DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335082	A. BUILDING ______ B. WING ______	02/01/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SHORE WINDS	**425 BEACH AVENUE ROCHESTER, NY 14612**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253 SS=B	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations, the facility did not provide an orderly environment in resident living and care areas. The deficient practice identified was the presence of worn and damaged bedside stands on five of seven units. Specifically, surfaces of bedside stands were worn with handles missing from drawers and doors and doors loose on hinges. This resulted in a pattern of no actual harm with potential for minimal harm that is evidenced by, but not limited to, the following: Observations on 1/29/07 between 9:02 a.m. and 1:00 p.m. revealed that the bedside stands in resident sleeping rooms were damaged and in need of repair. The damage included scrapes and gouges with chipped surfaces and portions of the wood veneer torn or peeling off. The drawers/doors were missing handles, and the doors were loose from the hinges. This was evidenced by, but not limited to, the following rooms: South 1: #102, #104, #114, #124, #129, and #130. South 2: #206, #210, #212, #222, #223, and #227. South 3: #304, #322, and #324. West 2: #203, #209, and #213.	F 253		2/22/07

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.

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F 253	Continued From page 1 North 1: #203, #204, and #214. [415.5(h)(2), 415.29(j)(1)]	F 253		
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interview, it was determined that 1 of 30 residents reviewed for professional standards, did not receive treatment or services that met professional standards of quality. The issues involved not following physician orders for administration of a nebulizer treatment and checking oxygen saturation rates. THIS IS A REPEAT DEFICIENCY FROM THE STANDARD SURVEY OF 3/10/06. This resulted in no actual harm with the potential for more than minimal harm that is not immediate jeopardy for Resident #17, and is evidenced by the following: Resident #17 was hospitalized in December 2006 for aspiration pneumonia. The 1/3/07 physician orders include a nebulizer treatment every two hours as needed for shortness of breath or wheezing. When observed on 1/30/07 at 7:15 a.m., the Certified Nursing Assistant (CNA) was finishing the resident's bath. The head of the bed was at 20 degrees. The resident's respiration rate was 68 breaths per minute, and he was wheezing. At 7:20 a.m., the CNA finished the bath, elevated the head of the bed to 45 degrees, and left the room. The resident's respiration rate was 60 and wheezing. The Licensed Practical	F 281		2/22/07

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Nurse (LPN) entered the room at 7:25 a.m. and gave the resident some water through the feeding tube. Another LPN entered the room and both LPNs pulled the resident up in the bed and elevated the head of the bed to 75 degrees. The resident's respiratory rate was 60 with slight wheezing. The resident was transferred to his chair at 7:35 a.m. by two CNAs. At 7:50 a.m., the LPN returned to the room and gave the resident more water through the feeding tube. The resident's respiratory rate was 54 with shallow abdominal breathing. The LPN left the room and began passing medications for other residents. At 8:05 a.m., the resident was observed with a respiratory rate of 50 with shallow abdominal breathing. The surveyor approached the LPN and asked if she had noticed the resident's labored respirations. The LPN responded that the resident is "always sorta like that." She also said she was going to give him the as needed nebulizer treatment. The resident was given the nebulizer treatment, during which his respiratory rate was 44 - 46. The resident's oxygen saturation rate was 93 percent at the start of the treatment and 96 percent at the end.

When interviewed on 1/30/07 at 9:20 a.m., the Nurse Manager (NM) said the resident should have been given his nebulizer treatment right away. An acute visit form was completed by nursing for the medical staff to see the resident. A physician note, dated 1/30/07, included that the resident had diffuse wheezes in the lungs and to obtain a chest x-ray in 24 hours if no improvement. A 2/1/07 nursing note included that the chest x-ray done on 1/31/07 showed increased right lower lobe pneumonia.

