assistant #3 stated they had not offered the resident the missing items. (continued on next page)

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	335825	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Brook at High Falls Nursing Home and Rehab Ctr	2150 St Paul Street Rochester, NY 14621

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/12/2024 at 8:41 AM, with the Registered Dietician and the Food Service Director, the Registered Dietician stated they had recently spoken with Resident #13 about their weight loss and asked if they could accommodate them with items of their preference, but the resident had not been interactive and offered no feedback. The Registered Dietician also stated they had not contacted the resident's family, and it was likely they were unaware the resident had experienced weight loss. Additionally, the resident's therapeutic diets (fortified foods and nutritional shakes) were their responsibility. The Food Service Director stated the kitchen staff were aware they had overlooked some of the residents who should have received fortified pudding, but they did not know which residents were missed. The Food Service Director also stated the kitchen staff were moving fast, and did not realize Resident #13 only received one mighty shake. During an interview on 11/12/2024 at 9:03 AM, Certified Nurse Assistant #3 stated they should have encouraged Resident #13 to eat when they saw they had not touched their meal, but the resident had wandered. During an interview on 11/12/2024 at 9:10 AM, Director of Nursing #2 stated if a resident was ordered to have fortified foods, they should receive what was ordered and if the resident had declined their entire meal tray, staff should encourage them. They also stated Certified Nursing Assistants should notify the nurse (if a resident did not eat everything). 415.14(c) (1-3)

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 45200 Based on observations and interview conducted during a Recertification Survey completed from 11/07/2024 to 11/14/2024, the facility did not safeguard resident medical record information against loss, destruction, or unauthorized use. Specifically, resident medical records were stored in damaged boxes and in a room that was unlocked. The findings are: Observations on 11/07/2024 at 11:50 AM included pallets of damaged boxes of records stored in the unlocked basement electrical room. Observations on 11/13/2024 at 10:55 AM included pallets of multiple damaged boxes of records (including, but not limited to, resident medical, billing, and discharge records) were stored in the basement electrical room. Additionally, the boxes were observed to be stacked two high and were falling over with many of the boxes in the pile badly damaged with files protruding. Some of the boxes were observed to have water damage and there was a pile of loose resident files stacked on other boxes. The door to this room was not locked. During an interview on 11/13/2024 at 11:08 AM, the Regional Director of Nursing was shown the area and the records, then verified that these were resident records and they should not be stored there. 10 NYCRR: 415.29, 415.22, 415.22(c)

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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. 46880 Based on observations, interviews, and record review conducted during a Recertification Survey from 11/07/2024 to 11/14/2024, the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of infection. Specifically, for one of one dining room reviewed during a meal, a staff member was observed making direct contact with a resident's food without applying gloves and did not perform hand hygiene after touching used meal trays and utensils prior to touching unused meal trays and meal set-up for multiple residents. For one of one laundry room, a laundry staff was observed handling soiled potentially contaminated linen without wearing appropriate personal protective equipment that included gowns. Additionally, the facility did not ensure the Infection Prevention and Control Program policies and procedures were reviewed at least annually as required. This is evidenced by the following: 1. The facility's Handwashing and Hand Hygiene policy, revised August 2019, documented that hand hygiene was considered the primary means to prevent the spread of infection. Use of an alcohol-based hand rub containing at least 62% alcohol or soap and water should be used before and after eating and handling food, and before and after assisting a resident with meals. During an observation on 11/12/2024 at 1:11 PM, Certified Nursing Assistant #2 picked up a resident's bread and applied butter with their bare hands. Certified Nursing Assistant #2 then touched used meal trays and equipment and, without performing hand hygiene, passed unused trays to other residents touching equipment. During an interview at this time, Certified Nursing Assistant #2 stated they should wear gloves when directly touching the resident's food, but did not have gloves readily available in their pocket. During an interview on 11/12/2024 at 1:31 PM, Director of Nursing #2 stated staff should never directly touch food with their bare hands. The Director of Nursing also stated staff should wear gloves to help meal set-up, and handwashing or hand sanitizing should be done in between helping residents. 2. The facility policy titled Infection Prevention and Control Program, last revised in August 2016, did not include the requirements for laundry staff when handling, storing, processing, and transporting linens and laundry, including soiled linens. During an observation on 11/12/2024 at 11:28 AM, Laundry Attendant #1 placed soiled linen in the washer wearing gloves but no gown. Laundry Attendant #1 stated they did not use gowns and were not sure where gowns were kept. Laundry Attendant #1 also stated if linen was in a red biohazard bag, which were used to collect contaminated laundry, they would wash the items separately, but only wore gloves to handle the laundry. During an interview on 11/14/2024 at 9:49 AM, Laundry Attendant #1 stated they had not been educated by the facility to wear a gown. (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 interview on 11/14/2024 at 10:10 AM, the Infection Preventionist stated they did not know the process at the facility for washing soiled clothing and linens, but laundry staff should be wearing protective gowns when handling soiled linens. The Infection Preventionist also stated they did not know the laundry room did not have gowns to use. During an interview on 11/14/2024 at 10:15 AM, Director of Nursing #2 stated they would expect laundry staff to wear protective gowns when handling soiled linen and did not know laundry staff did not have access to gowns. 3. Review of 15 various Infection Prevention and Control Program facility policies revealed all policies were last reviewed and/or revised in 2008, 2016, and 2022. The policy titled Infection Prevention and Control Program was last revised August 2016 and the Enhanced Barrier Precautions policy was undated. During an interview on 11/14/2024 at 12:44 PM, the Director of Nursing stated they did not know how often the infection control policies were reviewed or updated, but they did not consider polices revised in 2008, 2016, and 2022 as annually (per the regulations). During an interview on 11/14/2024 at 1:39 PM, the Regional Director of Nursing stated the Infection Prevention and Control Polices provided were the most current, revised, and up-to-date polices they had. 10 NYCRR 415.19(b)(4) & 415.19(c)

