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	01/16/2026

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

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility did not ensure it established and maintained an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for seven (7) of nine (9) residents (Residents #1, #2, #12, #18, #21, #25, and #33) and one (1) of one (1) residential unit reviewed. Specifically, staff were observed performing wound care for Resident #1 and touching environmental surfaces without appropriate glove changes and hand hygiene. For Residents #2, #18, #21, #25, and #33 medications were prepared and handled by a licensed nurse with their bare hands. For Residents #2, #12, #18, #21, #25, and #33 a reusable blood pressure monitoring device was not cleaned and disinfected between residents; Resident #33 was on enhanced barrier precautions (an infection control strategy that uses gloves and gowns during high contact resident care to reduce the spread of infection). Additionally, there were multiple resident rooms observed without hand hygiene supplies readily available and soiled linen bin were observed uncovered on multiple occasions. The findings include: The facility policy Handwashing/Hand Hygiene dated August 2019 included hand hygiene products and supplies, including soap and alcohol-based hand rub, shall be readily accessible and convenient for staff use. Hand hygiene should be performed before and after direct contact with residents' blood or bodily fluids and after removal of gloves. Wearing artificial fingernails was strongly discouraged among staff members with direct resident-care responsibilities. The facility policy Administering and Storage of Medications dated 12/13/2025 included staff should follow facility infection control procedures, including handwashing, antiseptic techniques, and glove use. The facility policy Cleaning and Disinfection of Resident-Care Items and Equipment dated July 2014 included reusable resident care equipment would be decontaminated between residents. Issue #1:During an observation on 01/12/2026 at 9:26 AM, there was no soap dispenser located in the bathroom of room [ROOM NUMBER].here was no soap dispenser located in the bathroom of room [ROOM NUMBER]. During an observation on 01/13/2026 at 8:32 AM, there was no soap dispenser located in the bathroom of room [ROOM NUMBER]. During intermittent observations on 01/12/2026 and 01/13/2026 from 7:30 AM to 3:30 PM, there were no alcohol-based hand sanitizer dispensers available on the unit. During an interview on 01/14/2026 at 7:20 AM, Certified Nursing Assistant #3 stated they carry hand sanitizer in their pocket because hand sanitizer was not readily available, and not all rooms had soap dispensers. During an interview on 01/14/2026 at 7:22 AM, Certified Nursing Assistant #4 stated they carry hand sanitizer in their pocket, use the sanitizer on the medication cart, or use a bathroom with a soap dispenser to wash their hands. During an interview on 01/16/2026 at 8:42 AM, the Infection Preventionist stated staff should not keep hand sanitizer in their pockets due to the risk of cross contamination. Issue #2:During an observation on 01/14/2026 at 8:45 AM, Licensed Practical Nurse #1 prepared medications for Resident #25. Licensed Practical Nurse #1 opened a stock (medications used for more than one resident) bottle of Vitamin D, poured tablets into the palm of their bare hand, dropped two tablets into a medication cup, and poured the remaining tablets back into the bottle. Licensed Practical Nurse #1 then removed tablets from blister packs of oxybutynin, losartan, and fluoxetine by pushing the tablets through the packaging and (continued on next page)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	pulling them out with their fingernails before placing them into the medication cup. Licensed Practical Nurse #1 placed a hand-held electronic blood pressure device in the resident's bed to obtain a blood pressure reading. The device was returned to the medication cart without cleaning. Licensed Practical Nurse #1 then handled the medications in the cup with their fingernails, removed the losartan, and administered the remaining medications. During an observation on 01/14/2026 at 9:01 AM, Licensed Practical Nurse #1 prepared medications for Resident #2 by pouring medications into their bare hand, returning unused tablets to stock bottles, removing blister-pack medications with fingernails, and using the same hand-held blood pressure device without cleaning it between residents or before returning it to the medication cart. During an observation on 01/14/2026 at 9:18 AM, Licensed Practical Nurse #1 used the same hand-held electronic blood pressure device to obtain vital signs for Resident #12 while the resident was in a wheelchair in the hallway. The device was returned to the medication cart without