The facility did not provide prompt respiratory

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F 281	Continued From page 3 treatment in accordance with the physician orders. In addition, physician orders, dated 1/3/07, include oxygen at 2 - 4 liters as needed for oxygen saturation rate under 92 percent and to check oxygen saturation every shift. The January 2007 Medication Administration Record indicates to check the oxygen saturation rate every month on the third day. There was no documented evidence that the resident's oxygen saturation rate was checked every shift as ordered by the physician. When interviewed on 1/30/07 at 9:20 a.m., the NM said they should have been checking the oxygen saturation every shift. [415.11(c)(3)(i)]	F 281		
F 311 SS=D	483.25(a)(2) ACTIVITIES OF DAILY LIVING A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interview, it was determined that one of nine residents reviewed for activity of daily living (ADL) concerns did not receive the necessary care and services to maintain their ambulatory status. The issue involved a resident who was not ambulated and transferred to maintain their ability. This affected Resident #18, resulting in no actual harm with potential for more than minimal harm that is not immediate jeopardy, and is evidenced by the following: Resident #18 was admitted to the facility on	F 311		2/22/07

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11/15/06. The 11/17/06 and 11/25/06 Minimum Data Set Assessments indicate that the resident ambulates with two person physical assistance in the room. Nursing admission assessment, dated 11/15/06, indicates the resident ambulates with two assists to the bathroom. Physical Therapy evaluation, dated 11/15/06, includes the resident ambulates with nursing assistance and a moderate assist of two to and from the bathroom. The current Certified Nursing Assistant (CNA) care card includes one assist for toileting and to ambulate the resident with one assist and rolling walker to and from the bathroom. There was no rolling walker observed in the resident's room on 1/29/07, 1/30/07, or 1/31/07.

When observed on 1/29/07 at 1:20 p.m., the primary CNA wheeled the resident into the bathroom in his wheelchair. The resident grabbed hold of the sink, stood, and with assistance of the CNA, pivoted onto the toilet and then off of the toilet, back into the wheelchair. When interviewed at this time, the CNA said the resident does not walk and is only able to pivot transfer.

When interviewed on 1/30/07 at 4:00 p.m., the primary evening CNA said the resident does not ambulate, and when toileted, she pushes his wheelchair into the bathroom and he pivots onto the toilet. She also said the resident's gait is very unsteady and, when he was first admitted, she tried to ambulate him, but he acted like he was scared. She believed nursing was aware of this.

When interviewed on 1/31/07 at 9:40 a.m., the primary day CNA said she could not remember if nursing was aware that the resident does not ambulate to the bathroom. When interviewed on

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F 311	Continued From page 5 1/31/07 at 10:00 a.m., the Nurse Manager (NM) said she was not aware the resident was not being ambulated to the bathroom. The NM said the CNAs should have told her and wanted Physical Therapy to re-evaluate the resident. The facility did not provide the necessary ADL assistance to maintain this resident's ambulatory status. [415.12(a)(2)]	F 311		
F 314 SS=D	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, it was determined that one of nine residents reviewed for pressure sores, did not receive necessary interventions to prevent the development of, or promote healing of, pressure sores. The issue involved a bed cradle device that was not in place for a resident with a history of foot and toe ulcers. This affected Resident #10, resulting in no actual harm with the potential for more than minimal harm that is not immediate jeopardy, and is evidenced by the following: Resident #10 has diagnoses including peripheral	F 314		2/22/07

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F 314	Continued From page 6 vascular disease (PVD) and a history of foot ulcers. The 11/21/06 nursing skin team note indicated the resident had a new Stage II pressure ulcer on the third right toe that measured 0.5 x 0.5 centimeters (cm) and a callus on the right second toe. The note included that the podiatrist was notified to evaluate the area. The 11/22/06 podiatry evaluation of the pressure ulcer included recommendations of a bed cradle to keep pressure off toes. The 11/22/06 nursing note included the podiatrist recommendations of a bed cradle. The 11/29/06 skin team note indicated the resident had new Stage II pressure ulcers on the right second and fourth toes. The 12/5/06 nursing note indicated that the second and fourth toe ulcers healed, and an ulcer on the third toe measured 0.3 x 0.3 cm. The 12/6/06 Medical Director note indicated that the pressure ulcer was caused by pressure and friction. The 1/20/07 podiatry evaluation indicated the resident was seen for complaints of severe pain on the right third toe. The podiatrist again recommended a bed cradle to relieve pressure from toes. The Comprehensive Care Plan for pressure ulcers and the current Certified Nursing Assistant sheet did not include use of a bed cradle. The skin care flow sheet included that on 1/25/07 the right third toe ulcer measured 0.3 x 0.2 cm. An observation on 1/30/07 at 11:55 a.m. with the Nurse Manager (NM) present, revealed the resident in bed with the bed covers taut around the resident's feet. There was no bed cradle on the foot of the bed to protect the resident's feet from pressure and friction of the bed covers. The NM said that she would try to find a bed cradle. When interviewed on 1/30/07 at 12:15 p.m., the Physician's Assistant said that she never saw the	F 314		

