STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335467	A. Building B. Wing	10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crest Manor Living and Rehabilitation Center	6745 Pittsford Palmyra Road 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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 46526 Based on interviews and record review conducted during a Recertification Survey and complaint investigation (ACTS Reference Number: NY00319641), for one (Resident #51) of three residents reviewed, the facility did not ensure that an incident resulting in a major injury was thoroughly investigated in order to rule out potential abuse, neglect, mistreatment, or care plan violation. Specifically, Resident #51 fell while being assisted in the bathroom by a staff member resulting in a patella fracture (broken kneecap). The facility was unable to provide evidence (including, but not limited to, statements from the resident, involved staff members or potential witnesses) that the incident was thoroughly investigated to rule out potential abuse, neglect, mistreatment, or care plan violation. This is evidenced by the following: The undated facility policy Accident and Incident Reporting documented the facility would provide an accurate record of all incidents occurring on the premises involving any resident, staff, vendors, visitors, volunteers, or clinical students. An incident would be any event which was not consistent with the routine operation of the facility or the routine daily pattern of the care of a resident. It may be an accident, a situation which could have resulted in an accident, or an unusual physical finding. Any time where a resident touched the floor (e.g., a fall) an Accident-Incident (A-I) report must be done. The Accident-Incident report is to include the Registered Nurse (RN) assessment, if necessary, based on nursing judgement, on-call medical provider notification, and statements from all staff who were present and will be gathered within 24-48 hours. The charge nurse or supervisor is to complete the report, review it, and forward it to the nurse manager or designee for root cause analysis investigation and care plan updates. Resident #51 had diagnoses that included anxiety, depression, and a history of falling. The Minimum Data Set Resident Assessment, dated 07/09/2024 documented Resident #51 was cognitively intact. The Minimum Data Set Resident Assessment, dated 04/24/2024 (prior to the fall), documented the resident required supervision or touching assistance for toilet transfers and ambulation with a walker. The Comprehensive Care Plan, revised 07/21/2024 (after the fall), documented that Resident #51 was a moderate fall risk related to deconditioning, gait/balance problems and psychoactive drug use. Resident #51 had an actual fall on 07/06/2024, while being assisted by a staff member with their walker, the resident's knees gave out and the resident fell on to their knees resulting in a patella (knee) fracture. During an interview on 10/07/2024 at 10:54 AM, Resident #51 said they fell while in the shower room and sustained a fractured knee cap. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335467	A. Building B. Wing	10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crest Manor Living and Rehabilitation Center	6745 Pittsford Palmyra Road 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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interdisciplinary team progress note, dated 07/06/2024 at 6:06 PM, Licensed Practical Nurse #9 documented that they were alerted to respond to a witnessed fall in a bathroom. Upon entering, Resident #51 was on their knees on the floor. The Certified Nursing Assistant reported that they were attempting to pull the (resident's) brief up and pivot the resident back to their wheelchair when the resident's knees buckled, and the resident fell to the floor. The Director of Nursing was notified, and the resident was assisted to a standing position with the assist of four staff. The medical provider was notified and x-rays were ordered of both knees. In a follow-up progress note at 9:10 PM, Licensed Practical Nurse #9 documented the radiology report was reviewed with the on-call medical provider, an inferior patellar fracture of the left knee was confirmed, and Resident #51 was sent to the emergency room for an orthopedic evaluation. Review of a #2242 Witnessed Fall Report (accident report) in Resident #51's electronic medical record, dated 07/06/2024 and completed by Licensed Practical Nurse #9, revealed that Resident #51 was unable to properly articulate the incident due to complaints of bilateral knee pain, which they rated 10 out of 10. The fall report listed five staff members' names and those statements had been obtained. The fall report did not include the staff members' actual statements, did not identify the Certified Nursing Assistant who was present during the resident's fall, or their statement pertaining to the events of the incident. The fall report did not include the resident's statement. A summary, completed by the Director of Nursing, dated 08/08/2024, documented the resident fell while attempting to transfer in the bathroom, an x-ray revealed a patella fracture, and the resident would follow-up with Orthopedics. During an interview on 10/11/2024 at 2:13 PM, Licensed Practical Nurse Manager #2 said resident-involved incidents that should be investigated included, but not limited to, a resident fall to determine if there was a break from the care plan (care plan not followed). Licensed Practical Nurse Manager #2 stated investigations consisted of obtaining witness statements, measuring a wound, obtaining x-rays, or anything that would be required to find out what happened. Licensed Practical Nurse Manager #2 said they or the nursing supervisor would investigate resident incidents, talk to the resident, and obtain statements from witnesses. Licensed Practical Nurse Manager #2 said everything (information related to the incident) is then given to the Director of Nursing. Licensed Practical Nurse Manager #2 said they were not in the facility at the time of Resident #51's fall on 07/06/2024. During an interview on 10/15/2024 at 8:51 AM, the Director of Nursing said investigations into resident incidents consisted of talking to resident(s) and staff to get statements to find out what happened. The Director of Nursing stated unit managers and nursing supervisors