cleaning. During an observation on 01/14/2026 at 9:50 AM, Licensed Practical Nurse #1 prepared medications for Resident #33 using the same practices. The hand-held blood pressure device was placed in the resident's bed and returned to the medication cart without cleaning. Resident #33 was on enhanced barrier precautions. During an observation on 01/14/2026 at 10:19 AM, Licensed Practical Nurse #1 used the same hand-held electronic blood pressure device for Resident #18 and returned it to the medication cart without cleaning. During an interview and observation on 01/14/2026 at 10:28 AM, Licensed Practical Nurse #1 stated the facility did not have a mobile vital sign machine and they were using personal vital sign equipment. Licensed Practical Nurse #1 stated the blood pressure cuff and machine were not cleaned between residents. Licensed Practical Nurse #1 stated handling medications with their hands was how they usually prepared medications, and they sanitized their hands between residents. When observed at that time, Licensed Practical Nurse #1's fingernails were approximately two (2) inches in length with visible dark debris underneath. During an interview on 01/16/2026 at 8:42 AM the Infection Preventionist stated medications should be popped directly into a medication cup or poured from a bottle lid into the cup. The Infection Preventionist stated staff should not touch pills with bare hands or fingernails, returning pills from hands to stock bottles could contaminate the entire bottle, long fingernails can harbor germs, and vital sign equipment should be cleaned between each resident regardless of precautions. Issue #3:During an observation on 01/14/2026 at 8:20 AM, the Director of Nursing, while wearing gloves, sprayed wound cleanser onto adhered dressings on Resident #1's right heel and right ankle and removed both dressings using the same pair of gloves. The Director of Nursing removed gloves and exited the room to gather supplies. Upon return, the Director of Nursing wore gloves and cleansed both wounds using the same pair of gloves. The Director of Nursing changed gloves and applied betadine to the right heel, then applied Medi-honey (a wound care treatment) to a dressing base by touching the inside of the dressing with a gloved hand and applied dressings to both wounds. Without changing gloves or performing hand hygiene, the Director of Nursing pulled up the resident's blankets, touched items on the over-bed table, opened window blinds, touched the door handle when exiting the room, and placed resident-care supplies on the treatment cart. During an interview on 01/16/2026 at 8:42 AM the Infection Preventionist stated touching environmental surfaces with gloves used for wound care increases the risk of cross contamination. Issue #4:During observations on 01/12/2026 at 9:47 AM and 12:48 PM, 1/13/2026 at 11:48 AM, and 01/16/2026 at 8:01 AM and 9:47 AM, the dirty linen bins located in the hallway across from room [ROOM NUMBER] were uncovered and contained soiled linens. During an interview on 01/16/2026 at 8:42 AM, the Infection Preventionist stated dirty linen bin lids should remain closed to control odors and germs and stated they are constantly closing the lids. 10 NYCRR 415.19

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on interview and record review, the facility did not ensure residents exercised their rights without interference, coercion, discrimination, or reprisal from the facility for one (1) of five (5) residents reviewed (Resident #4). Specifically, the facility did not ensure changes in Resident #4's Medicare health coverage were initiated by the resident or the resident's authorized representative, and did not ensure the resident and/or responsible party received required oral and written explanations regarding the impact of changing Medicare coverage.The findings include: The Centers for Medicare and Medicaid Services (CMS) undated publication Your Rights and Protections as a Nursing Home Resident requires nursing homes to inform residents of their rights and explain those rights orally and in writing in a language the resident understands. The Centers for Medicare and Medicaid Services Memo to Long Term Care Facilities on Medicare Health Plan Enrollment, dated October 2021, states only a Medicare beneficiary, the beneficiary's authorized or designated representative, or a party authorized to act on behalf of the beneficiary under state law may request enrollment in or voluntary disenrollment from a Medicare health or drug plan. Changes in Medicare health coverage generally must be initiated by the beneficiary or the beneficiary's representative. Facilities must explain orally and in writing the impact to the beneficiary if coverage is changed. At a minimum, explanations must include:-A clear explanation, where applicable, the beneficiary would no longer be a member of the Medicare health plan;-An