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F 314	Continued From page 7 recommendations for the bed cradle and acknowledged that the resident's diagnosis of PVD puts her at higher risk for pressure ulcer development and that she would try a bed cradle. [415.12(c)(2)]	F 314		
F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record reviews, it was determined that one of two residents reviewed for urinary catheters, was not assessed for continued catheter use, or provided with a plan for bladder training. This resulted in no actual harm with the potential for more than minimal harm that is not immediate jeopardy for Resident #1, and is evidenced by the following: Resident #1 was admitted to the facility on 9/8/06 with diagnosis including dementia and urinary tract infection (UTI). The Minimum Data Set Assessments dated 9/18/06 and 10/22/06 indicated the resident was frequently incontinent of bladder. The Comprehensive Care Plan, initiated 9/21/06, included history of UTI and interventions were to implement a toileting	F 315		2/22/07

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F 315	Continued From page 8 schedule and to monitor voiding patterns. The resident was hospitalized from 10/28/06 - 10/31/06 and 11/3/06 - 11/7/06 with UTIs. The 10/31/06 and 11/7/06 hospital discharge reports included that the resident had a Foley catheter. The reports did not include a rational for the Foley catheter or recommendation for continued catheter use. The attending physician's re-admission note, dated 11/13/06, addressed these latest hospitalizations and included the Foley for urinary retention. The note did not specify reasons for retention or continued Foley use, or a plan to address restoration of bladder function. The Comprehensive Care Plan was not updated to include the presence of the Foley catheter or any goal for bladder restoration. When interviewed on 1/30/07 at about 10:30 a.m., the Nurse Manager stated that the resident used to be toileted and that she was also concerned about the length of time the Foley has been in. An interview with the Physician's Assistant (PA) on 1/30/07 at about 4:30 p.m., revealed that she believed the hospital had noted a problem with retention; however, when reviewed, the hospital discharge summaries made no reference to this problem. The PA said that it was possible the resident had so many UTIs because of urine retention. The facility did not ensure that a resident who was incontinent of bladder received treatment and services to restore bladder function or ensure that catheterization was medically justified. [415.12(d)(1)]	F 315		
F 322	483.25(g)(2) NASO-GASTRIC TUBES	F 322		2/23/07

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Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.

This REQUIREMENT is not met as evidenced by:
Based on observations, record review, and staff interviews, it was determined that one of four residents reviewed for tube feedings, did not receive the necessary treatment to prevent the potential for aspiration pneumonia. The issue involved the inappropriate positioning of a resident while the tube feeding was being administered. This affected Resident #21, and resulted in no actual harm with potential for more than minimal harm that is not immediate jeopardy, and is evidenced by the following:

Resident #21 has diagnoses including cerebral vascular accident, dementia, dysphagia (difficulty swallowing), and, most recently, aspiration pneumonia on 12/22/06. The resident has a feeding tube for nutrition. The January 2007 physician orders indicate the resident receives a continuous tube feed. The 1/9/07 Comprehensive Care Plan and December 2006 Certified Nursing Assistant (CNA) care card identify the resident at risk for aspiration and include approaches of keeping the head of the bed elevated at 35 - 40 degree angles at all times and not laying flat.

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F 322	Continued From page 10 The resident was observed on 1/30/07 from 5:40 p.m. to 6:30 p.m. Two CNAs came into the room at 6:10 p.m. to reposition the resident. The head of the bed was lowered so that the resident was lying in a flat position. CNA #1 observed that his brief needed to be changed and left the room to get supplies, leaving the resident flat on his back. She returned several minutes later and provided care to the resident raising the head of the bed at 6:18 p.m. When interviewed on 1/30/07 at 6:25 p.m., the CNAs revealed that they always provide care to the resident in a prone position and were unsure about any special precautions for residents with tube feedings. The resident was again observed on 1/31/07 at 9:37 a.m. Two CNAs were providing care and proceeded to lay the resident flat in his bed for approximately 10 minutes. At this time, the Licensed Practical Nurse came into the room and disconnected the tube feeding for transfer out of bed. The facility's tube feeding policy, dated May 2006, includes keeping residents at a 30 - 45 degree angle while the tube feeding is being administered and to not lay flat until one hour after a feeding is stopped. [415.12(g)(2)]	F 322		
F 323 SS=E	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by:	F 323		2/21/07

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Based on observations and staff interviews, it was determined that the facility did not ensure that the resident environment remain as free of accident hazards as is possible. The issue was related to inappropriate hot water temperatures in faucets that were accessible to residents on the North and West wings of the building. This resulted in a pattern of no actual harm with a potential for more than minimal harm that is not immediate jeopardy, and is evidenced by the following:

During tour of the building on 1/29/07 between the hours of 9:02 a.m. and 1:00 p.m., hot water temperatures were measured in resident bathrooms on the North and West wings. The Director of Maintenance (DOM) accompanied the surveyor.