help with the investigations, and if there are any questions, the Director of Nursing interviews staff to determine what occurred. The Director of Nursing stated Resident #51 was in the bathroom with a Certified Nursing Assistant, who was helping the resident pull up their pants (when the resident fell). The Director of Nursing said Resident #51's statement included that they were pulling up their pants when they fell to their knees. The Director of Nursing said a statement was obtained from the involved Certified Nursing Assistant on paper, but they could not find it and the employee was no longer employed by the facility. The Director of Nursing stated it was not a complete investigation without the involved Certified Nursing Assistant's statement and they did not know if the involved Certified Nursing Assistant followed the resident's care plan. 10 NYCRR 415.4(b)(1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335467	A. Building B. Wing	10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crest Manor Living and Rehabilitation Center	6745 Pittsford Palmyra Road 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 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. 49447 Based on observations, interviews, and record review conducted during the Recertification Survey and complaint investigations (NY00354611 and NY00349191), for two (Residents #25, and #53) of seven residents reviewed for activities of daily living, the facility did not ensure that residents who were unable to carry out activities of daily living received the necessary services to maintain good grooming and personal hygiene. Specifically, residents' fingernails were observed unclean and uncut over multiple days. Additionally, Resident #53 was observed eating with their hands while their fingernails remained dirty. This is evidenced by the following. The undated facility policy Care of Fingernails/Toenails included that the purpose was to clean the nail bed, to keep nails trimmed, and to prevent infections. The policy included that nail care included daily cleaning and regular trimming and that the treatment should be documented in the resident ' s medical record. Additionally, the policy included that the supervisor should be notified if the resident refuses the care. 1. Resident #53 had diagnoses that included a stroke with left sided hemiplegia (muscle weakness or partial paralysis on one side of the body), diabetes, and anxiety. The Minimum Data Set Resident Assessment, dated 08/11/2024, documented the resident was moderately impaired cognitively, did not reject care, had an impairment on the left side of the body, and was dependent on staff for assistance with all activities of daily living. Review of the Comprehensive Care Plan, revised on 05/29/2024, and the undated Kardex (a care plan used by the Certified Nursing Assistants to provide daily care) revealed the resident preferred showers, often refused their showers, and if they refused to wait 30 minutes to reapproach, and if refused again offer a bed bath. The Comprehensive Care Plan included that the resident's nails should be observed for debris, appropriate length, and jagged edges weekly on their shower day (scheduled on Monday evenings). Review of Resident #53's electronic medical record revealed no documented evidence of Resident #52 had refused nail care. During an observation on 10/07/2024 at 10:08 AM, Resident #53's fingernails were long and unclean with a dark substance underneath them. During observations on 10/08/2024 at 9:03 AM, 10/09/2024 at 8:49 AM and on 10/10/2024 at 1:20 PM Resident #53 was eating both breakfast and lunch food with their hands. The nails remained unclean with a dark substance underneath them. During an interview on 10/10/2024 at 9:10 AM, Resident #53 stated they had received a shower this week but did not get their fingernails cleaned and would like them cleaned. During an interview on 10/10/2024 at 11:25 AM, Licensed Practical Nurse #4 stated if a resident refused a shower or nail care, staff should reapproach, and that all refusals should be documented. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335467	A. Building B. Wing	10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crest Manor Living and Rehabilitation Center	6745 Pittsford Palmyra Road 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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/10/2024 at 1:43 PM, Certified Nursing Assistant #6 (assigned to Resident #53) stated nail care is completed as needed and on shower day and includes trimming and cleaning. If residents refuse nail care, they should tell the nurses and reapproach the resident to attempt care again later. Nail care that is refused should be documented in the electronic medical record. During an interview on 10/10/2024 at 5:18 PM, Licensed Practical Nurse Manager #2 stated that nail care should be completed during every shower and as needed if there is debris under the nails. Licensed Practical Nurse Manager #2 stated that nail care is important for infection control. 2. Resident #25 had diagnoses that included diabetes, high blood pressure, and end stage kidney disease requiring dialysis. The Minimum Data Set Resident Assessment, dated 07/25/2024, documented the resident was cognitively intact and required assistance with hygiene. Review of the Unit 2 Assignment Sheet included Resident #25's shower day was on Tuesdays during the day shift. Review of the current Comprehensive Care Plan and the Certified Nursing Assistant Kardex included Resident #25 required extensive assistance with grooming. During an observation on 10/07/2024 at 3:05 PM, Resident #25 had long fingernails with dark brown debris under all nails on both hands. During an interview at this time, Resident #25 stated no one has helped them cut or clean their fingernails and their fingernails needed to be trimmed and cleaned. During observations on 10/09/2024 (one day after their shower day) at 11:23 AM and on 10/10/2024 at 9:01 AM, Resident #25's fingernails remained long with dark debris underneath. During an interview on 10/10/2024 at 10:26 AM, Certified Nursing Assistant #7 stated nail care should be done on shower day and as needed. During an interview on 10/10/2024 at 11:13 AM, Licensed Practical Nurse #1 stated they did a skin check for Resident #25 on Tuesday after their shower but did not look at their fingernails or do nail care. During an observations and interview on 10/10/2024 at 11:17 AM, Licensed Practical Nurse Manager #1 stated nail care including trimming and cleaning of any debris under the nails should be completed on shower days and as needed. During an observation at this time, Licensed Practical Nurse Manager #1 stated Resident #25's nails were long and dirty and should have been trimmed and cleaned on their shower day. During an interview on 10/11/2024 at 2:43 PM, the Director of Nursing stated nail care should be done on shower days, when requested, and as needed, and should not be overly long or dirty. 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