explanation medical services would be billed to Original Medicare and/or Medicaid, including deductibles, co-payments, and coinsurance obligations, and the absence of supplemental coverage;-The name of the prescription drug plan covering medications, including deductibles and co-payments/coinsurance, particularly related to the resident's current drug therapy; and-Information regarding opportunities to change Medicare health plans and prescription drug coverage while residing in the facility and following discharge. The facility policy Resident Health Care Coverage Changes and Disenrollment from Health Maintenance Organizations (HMOs), reviewed 08/20/2025, states the facility shall not require, coerce, or improperly influence a resident to enroll in, disenroll from, or change any health care coverage plan. The policy requires coverage changes be resident-initiated or legally authorized, fully informed, documented, and compliant with federal and state regulations. The policy further states residents have the right to choose, retain, or change health care coverage without interference and must receive clear, unbiased information regarding available options. The policy specifies the facility may not initiate coverage changes unless the resident or legally authorized representative provides explicit written consent, and any facility assistance must be strictly administrative. The policy prohibits recommending disenrollment for facility convenience, misrepresenting coverage limitations, or applying pressure, and requires documentation of the resident or representative request, education provided regarding potential impacts, written consent when applicable, and actions taken by facility staff. Resident #4 had diagnoses including cerebral infarction (stroke) with hemiparesis (one sided muscle weakness), diabetes mellitus, and chronic kidney disease. The Minimum Date Set (a resident assessment tool), dated 11/24/2025, documented the resident had moderate cognitive impairment and did not have a Medicare-covered stay since the most recent entry. Addendum VII, Authorization for Legal Representantion (sic) for Medicare Part D, dated 11/13/2025, documented the sister facility Business Office Manager recorded verbal authorization over the phone from Resident #4's responsible party at 1:40 PM for the facility Administrator to act as a limited legal representative for Medicare Part D. The authorization applied only to Medicare Part D, was valid only during the resident's stay at the facility, and included enrollment and plan changes, insurance transactions, and claims and litigation. During a telephone interview on 01/15/2026 at 9:55 AM, Resident #4's responsible party stated they received a telephone call from facility staff on 11/13/2025 indicating it was important to allow the facility to change Resident #4's insurance coverage because more services would be (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	covered. The responsible party stated they were not advised of deductibles, co-payments, or reenrollment rights and did not receive written information regarding the impact of the coverage change. During a telephone interview on 01/15/2026 at 10:16 AM, Business Office Manager #2 (from a sister facility) stated Resident #4 was initially admitted to their facility and later transferred. The Business Office Manager stated they contacted Resident #4's responsible party on 11/13/2025 to discuss changing insurance coverage to Original Medicare, stating Managed Medicare Plans typically cover skilled services for 10-14 days, while Original Medicare provides additional benefit days. The Business Office Manager stated the facility does not want the payor source to change to Medicaid because Medicaid is a lower reimbursement source. The Business Office Manager further stated residents admitted with Managed Medicare Plans are approached to explain the disenrollment process to allow residents to receive additional coverage days. During an interview on 01/15/2026 at 11:34 AM, Business Office Manager #1 stated the facility approaches all residents and/or responsible parties enrolled in Managed Medicare Plans to discuss disenrollment from their current health coverage. The Business Office Manager stated Original Medicare is explained as offering 100 benefit days without the constraints of Managed Medicare Plans. The Business Office Manager confirmed written information regarding the impact of coverage changes is not provided to residents or responsible parties. During an interview on 01/15/2026 at 12:02 PM, the Administrator stated when the facility becomes aware a resident may require a longer stay than their insurance will cover, the facility offers residents and/or responsible parties the option to disenroll from their current insurance coverage and enroll in Original Medicare. During a follow-up interview on 01/16/2026 at 12:07 PM, the Administrator stated the facility informs residents and/or responsible parties their current insurance coverage is ending and makes them aware of another option. 10 NYCRR 415.3(d)(1)(i)