In the North wing, the hot water temperature in the bathroom sink in Room #205 was 123 degrees Fahrenheit (*F). In the West wing, the hot water temperatures in Rooms #211 and #213 were 120 and 123 *F, respectively. When asked if the hot water temperatures are checked, the DOM responded that the water temperature is checked at the boiler and after the hot water mixing valve. The DOM said that these temperatures are recorded on a log sheet in the boiler room. When asked if hot water temperatures are checked in resident sleeping rooms, the DOM answered "no." At approximately 12:05 p.m., the hot water tank and mixing valve hot water temperatures were checked in the boiler room. The DOM showed the surveyor the Water Temperature Log. The last recording of the hot water was dated 1/27/07. The temperature at the hot water tank was 138 *F, and the hot water gauge after the mixing valve read 122 *F. When the DOM and surveyor

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F 323	Continued From page 12 looked at the hot water gauge it read 138 *F, and the gauge after the mixing valve read 122 *F. The DOM then adjusted teh mixing valve. The DOM and surveyor both observed the gauge, the hot water mixing valve was fluctuating approximately 10 to 15 degrees. The DOM then said he was going to call the facility's contractor. On 1/30/07 at approximately 9:05 a.m., the DOM informed the surveyor that the mixing valve may need rebuilding. The DOM told the surveyor that maintenance is taking temperatures in the boiler room and resident rooms every hour and documenting the hot water temperatures. The facility did not have a system in place to monitor water temperatures in resident rooms to prevent potential accidents related to hot water temperatures. [415.12(h)(1), 415.29(f)(6)]	F 323		
F 324 SS=D	483.25(h)(2) ACCIDENTS The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interview, it was determined that one of four residents reviewed for falls did not receive assistive devices to prevent potential fall related injury. The issue involved the lack of hip protectors for Resident #18. This resulted in no actual harm with the potential for more than minimal harm that is not immediate jeopardy, and is evidenced by the following:	F 324		2/20/07

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 324	Continued From page 13 Resident #18 was admitted to the facility on 11/15/06. Physician orders, dated 11/17/06 and 1/12/07, include the resident to have hip protectors at all times due to a history of falls. The 11/15/06 Fall Risk Assessment indicates the resident is high risk for falls. The current Certified Nursing Assistant (CNA) care sheet includes the resident to have hip protectors at all times as a fall prevention. When observed on 1/29/07 at 1:20 p.m. and 1/31/07 at 9:15 a.m., the resident did not have hip protectors on. During the observation on 1/31/07 at 9:15 a.m., the resident, who was seated at the far end of the hall, half stood from his wheelchair. While holding this position, he opened his pants and repeatedly smoothed his underclothing. The November and December 2006 Treatment Administration Records (TAR) had the hip protectors listed, but the nursing initials were circled, indicating this was not done. The January 2007 TAR does not list the hip protectors. When interviewed on 1/31/07 at 9:40 a.m., the primary CNA said she has never seen hip protectors for this resident. When interviewed on 1/31/07 at 9:45 a.m., the Licensed Practical Nurse said the hip protectors have been ordered. When interviewed on 1/31/07 at 10:00 a.m., the Nurse Manager said she has ordered the hip protectors several times and was told that they are coming. When interviewed on 1/31/07 at 1:30 p.m., the Central Supply staff said she received an order two weeks ago for the hip protectors and also sometime before the holidays. The staff member said she believes the item is backordered.	F 324		

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THE SHORE WINDS	**425 BEACH AVENUE** **ROCHESTER, NY 14612**