	335467	A. Building B. Wing	10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crest Manor Living and Rehabilitation Center	6745 Pittsford Palmyra Road 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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 46526 Based on observations, interviews, and record review conducted during the Recertification Survey and complaint investigation (NY00354611), for one (Resident #2) of one resident reviewed, the facility did ensure the resident's pain was managed to the extent possible in accordance with the comprehensive assessment and plan of care, current professional standards of practice, and the residents goals and preferences. Specifically, Resident #2 did not receive their pain medication as ordered by the physician on multiple occasions. In addition, there was no evidence that the medical team was notified. This is evidenced by the following: The facility policy Pain Assessment and Management, dated revised October 2010, included to assess the resident's pain and consequences of pain at least every shift for acute pain or significant changes in levels of chronic pain, and at least weekly in stable chronic pain. Ask the resident if they are experiencing pain and be aware that the resident may avoid the term pain and use other descriptors such as throbbing, aching, hurting, cramping, numbness, or tingling. The policy included to review the Medication Administration Record to determine how often the individual requested and received pain medication and to what extent the administered medications relived the resident's pain. The undated facility policy Administration of Oral Medications included the administration of medications would be performed following the six rights of medication administration. The right medication would be administered to the right resident in the right dose, at the right time, via the right route, followed by right documentation. Resident #2 had diagnoses that included chronic pain, osteoporosis (disorder in which bones become weak and brittle), and polymyalgia rheumatica (a form of inflammatory arthritis causing muscle and joint pain). The Minimum Data Set Resident Assessment, dated 08/24/2024, revealed Resident #2 was cognitively intact. The Comprehensive Care Plan included that Resident #2 had chronic pain related to arthritis. Interventions included to administer analgesics (medications to relieve pain) as ordered, monitor and report resident complaints of pain to the nurse, and respond immediately to any complaint of pain. Active physician's orders included tramadol 50 milligrams four times a day for pain (start date 09/26/2024). Review of the Medication Administration Record for October 2024 revealed tramadol doses were not documented as administered on the following dates and scheduled times. - 10/07/2024 at 8:00 AM and 12:00 PM - 10/08/2024 at 8:00 AM and 12:00 PM - 10/09/2024 at 8:00 AM - 10/10/2024 at 4:00 PM and 8:00 PM (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335467	A. Building B. Wing	10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crest Manor Living and Rehabilitation Center	6745 Pittsford Palmyra Road 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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Pharmacy Controlled Substance audit list (resident-specific list of medications removed from the Pyxis [automated medication dispensing system that stored medications] which included the names of nurses who removed the medications) revealed no tramadol doses were removed from the Pyxis with corresponding dates and times to the missing doses observed on the October 2024 Medication Administration Record. During an interview on 10/07/2024 at 11:45 AM, Resident #2 stated they had nerve pain in their legs and feet, which they rated at an eight on a scale of zero to ten. Resident #2 stated they were given pain medications that do not help. In Order-Administration notes, dated 10/07/2024 at 9:05 AM and at 1:30 PM, Licensed Practical Nurse #3 documented that Resident #2's tramadol medication had not been delivered, and they were awaiting arrival from pharmacy. Licensed Practical Nurse #3 documented that the pharmacy was contacted, and the nursing supervisor was made aware. There was no documented evidence that the medical provider had been notified that the medication was unavailable. In Order-Administration notes, dated 10/08/2024 at 1:13 PM and 1:15 PM, Licensed Practical Nurse #3 documented that Resident #2's tramadol had been ordered, were awaiting from pharmacy, and the nurse manager was notified. There was no documented evidence that the medical provider had been notified that the medication was unavailable. In a nursing progress note, dated 10/08/2024 at 2:45 PM, Licensed Practical Nurse Manager #2 documented that they called the pharmacy due to the tramadol not being delivered. Licensed Practical Nurse Manager #2 documented that they spoke with pharmacy's Regional Director of Client Services, and a script (order) was sent to the pharmacy. There was no documented evidence that the medical provider had been notified that the medication remained unavailable. During an interview on 10/09/2024 at 10:29 AM, Resident #2 was in bed and stated they had pain in their legs, which they rated between eight and nine out of ten. Resident #2 stated they asked staff to get them out of bed, so they could put their feet down (which would help their pain). In an Order-Administration note, dated 10/09/2024 at 2:42 PM, Licensed Practical Nurse #3 documented that the pharmacy had not delivered the tramadol and they were unable to get into the emergency medication box in order to administer the medication. Licensed Practical Nurse #3 documented that the nurse manager and the pharmacy had been notified. There remained no documented evidence that the medical provider had been contacted or notified that the medication remained unavailable. During an observation and interview on 10/10/2024 at 10:42 AM, Resident #2 was in bed and stated that staff had brought in the APEX (equipment used to assist residents with transfers out of bed) to get them out of bed, but then someone else came and took it and they remained in bed. Resident #2 stated they were having pain. During an interview on 10/11/2024 at 12:25 PM, Resident #2 was out of bed and stated when they get out of bed and put their feet down, their pain is better. During an interview on 10/11/2024 at 12:37 PM, Certified Nursing Assistant #1 stated Resident #2 had complained of pain and asked staff to place pillows under their legs but that no one seems to help the resident with their pain. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335467	A. Building B. Wing	10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crest Manor Living and Rehabilitation Center	6745 Pittsford Palmyra Road 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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 10/11/2024 at 12:56 PM, a blister pack of tramadol tablets with Resident #2's name was in a medication cart on the third-floor residential unit. The blister pack label listed a date of 10/09/2024, and review of the corresponding narcotic count sheet revealed that the blister pack was received on 10/09/2024 at 11:35 PM (well before the missed doses on 10/10/2024). During an interview at the time, Licensed Practical Nurse #1 stated they will ask residents if they are having pain every shift and document it in the Medication Administration Record. Licensed Practical Nurse #1 stated if a medication was due to be given and was not available, they check the Pyxis, and if not there, they would tell the nurse manager, call the pharmacy, inform the oncoming nurse, and document it on the 24-hour report. Licensed Practical Nurse #1 stated Resident #2 had more pain when in bed, and when they saw Resident #2 earlier in the morning, the resident did not express that they were in pain. Additionally, Licensed Practical Nurse #1 stated Resident #2 was scheduled to receive tramadol three to four times a day. During an interview on 10/11/2024 at 2:13 PM, Licensed Practical Nurse Manager #2 stated it is on the resident's Medication Administration Record to ask residents about their pain level daily. Licensed Practical Nurse Manager #2 stated Resident #2 complained of pain all day, every day, and received tramadol four times a day. Licensed Practical Nurse Manager #2 stated the physician said there was not much else they can do since the resident's body is in pain from aging. During a review of Resident #2's October 2024 Medication Administration Record at this time, Licensed Practical Nurse Manager #2 stated they went to the Pyxis and got tramadol doses on 10/07/2024 for Resident #2's scheduled 8:00 AM and 12:00 PM administration (review of the Pharmacy Controlled Substance audit list could not confirm any tramadol doses were removed from the Pyxis by Licensed Practical Nurse Manager #2). Licensed Practical Nurse Manager #2 stated the nurses should document in a progress note if a medication was taken from the Pyxis and given to a resident. During an interview on 10/15/2024 at 8:51 AM, the Director of Nursing stated if a medication was due to be given and was unavailable, they should check the Pyxis, and if it was still unavailable, go to their supervisor. The Director of Nursing stated the supervisor should them notify them if they need the medication immediately. The Director of Nursing stated the steps for nurses to take if a medication was unavailable were posted on each medication cart. The Director of Nursing stated if a nurse gave a medication after it was unavailable, it should be documented in a progress note. The Director of Nursing stated sometimes there are issues with getting narcotic medications (from the pharmacy) because the order must have a doctor's signature before it is sent. The Director of Nursing stated resident's pain levels must be documented every shift, and it is important for residents to receive pain medication, so they are kept out of pain. The Director of Nursing stated it was hard to answer why there are issues with getting medications from the pharmacy since the process should be automatic. 10 NYCRR 415.12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335467	A. Building B. Wing	10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crest Manor Living and Rehabilitation Center	6745 Pittsford Palmyra Road 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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 46526 Based on observations, interviews, and record review conducted during the Recertification Survey and complaint investigations (NY00354611 and NY00349191), for two (Second Floor and Third Floor) of two resident units, the facility did not ensure sufficient staffing to provide nursing services to attain or maintain the highest practical physical, mental, and psychosocial well-being for residents in the facility. Specifically, there were several observations of residents who were in bed and wearing hospital gowns during the late morning hours, residents with dirty, unkept fingernails, and residents that were not provided assistance with meals as care planned. The findings include, but not limited to, the following: For additional information see the Centers for Medicare/Medicaid Services Form 2567: F677 Activities of Daily Care Provided for Dependent Residents, F565 Resident/Family Group and Response, and F692 Nutrition/Hydration Status and Maintenance. Review of the Facility Assessment, dated October 2024, revealed the facility was licensed for 80 beds with an average daily census of 70 to 75 residents. Resident care and services included, but were not limited to, assistance with activities of daily living. The facility's staffing plan listed eight Certified Nursing Assistants from 7:00 AM to 3:00 PM (day shift), eight from 3:00 PM to 11:00 PM (evening shift), and four from 11:00 PM to 7:00 AM (night shift). The direct care staff (Certified Nursing Assistant) to resident ratio listed one Certified Nursing Assistant to eight residents for day shift, one Certified Nursing Assistant to 10 residents for evening shift, and one Certified Nursing Assistant to 20 residents for night shift. During the entrance conference on 10/07/2024 at 8:58 AM with the Administrator and Director of Nursing, it was reported that the facility census was 73 residents. Observations and interviews on the Third-floor unit (unit census was 39 residents) included: a. During observations on 10/07/2024 at 7:54 AM, Licensed Practical Nurse Manager #2 was passing medications to residents and the Medical Records Coordinator was assisting on the unit. b. During observations on 10/07/2024 at 8:23 AM, Licensed Practical Nurse Manager #2 and the Medical Records Coordinator were passing breakfast trays to residents. c. During an interview on 10/07/2024 at 9:00 AM, Resident #38 stated staff sometimes do not get them up until 12:00 PM, when the resident would prefer to get up between 10:00 AM to 10:30 AM. d. On 10/07/2024 at 9:35 AM, two Certified Nursing Assistants and two nurses were observed on the unit. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335467	A. Building B. Wing	10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crest Manor Living and Rehabilitation Center	6745 Pittsford Palmyra Road 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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	e. During observations on 10/07/2024 between 9:50 AM to 1:17 PM, 14 residents were still in bed wearing hospital gowns/night shirts. At 11:46 AM, Resident #2 was still in a hospital gown. During an interview at this time, Resident #2 stated they wanted the hospital gown off and had been asking to get out of bed since 10:00 AM. They were supposed to be up and dressed for lunch in the dining room. Resident #2 stated since they had not been assisted out of bed, they would not be able to go to lunch in the dining room. f. During observations on 10/07/2024 at 12:17 PM, a white board behind the nurses' station read All residents up by 11:00 AM. g. During an interview on 10/07/2024 at 3:30 PM, Licensed Practical Nurse Manager #2 stated the unit had 22 residents that required a mechanical lift and 17 residents that required a standing lift for transfers. The unit would frequently have only two Certified Nursing Assistants and the residents' needs were too heavy to have only two aides. h. During observations on 10/9/2024 at 8:45 AM and 12:55 PM, and on 10/10/2024 at 8:38 AM, Resident #38 who was care planned to receive extensive assistance during meals, was eating independently and without the assistance of staff. i. During observations on 10/09/2024 at 10:20 AM, 10/10/2024 at 11:58 AM, and 10/11/2024 at 12:31 PM, Resident #11 had debris underneath their fingernails. On 10/09/2024 at 1:24 PM and 10/10/2024 at 12:52 PM, Resident #11 who was care planned to receive extensive assistance during meals, was eating independently and without the assistance of staff. Observations and interviews on the Second-floor unit (unit census was 34 residents) included: a. During an observation and interview on 10/07/2024 at 10:07 AM, Resident #10 was in bed wearing a hospital gown. They stated they preferred to be up by 9:00 AM and almost never got up that early because there was no staff. Resident #10 stated they were told there was only one Certified Nursing Assistant, and it would be 11:00 AM or 12:00 PM before someone could assist them. At 11:29 AM, Resident #10 was wearing a shirt and stated they were half dressed and waiting for assistance with lower body dressing. b. During an interview on 10/07/2024 at 10:08 AM, Licensed Practical Nurse Manager #1 stated staffing on the second-floor unit for that day was two Licensed Practical Nurses, two Certified Nursing Assistants, and a unit manager to care for 34 residents. They stated a staff member had called off, and normally day shift staffing was two Licensed Practical Nurses and four Certified Nursing Assistants. Licensed Practical Nurse Manager #1 stated the nurses should be helping with residents who required the assistance of two staff and answering call bells. c. During an interview on 10/07/2024 at 10:51 AM, Resident #47 stated there was only one Certified Nursing Assistant on night shifts, had to wait forever to get assistance with care, and would end up soiling themselves (episode of incontinence). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335467	A. Building B. Wing	10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crest Manor Living and Rehabilitation Center	6745 Pittsford Palmyra Road 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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a special Resident Council meeting on 10/09/2024 at 11:00 AM, residents voiced the facility was often short staff on the evening shifts, which staff often expressed to the residents. Residents stated on Monday, 10/07/2024, the third-floor unit started with one aide. On a Sunday day shift, about one month and a half prior, there were only two Certified Nursing Assistants working on the third floor, residents were unable to get out of bed and were told to stay in bed because staff did not have time. Residents stated they were told by staff (scheduled to leave at 7:00 PM), if they did not go to bed before 7:00 PM, they would have to wait for the next shift (11:00 PM) to receive assistance. Resident #26 stated at times they have had to wait a long time, between two to ten hours (after pressing their call button) for assistance and some days they gave up and went to their activity soaked (incontinent). Review of actual nursing staffing sheets from 08/01/2024 to 10/10/2024, for the two 40-bed units, revealed the following: - On 08/10/2024, there were two Certified Nursing Assistants on the Third floor from 3:00 PM to 11:00 PM. - On 08/18/2024, there were two Certified Nursing Assistants on the Third floor from 7:00 AM to 3:00 PM. - On 08/19/2024, there were two Certified Nursing Assistants on each unit (Second and Third floors) from 3:00 PM to 11:00 PM. - On 08/23/2024, there was one Certified Nursing Assistant on the Second floor from 11:00 PM to 7:00 AM. - On 08/25/2024, there were two Certified Nursing Assistants on the Second floor from 7:00 AM to 3:00 PM, with documentation that both arrived late. - On 08/26/2024, there was one Certified Nursing Assistant on each floor from 11:00 PM to 7:00 AM. - On 08/25/2024, there were two Certified Nursing Assistants on the Second floor from 7:00 AM to 3:00 PM, with documentation that both arrived late. - On 09/04/2024, there was one Certified Nursing Assistant on each floor from 11:00 PM to 7:00 AM. - On 09/05/2024, there were two Certified