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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** Based on observation and interview, the facility did not ensure housekeeping and maintenance services were provided to maintain a sanitary, orderly, and comfortable interior for one (1) of one (1) resident use floor and one (1) of one (1) kitchen. Specifically, the facility did not ensure interior spaces were maintained free from unsanitary conditions and environmental hazards, as evidenced by damaged, jagged, or missing radiator covers; a dirty bathtub with a non-functioning lift chair; wall damage; a non-functional fan used for air drying dishes; cracked light lenses and missing end caps above the kitchen tray line; a damaged ice machine lid with exposed ice; and dirty floors and surfaces in resident rooms.The findings include: During observations in the main kitchen on 01/12/2026 from 8:50 AM to 9:05 AM, a wall-mounted fan in the dish room was not functional. Multiple racks of dishes recently cleaned in the dishwashing machine were stored nearby. During an immediate interview, the Head [NAME] stated they were not sure what happened, and the fan had not worked for approximately one month. Additionally, a large section of blue wallpaper behind the gas range was peeling, and multiple areas of brown splattered material were observed on the wall. During an observation on 01/12/2026 at 9:11 AM, the reach-in bin-style ice-making machine located in the employee break room did not have a cover, leaving an approximately two (2)-foot by one (1)-foot opening exposing ice within the bin. The broken cover was lying on top of the bin. The back interior of the ice machine near the drip tray had dark residue appearing to be mildew. During an observation on 01/12/2026 at 9:29 AM, the base of the radiator cover near the floor in the hallway outside Resident room [ROOM NUMBER] was jagged and sharp. During an observation on 01/12/2026 at 9:42 AM, a floor-level radiator was missing an approximately four (4)-foot-long section of cover, exposing metal radiator fins. During an observation on 01/12/2026 at 9:55 AM, the floor in Resident room [ROOM NUMBER] had multiple areas of dirty dried debris. The walls and light switch also had areas of brown dried debris. Observation on 01/12/2026 at 10:24 AM revealed the floor in Resident room [ROOM NUMBER] had multiple areas of dirty dried debris. During an observation on 01/12/2026 at 11:39 AM, the baseboard of the heater in Resident room [ROOM NUMBER]'s bathroom was separated from the wall, with the cover not fully in place. There was no garbage can present in the bathroom. During an observation on 01/12/2026 at 3:17 PM, the floor-level radiator behind the door-side bed in Resident room [ROOM NUMBER] was missing a cover, exposing multiple damaged metal radiator fins.During an observation on 01/13/2026 at 12:55 PM, 10 fluorescent tube light bulbs directly above the main tray line and throughout the kitchen had plastic sleeves that were partially cracked and missing end caps. During an observation on 01/14/2026 at 8:49 AM, there was dried debris, hair, and residue at the bottom of the bathtub in the shower room. The lift chair for the tub did not function when tested by the Director of Maintenance. The bathtub was one (1) of two (2) bathing fixtures available throughout the facility. During an immediate interview, the Director of Maintenance stated the tub should be usable, but they were not aware of any residents currently using it. 10 NYCRR: 415.29, 415.29(b), 415.29(i)(1), 415.29(j)(1),10 NYCRR: Subpart 14-1, 14-1.171, 14-1.188(c)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, interview, and record review, the facility did not ensure the resident environment remained free of accident hazards for one (1) of one (1) resident use floor. Specifically, hot water exceeding 120 degrees Fahrenheit (F) was accessible to residents at point of use, creating a risk for scalding.The findings include: The undated facility policy Water Temperatures, Safety of included tap water in the facility shall be maintained within a temperature range to prevent scalding of residents. The policy specified water heaters servicing resident rooms, bathrooms, common areas, and tub/shower areas shall be set to maintain temperatures between 90 and 120 degrees Fahrenheit. On 01/12/2026 at 9:20 AM, the surveyor's [NAME] brand thermocouple was checked for proper calibration in the main kitchen using the ice-point method and read 32.6 degrees Fahrenheit. During observation on 01/12/2026 from 9:35 AM to 9:56 AM, hot water temperatures from resident-accessible bathroom and shower room sinks exceeded 120 degrees Fahrenheit as follows: -room [ROOM