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide bedrooms that don't allow residents to see each other when privacy is needed. 49368 Based on observations, interviews, and record review conducted during the Recertification Survey from 11/07/2024 to 11/14/2024, the facility did not ensure all resident rooms were equipped with privacy curtains which extended around the bed to provide total visual privacy in combination with adjacent walls and curtains for two (Residents #9 and #15) of two residents reviewed. Specifically, privacy curtains were not present in two semi-private rooms both occupied with two residents. This is evidenced by the following: 1. Resident #15 had diagnoses including congestive heart failure, depression, and diabetes. The Minimum Data Set Resident Assessment, dated 09/20/2024, documented the resident was moderately impaired of cognitive function. During observations on 11/08/2024 at 1:12 PM, 11/12/2024 at 8:27 AM, 11/13/2024 at 9:22 AM, and 11/14/2024 at 10:05 AM, Resident #15's, double occupancy room did not have a privacy curtain in place. During an interview on 11/08/2024 at 1:19 PM, Resident #15 stated there had not been a curtain since they had been in that room, they like their privacy, and having the curtain hung would help them to receive privacy as they do not want their roommate or others seeing them getting care or without their clothes on. During an interview on 11/13/2024 at 9:22 AM, Resident #15's (whose door was open) stated they really do not like their door open because everyone can see in and it was nobody's business (what they were doing). Resident #15 also stated they would prefer to have their door closed for privacy since the curtain has been down for a few weeks and were told it was being washed. 2. Resident #9 had diagnoses including depression, schizophrenia, and anxiety. The Minimum Data Set Resident Assessment, dated 08/15/2024, documented the resident was severely impaired of cognitive function. During observations on 11/08/2024 at 11:42 AM, 11/12/2024 at 8:28 AM, and 11/13/2024 at 9:31 AM, Resident #9's double occupancy room did not have privacy curtains in place while the resident was in their bed with their door open and the room visible from the hallway. During an interview on 11/12/2024 at 12:47 PM, Resident #9 stated the curtain was taken down to get washed, but they liked their privacy and would like the curtain back up. During an interview on 11/13/2024 at 9:34 AM, Certified Nursing Assistant #1 stated that privacy curtains were not hung in some bedrooms because the bedrooms were being refurbished. They also stated when they asked housekeeping to put the privacy curtains back up, housekeeping said they did not know where the curtain hooks were. Certified Nursing Assistant #1 pointed to a black garbage bag in an alcove by equipment and stated the curtains were right there. During an interview on 11/13/2024 at 9:50 AM, Licensed Practical Nurse Manager #1 stated that the privacy curtains were taken down to be washed about a week and a half ago and were unaware that they were sitting in the alcove. (continued on next page)

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/13/2024 at 1:58 PM, Director of Nursing #2 stated they had taken all privacy curtains down to have them all washed due to a family member complaining of a soiled one, they had asked maintenance to put the curtains back up, and had reached out to the Administrator and reminded them that no one had put the privacy curtains back up. 10 NYCRR 415.29