Nursing Assistants on the Second floor from 7:00 PM to 11:00 PM. - On 09/06/2024, there was one Certified Nursing Assistant on each floor from 11:00 PM to 7:00 AM. - On 09/07/2024, there was one Certified Nursing Assistant on the Third floor from 11:00 PM to 7:00 AM. - On 09/08/2024, there was one Certified Nursing Assistant on the Third floor from 7:00 PM to 11:00 PM, and one Certified Nursing Assistant on the Second floor from 8:00 PM to 11:00 PM. - On 09/10/2024, there was one Certified Nursing Assistant on each unit from 11:00 PM to 7:00 AM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335467	A. Building B. Wing	10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crest Manor Living and Rehabilitation Center	6745 Pittsford Palmyra Road 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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- On 09/11/2024, there was one Certified Nursing Assistant on each unit from 11:00 PM to 7:00 AM. - On 09/17/2024, there were two Certified Nursing Assistants on the Third floor from 8:00 PM to 11:00 PM. - On 09/19/2024, there were two Certified Nursing Assistants on the Third floor from 1:00 PM to 4:30 PM. - On 09/28/2024, there was one Certified Nursing Assistant on the Third floor from 11:00 PM to 7:00 AM. - On 10/07/2024, there were two Certified Nursing Assistants on the Second floor from 7:00 AM to 3:00 PM. On the Third floor, one Certified Nursing Assistant was scheduled to start at 7:00 AM, another scheduled to start at 8:00 AM, and a third scheduled to start at 12:00 PM. During an interview on 10/10/2024 at 5:18 PM, Licensed Practical Nurse Manager #2 stated on Monday morning (10/07/2024) at the start of the day shift (7:00 AM), the night shift staff had already left and there were no Certified Nursing Assistants assigned to the unit. They were the only nurse and the only other staff member on the unit was the Medical Records Coordinator. During an interview on 10/11/2024 at 12:37 PM, Certified Nursing Assistant #1 stated the unit was short-staffed on Monday (10/07/2024) day shift and they forgot to document a resident's bowel movement. During an interview on 10/11/2024 at 12:56 PM, Licensed Practical Nurse #1 said on Monday, 10/07/2024 day shift, there were only two Certified Nursing Assistants on the Second-floor unit, staffing was typically like that on weekends. Licensed Practical Nurse #1 stated depending on the resident census, with two Certified Nursing Assistants, they could potentially have an assignment of 20 residents each. During an interview on 10/15/24 at 8:51 AM, the Director of Nursing stated minimum nursing staffing in the facility consisted of two nurses, a unit manager and four Certified Nursing Assistants on each floor during the day shift; four Certified Nursing Assistants for each unit on the evening shift, and four Certified Nursing Assistants would be in the building for the night shift (two assigned to each unit). The Director of Nursing stated if minimum staffing levels were not met, everyone would assist, and attempts would be made to replace the (missing) staff. If minimum staffing levels were not met, the impact would include residents getting up late or scheduled showers postponed until the next day when the unit was fully staffed. During an interview on 10/15/2024 at 11:11 AM with the Administrator and Regional Administrator, the Regional Administrator stated the facility had met their staffing levels. 10 NYCRR 415.13 (a)(1)(i-iii)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335467	A. Building B. Wing	10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crest Manor Living and Rehabilitation Center	6745 Pittsford Palmyra Road 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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 46526 Based on observations, interviews, and record review conducted during a Recertification Survey and complaint investigations (NY00354611 and NY00349191), for two (Residents #1 and #182) of six residents observed during medication administration, the facility did not ensure its medication error rate was less than five percent. There were three medication errors for 47 opportunities resulting in a medication error rate of 6. 38 percent. Specifically, three medications were omitted (resident did not receive a medication that was ordered) during the observation due to being unavailable in the facility. This is evidenced by the following: 1. Resident #1 had diagnoses including bipolar disorder, anxiety disorder, and major depressive disorder. The Minimum Data Set Resident Assessment, dated 09/07/2024, included the resident was cognitively intact. Current physician's orders included, but were not limited to, lamotrigine 100 milligram tablet, give 50 milligrams with 25 milligram tablet (total dose = 75 milligrams) daily at 8:00 AM for bipolar disorder. During a medication administration observation on 10/10/2024 at 8:16 AM with Licensed Practical Nurse #4, the dose of lamotrigine was unavailable in the facility for administration. During an interview on 10/10/2024 at 8:30 AM, Licensed Practical Nurse #4 stated they had checked the Pyxis (an automated medication dispensing system), but the lamotrigine dose was not available. 2. Resident #182 had diagnoses including neuropathy (weakness, numbness, and pain from nerve damage), vitamin B12 deficiency, and hypertension. The Minimum Data Set Resident Assessment, dated 10/01/2024, included the resident was cognitively intact. Current physician orders included, but were not limited to, gabapentin 400 milligram capsule, give four capsules (total dose = 1600 milligrams) daily for pain, and cyanocobalamin 500 micrograms daily for vitamin B12 deficiency. During a medication administration observation and interview on 10/10/2024 at 8:57 AM with Licensed Practical Nurse #2, the doses of cyanocobalamin and gabapentin were unavailable in the facility for administration. During an interview at that time, Licensed Practical Nurse #2 stated they had contacted the pharmacy the previous day to reorder the cyanocobalamin, but it had not been delivered yet. They stated the gabapentin dose was not available in the Pyxis and the pharmacy would need to be notified. Licensed Practical Nurse #2 stated the facility had issues with medications not being available due to the pharmacy not delivering them timely. During an interview on 10/11/2024 at 2:13 PM, Licensed Practical Nurse Manager #2 stated that omitting a medication would be considered a medication error. During an interview on 10/15/2024 at 8:51 AM, the Director of Nursing stated that omitting a medication would be considered a medication error. They were only aware of medications not being available to administer when they were directly involved with getting the medications sent from pharmacy. