STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335863	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/01/2024
NAME OF PROVIDER OR SUPPLIER St John's Penfield Homes		STREET ADDRESS, CITY, STATE, ZIP CODE 65 Sonoma Drive Fairport, NY 14450	

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 39181 Based on observations, interviews, and record review conducted during the Recertification Survey from 09/25/2024 to 10/01/2025, the facility did not develop and implement a baseline care plan (a person-centered care plan that is developed within 48 hours of a resident's admission) for each resident that includes the minimum healthcare information necessary to properly care for the immediate needs of the resident and provides a summary of the baseline care plan in a manner the resident and/or representative could understand. Specifically, Resident #169 was recently admitted to the facility and prescribed high-risk medications (medications that have potential side effects that could cause serious harm or death if used incorrectly), that included an anticoagulant (a medication that prevents or treats blood clots) and a diuretic (a medication used to help the body get rid of excess fluid and salt). The baseline care plan did not address the medications and other required information. Additionally, the Admission Minimum Data Set Resident Assessment (a tool used to evaluate the health needs of each resident and facilitate care management) did not indicate Resident #169 was taking the high-risk medications. This is evidenced by the following: Review of the facility policy and procedure, Care Plan: Baseline (Welcome) Care Plan, dated June 2018, included that a baseline care plan would be developed for each resident who was newly admitted to the facility within 48 hours of admission and include the instructions needed to provide effective and person-centered care. The baseline care plan would, include but was not limited to, initial goals based on admission medical orders and a summary of medical orders. The Social Worker would provide a copy of the baseline care plan and the resident Kardex (includes the basic care to be provided daily) and would request a signature from the resident or representative acknowledging receipt of the baseline care plan. Original documents would be filed in the resident's chart. Resident #169 was recently admitted to the facility with diagnoses including congestive heart failure, atrial fibrillation (irregular heartbeat), and sick sinus syndrome (abnormal heart rhythm) with the presence of a cardiac pacemaker. The Minimum Data Set Resident Assessment, dated 09/15/2024, included the resident was cognitively intact and did not indicate the resident was taking high-risk medications to include an anticoagulant or diuretic. Review of physician's orders, dated 09/09/2024, included both Apixaban (an anticoagulant) and furosemide (a diuretic) to be taken twice daily to treat atrial fibrillation and heart failure. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335863	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St John's Penfield Homes	65 Sonoma Drive Fairport, NY 14450

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a baseline care plan, dated 09/11/2024, did not include a summary of Resident #169's medical orders, any reference to taking an anticoagulant or diuretic, or the instruction needed to provide effective care to a resident with diagnoses of congestive heart failure and atrial fibrillation. Additionally, the comprehensive care plan that was due to be completed within 21 days of admission did not include measurable goals and/or interventions related to the high-risk medications or diagnoses. A progress note, dated 09/11/2024 at 10:41 AM and signed by Social Worker #1, did not include that admission medical orders had been reviewed with Resident #169 or if a summary of the baseline care plan had been provided to the resident or their representative. During a phone interview on 10/01/2024 at 9:05 AM, Social Worker #1 stated the baseline care plan was usually initiated at the time of admission and completed within 24 to 48 hours. The baseline care plan should include the main goals for the resident and each section of the document completed by the respective discipline. Social Worker #1 stated nursing was responsible for entering relevant medical information, including medications. Social Worker #1 said they were certain the baseline care plan had been reviewed with Resident #169, who was cognitively intact, on 09/11/2024, and although the progress note did not include that information, it should have. When reviewed at this time, Social Worker #1 stated Resident #169's baseline care plan had information related to the resident's goals, code status, and allergies, but all other sections of the document were blank. The signature page included Social Worker #1's signature but had not been signed by Resident #169 or their representative. Social Worker #1 stated if a resident was cognitively intact, they should have the resident sign the baseline care plan. Social Worker #1 could not account for why the baseline care plan was not completed or signed by Resident #169. During an interview on 10/01/2024 at 10:04 AM, the Administrator stated they were not aware of concerns related to completion of the baseline care plan, but felt the clinical team discussed the baseline care plan frequently, considering the regulation and need to complete it within the specified timeframe. The Director of Nursing was unavailable for interview. 10 NYCRR 415.11

Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

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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 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.

26883

Based on observations, interviews, and record review conducted during the Recertification Survey completed from 09/25/2024 to 10/01/2024, for one (Cottage #65) of two residential greenhouses, the facility did not store, prepare, distribute, and serve food in accordance with professional standards for food service safety. Specifically, potentially hazardous foods (raw shell eggs) were not being fully cooked, and there were no policies/procedures for maintaining gardens producing foods for residents. The findings are:

Observations on 09/25/2024 at 10:05 AM included Resident #11 (Cottage #65) was served breakfast including a fried egg with a liquid center. Resident #11 was observed to eat 100% of the meal.

Observations on 09/25/2024 at 11:15 AM included containers of Wegmans brand Grade AA large eggs were present in the Cottage #65 kitchen refrigerator. The carton of eggs did not list that they were pasteurized and there was no letter P on any of the eggs in the container.

Observations on 09/25/2024 at 2:18 PM included four 18-count containers of raw shell eggs in the Cottage #65 kitchen refrigerator. Record review of the temperature logbook on the counter revealed a line item for Hot Foods-scrambled and there were no temperatures recorded for eggs on 09/25/2024. During an interview at this time, Shahbaz/Certified Nursing Aide #1 stated that they take the temperature of the outside of the cooked eggs but not the inside, and that Resident #11 just started requesting fried eggs over easy (soft-cooked).

Observations on 09/25/2024 at 10:20 AM included an exterior courtyard between cottages #65 and #75 with gardens that had tomatoes and peppers growing. During an interview at this time, when asked by the surveyor if any of the residents eat vegetables from the garden, Shahbaz/Certified Nursing Aide #2 stated: Yes, some of them do.

On 09/26/2024 at approximately 3:30 PM, the surveyor requested a copy of policies and procedures related to cooking of eggs and the use of garden vegetables for resident consumption. No policies were provided by the facility as of 10/01/2024.

10NYCRR: 415.14(h);

10NYCRR: Subpart 14-1.31(c), 14-1.82(d)

CMS Ref: S&C 14-34-NH