NUMBER]: 124.0 degrees Fahrenheit-room [ROOM NUMBER]: 125.1 degrees Fahrenheit-room [ROOM NUMBER]: 122.8 degrees Fahrenheit-room [ROOM NUMBER]: 124.5 degrees Fahrenheit-Shower Room: 122.2 degrees Fahrenheit Record review on 01/13/2026 at 03:33 PM of the facility's hot water temperature logs revealed temperatures were documented approximately every three (3) to seven (7) days from 02/25/2025 through 12/18/2025. The next recorded temperature entry was dated 01/13/2026, indicating no documented monitoring between 12/18/2025 and 01/13/2026. During an immediate interview, the Director of Maintenance stated no hot water temperatures were taken during this period because maintenance staff were assigned to assist at an affiliated facility. 10 NYCRR: 415.12(h)(1), 415.29, 415.29(a), 415.29(f)(6)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility did not ensure medications were stored securely and accessible only to authorized personnel, in accordance with professional standards of practice and State and Federal regulations, for one (1) of one (1) residential unit reviewed. Specifically, the facility stored medications in an unsecured and frequently opened soiled linen room being used as a temporary medication room during renovations. Medications stored in this area were accessible to residents, visitors, and non-authorized staff. Additionally, there were unidentified, loose pills found in a medication cart and missing signatures identified on narcotic count sheets for various shifts with no additional evidence of accurate narcotic counts and/or accountability for controlled substances.The findings include: The facility policy Administering and Storage of Medications revised [DATE], included, but was not limited to, medications should be checked monthly in the medication cart and in the overflow room of stock medications for expiration dates. If expired, medications need to be sent back to pharmacy and replaced immediately. During an observation and interview on [DATE] at 11:46 AM, a medication cart (located near the lower room numbers) was found to contain two (2) loose pills lying unsecured in the bottom of the second drawer. The pills were not labeled and were not contained in individual packaging, preventing verification of medication integrity, dose, or intended recipient. When interviewed at that time, Licensed Practical Nurse #1 stated medication carts were checked by nursing staff during their shift and loose pills found in carts would be discarded in a sharps container (specialized, puncture-resistant, and leak-proof containers designed for the safe disposal of needles, syringes, and other medical sharps). During an observation and interview on [DATE] at 12:02 PM, there were multiple medications stored on the top shelf of a three (3)-tiered cart in the temporary medication room (labeled soiled linen room). The room door was unsecured and unlocked. Review of medications included an unopened bottle of Vitamin B with an expiration date of February 2024. When interviewed at that time, Licensed Practical Nurse #1 stated the Nurse Manager usually checks the medication room, the medication must be taken to the Director of Nursing for the discard process and acknowledged it may have been missed during prior checks. During an observation on [DATE] at 12:17 PM, 14 missing signatures were identified on narcotic count sheets during shift changes for various shifts between [DATE] and [DATE]. The facility was unable to provide verification of accurate narcotic counts and accountability for controlled substances on those shifts. When interviewed at that time, Licensed Practical Nurse #1 stated they were not aware why the signatures were missing and suggested staff working double shifts may forget to re-sign. Staffing schedules and time punches were reviewed for this timeframe and did not support double shifts as the cause of the missing signatures. During an interview on [DATE] at 10:35 AM, the Director of Nursing stated nurses on shift were primarily responsible for the medication carts they worked on, and the Director of Nursing checked carts weekly as part of auditing. The Director of Nursing stated the facility was undergoing renovations and awaiting approval from the Drug Enforcement Administration to relocate the medication cabinet. The Director of Nursing stated they were responsible for maintaining medication storage and securing medications in the storage room. The Director of Nursing stated loose pills were discarded in a sharps containers and expired or discontinued medications were returned to the pharmacy. The Director of Nursing stated medications should be locked and medication room doors should remain closed and locked. During an observation on [DATE] from 9:40 AM to 10:00 AM, the medication room door was open and unlocked while staff passed by performing routine tasks without securing the room. 10 NYCRR 415.18(e)(1-4)