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335467	A. Building B. Wing	10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crest Manor Living and Rehabilitation Center	6745 Pittsford Palmyra Road 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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/15/2024 at 11:11 AM with the Administrator and Regional Administrator, the Regional Administrator stated the facility was aware that there was an ongoing issue related to medications not being available at the time of administration, and the Director of Nursing had previously done weekly audits and reeducated the staff. 10 NYCRR 415.12(m)(1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335467	A. Building B. Wing	10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crest Manor Living and Rehabilitation Center	6745 Pittsford Palmyra Road 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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. 39181 Based on observations, interviews, and record review conducted during the Recertification Survey and complaint investigations (ACTS Reference Numbers: NY00354611 and NY00349191), for three (Residents #1, #2, and #53) of eight residents reviewed, the facility did not ensure residents were free from significant medication errors. Specifically, for Resident #1 who had diagnoses of a bipolar disorder and anxiety and was prescribed an antianxiety (lorazepam) medication and a mood stabilizer (lamotrigine), a medication administration observation and medical record review revealed the medications were frequently documented as unavailable in the facility for administration. For Resident #2 who had chronic pain and was prescribed a narcotic pain medication (tramadol), there was frequent documentation in the medical record that indicated the medication was unavailable in the facility to be administered. For Resident #53 who had diagnoses of major depressive disorder, hypertensive heart disease with heart failure, history of stroke, and diabetes and was prescribed an antihypertensive (metoprolol), an anticoagulant (clopidogrel), an antidepressant (trazodone), and insulin (Humalog), there was frequent documentation in the medical record that indicated the medications were unavailable in the facility to be administered. This is evidenced by the following: The facility policy and procedure Medication Error, dated 12/19/2022, included a type of medication error was omission (not administered before the next scheduled dose was due). When a medication error occurred, the physician should be notified and evaluate the resident, the notification of the physician should be recorded in the medical record with any resultant orders, and any actions or clinical interventions taken should be recorded. 1. Resident #1 had diagnoses including bipolar disorder, anxiety disorder, and major depressive disorder. The Minimum Data Set Resident Assessment, dated 09/07/2024, included the resident was cognitively intact and had moderate depression. Review of the current Comprehensive Care Plan included Resident #1 used an antidepressant medication to treat depression and an antianxiety medication to treat anxiety disorder. Interventions included, but were not limited to, administer medications as ordered by the physician. Review of current medical orders included, but were not limited to, lorazepam at bedtime for anxiety and lamotrigine twice daily for bipolar disorder. During a medication administration observation on 10/10/2024 at 8:16 AM with Licensed Practical Nurse #4, the dose of lamotrigine was unavailable in the facility for administration. During an interview on 10/10/2024 at 8:30 AM, Licensed Practical Nurse #4 stated they had checked the Pyxis (an automated medication dispensing system), but lamotrigine was not available. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335467	A. Building B. Wing	10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crest Manor Living and Rehabilitation Center	6745 Pittsford Palmyra Road 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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the September 2024 Medication Administration Record revealed lamotrigine scheduled on 09/29/2024 at 7:00 PM was signed and coded 9 (see progress note). Lorazepam scheduled on 09/07/2024, 09/11/2024, 09/12/2024, 09/13/2024, 09/14/2024, and 09/25/2024 at 9:00 PM were signed and coded 9; on 09/24/2024 at 9:00 PM was signed and coded 5 (hold/see progress notes); and on 09/27/2024 at 9:00 PM was blank (no documentation to show the medication was administered). Review of corresponding progress notes revealed the medication was on order and awaiting arrival from pharmacy. Review of progress notes did not include relevant documentation about the missed lorazepam dose on 09/27/2024. Review of the June 2024 Medication Administration Record revealed lorazepam scheduled on 06/11/2024, 06/12/2024, 06/13/2024, and 06/14/2024 at 9:00 PM was signed and coded 9. Review of corresponding progress notes revealed the medication was on order awaiting arrival from pharmacy or awaiting a provider signature. 2. Resident #2 had diagnoses including chronic pain, hypertension, and anemia. The Minimum Data Set Resident Assessment, dated 08/24/2024, included the resident was cognitively intact. Review of the current Comprehensive Care Plan included Resident #2 had chronic pain related to arthritis and polymyalgia rheumatica (an inflammatory disorder that causes muscle pain and stiffness). Interventions included, but were not limited to, administer medication as per medical orders, anticipate the resident's need for pain relief, and respond immediately to any complaint of pain. Review of current medical orders included, but were not limited to, tramadol hydrochloride (a narcotic medication used to treat moderate to severe pain) 50 milligrams four times daily for pain. Review of the September 2024 Medication Administration Record revealed tramadol scheduled on 09/09/2024 at 8:00 PM; on 09/10/2024 at 8:00 AM, 12:00 PM, 4:00 PM and 8:00 PM; on 09/18/2024 at 12:00 PM, on 09/20/2024 at 4:00 PM; and on 09/22/2024 at 4:00 PM were signed with code 9. Review of corresponding progress notes revealed the medication was on order and awaiting arrival from pharmacy, order was pending a provider signature, or was unavailable. Review of the October 2024 Medication Administration Record revealed tramadol scheduled on 10/07/2024 at 8:00 AM and 12:00 PM; on 10/08/2024 at 8:00 AM and 12:00 PM; on 10/09/2024 at 8:00 AM; and on 10/10/2024 at 4:00 PM and 8:00 PM were signed with code 9. On 10/07/2024 at 4:00 PM and 8:00 PM were signed with code 5. Review of corresponding progress notes revealed the medication was on order and awaiting arrival from pharmacy. 