

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 335082	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/10/2020
NAME OF PROVIDER OF SUPPLIER THE SHORE WINDS, L L C		STREET ADDRESS, CITY, STATE, ZIP 425 BEACH AVENUE ROCHESTER, NY 14612	
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 0607 Level of harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on an interview and record reviews conducted during the COVID-19 Focused Infection Control Survey (complaint #NY 132), it was determined that the facility did not screen 1 (Temporary Nurse's Aide) of 11 employees through the New York State Nurse Aide Registry prior to onset of employment. This is evidenced by the following: A review of the facility policy, Abuse, Neglect, and Exploitation Prohibition, Training, Investigation and Reporting, dated December 2016, revealed the policy included the statement: All staff that are being considered for hire must also be checked with the NYS Nurse Aide Registry for a history of findings. Record review revealed one Temporary Nurse's Aide began work at the facility on 7/1/20, and there was no documentation to show a Nurse Aid Registry verification was performed prior to their start date. Further review of the employee's supervision documentation revealed this person worked a total of seven shifts, including: 7/1/20, 7/2/20, 7/6/20, 7/7/20, 7/8/20, 7/9/20, and 7/10/20. During an interview on 7/10/20 at 1:45 p.m., the Director of Human Resources stated she was unable to locate the Nurse Aid Registry verification for the Temporary Nurse's Aide. (10 NYCRR 415.4(b)(1)(ii)(a)(b))		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE		(X6) DATE

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.