3. Resident #53 had diagnoses including major depressive disorder, hypertensive heart disease with heart failure, history of stroke, and diabetes. The Minimum Data Set Resident Assessment, dated 08/11/2024, included the resident had moderately impaired cognition. Review of the current Comprehensive Care Plan included Resident #53 was prescribed antidepressant medications related to a diagnosis of depression, was on anticoagulant therapy related to history of stroke, and had diabetes. Interventions included, but were not limited to, administer medications as ordered by the physician. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335467	A. Building B. Wing	10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crest Manor Living and Rehabilitation Center	6745 Pittsford Palmyra Road 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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of current medical orders included, but were not limited to, metoprolol twice daily for hypertension, clopidogrel once daily for cerebral vascular accident, trazadone at bedtime for anxious depression, and Humalog (a fast-acting insulin) twice daily for diabetes. Review of discontinued orders included an order dated 06/13/2024 for Diflucan (medication used to treat yeast infections) 150 milligram tablet give one tablet on 06/13/2024 and one on 06/16/2024 for peri-rectal area and folds. Review of the September 2024 Medication Administration Record revealed metoprolol scheduled on 09/17/2024 at 8:00 PM, 9/18/2024 and 09/19/2024 at 8:00 AM were signed with code 9. Clopidogrel scheduled on 09/18/2024 at 8:00 AM was signed with code 9. Trazodone scheduled on 09/27/2024 at 9:00 PM was blank (no documentation to show the medication was administered). Review of corresponding progress notes revealed the metoprolol and clopidogrel were on order and there was no relevant documentation about the missed dose of trazodone. Review of the August 2024 Medication Administration Record revealed trazodone scheduled on 08/03/2024 at 9:00 PM was blank (no documentation to show the medication was administered). Review of progress notes did not include relevant documentation about the missed medication. Review of the June 2024 Medication Administration Record revealed trazodone scheduled on 06/08/2024 at 9:00 PM was signed with code 9. Humalog insulin scheduled on 06/21/2024 at 4:00 PM was signed with code 9 and there was no blood glucose value documented. Diflucan 150 milligrams scheduled on 06/16/2024 at 9:00 AM was signed with code 9. Review of corresponding progress notes revealed the medications were unavailable. During an interview on 10/11/2024 at 3:34 PM, the Medical Director stated that all medications are significant with the exception of an as needed medication that is not being used. Medications to treat anxiety or depression would be significant for a resident with those diagnoses. The Medical Director stated there were a number of issues with medications not being available when they took over the position of Medical Director in March 2024. They felt there was a lack of communication where the pharmacy was concerned, including inconsistent follow-up with the nurses and/or providers when medications were not available, and poor management with how the pharmacy received and tracked orders. The Medical Director stated they were not aware of current issues with medications being unavailable for any prolonged period of time and was under the impression the process had improved. If a medication was unavailable, the Medical Director stated the nursing staff should contact pharmacy to get it delivered and important medications could be sent on a rush delivery. There were times that some medications were held up at the pharmacy because they required a physician's order. The Medical Director stated that some medications could wait to be given and others could not. There were alternative medications available in the facility that could be ordered if there was a concern with a medication not being available. The Medical Director stated nursing staff would typically notify a medical provider when a medication was unavailable or if a medication order needed to be signed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335467	A. Building B. Wing	10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crest Manor Living and Rehabilitation Center	6745 Pittsford Palmyra Road 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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/15/2024 at 8:51 AM, the Director of Nursing stated almost all medications would be considered significant because every medication was prescribed for a reason. Some significant medications would include cardiac, pain, and diabetic medications. The Director of Nursing stated that omitting a medication would be considered a medication error, and they were only aware of medications not being available to administer when they were directly involved with getting the medications sent from pharmacy. If a medication was unavailable, the Director of Nursing stated they would expect the nurse to first check the Pyxis (an automated medication dispensing system), and if still not available, to contact the nursing supervisor so the medication could be delivered from pharmacy right away. They would also expect the nurse to document in a progress note once the medication was received from pharmacy and administered. During an interview on 10/15/2024 at 11:11 AM with the Administrator and Regional Administrator, the Regional Administrator stated the facility was aware there was an ongoing issue related to medications not being available at the time of administration and the Director of Nursing had previously done weekly audits and reeducated the staff. 10 NYCRR 415.12(m)(2)