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F 324	Continued From page 14 When interviewed on 2/1/07 at 10:00 a.m., the Director of Nursing said she was not aware the resident had been waiting this long for the hip protectors. [415.12(h)(2)]	F 324		
F 333 SS=D	483.25(m)(2) MEDICATION ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, it was determined that one of six residents reviewed for medications was not free of a significant medication error. THIS IS A REPEAT DEFICIENCY FROM THE ABBREVIATED SURVEY OF 4/7/06. The issue involved a medication error that resulted in an incorrect dosage of Coumadin being administered. This affected Resident #12, resulting in no actual harm with potential for more than minimal harm that is not immediate jeopardy, and is evidenced by the following: Resident #12 was admitted to the facility on 1/17/07 following repair of a hip fracture. The hospital discharge summary, dated 1/10/07, included that the resident seems to be very sensitive to Coumadin (a medication used to prevent blood from clotting). A physician's order of 1/17/07 included Coumadin 2.5 milligrams (mg) daily. The Medication Administration Record (MAR) revealed that the Coumadin was given, as ordered, on 1/17/07. An order written by a Physician's Assistant (PA) on 1/18/07 included to decrease Coumadin to 2 mg. The order was not	F 333		2/23/07

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THE SHORE WINDS	**425 BEACH AVENUE ROCHESTER, NY 14612**

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F 333	Continued From page 15	F 333		

clearly written as a 2 or a 3. The MAR revealed that a new order was written on 1/18/07 for Coumadin 2 mg. On 1/22/07, a different PA wrote a new Coumadin order. It indicated to "continue with Coumadin 3 mg every day." (An increase of 1 mg from the current order.) This order was transcribed by a Licensed Practical Nurse on 1/18/07.

When interviewed on 1/29/07 at 10:30 a.m., the Nurse Manager (NM) confirmed that the 1/18/07 order was not clearly written as a 2 or a 3, and the second PA must have thought that it was a 3. The NM acknowledged that it was hard for her to decipher if the number was a 2 or a 3. Review of the MAR revealed that the resident received 3 mg of Coumadin on 1/22 and 1/23/07. A laboratory report, dated 1/25/07, revealed an International Normalized Ration (INR), which measures bleeding time, was 6.3 (the safe therapeutic range is 0.9 - 1.1). A PA note of 1/25/07 revealed acknowledgement of the high INR rate and ordered Vitamin K to counteract any potential bleeding and re-ordered blood work.

An interview with the Medical Director on 1/30/07 at 12:00 p.m., revealed that if an order is unclear,the nurse should call the provider or the doctor to clarify the order. The PA that wrote the 1/22/07 order to continue the Coumadin at 3 mg was interviewed on 1/31/07 at 10:15 a.m. She stated that she assumed that the previous order was for 3 mg and did not ask anyone to clarify the order but stated that she should have.

The facility policy for noting physician orders, dated 2/28/06, includes that after an order is transcribed, a second nurse will check the orders against the MAR and place a check mark on the

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F 333	Continued From page 16 original order sheet with their initials, date, and time. The policy also indicates that the day nurse will check the orders and MARs each morning and, after checking, will sign and date the original order. When the physician orders were reviewed, there was no evidence that these two checks were completed following the transcription of the above orders. [415.12(m)(2)]	F 333		

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K 000	INITIAL COMMENTS The facility must meet the applicable requirements of the Life Safety Code of the National Fire Protection Association. During the survey, the CMA 2786R "Fire Safety Survey Report 2000 Code - Health Care" was used.	K 000		
K 017 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 This STANDARD is not met as evidenced by: On January 30, 2007, the portions of the building above the suspended ceiling tile system wwas examined for compliance with the applicable standards. The inspection was performed in the presence of the Director of Maintenance, Environmental Services Director, and a maintenance person. The following situations	K 017		3/7/07

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.

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K 017	Continued From page 1	K 017		

were present on two of three wings:

1. The South Wing is three stories tall with a full basement, and the wing is not protected by a fire protection sprinkler system. The resident sleeping rooms are on all three floors. All of the corridor walls on the three resident care stories do not reach the floor decks and roof decks above. The walls end at the underside of the suspended ceiling tile system.

2. The West Wing is two stories tall with a partial basement and is not equipped throughout with a fire protection sprinkler system. There are resident sleeping rooms on the two floors. On the second story, the corridor walls do not reach the roof deck. There is a 2-inch gap between the top of the wall and the roof deck that extends the entire north/south length of the story. On the first story, there is a dining room and a medical records storage room in the east arm of the floor going towards the south wing. For those rooms, the corridor walls end at the underside of the suspended ceiling tile system.

Regarding items 1 and 2, this requirement of the Life Safety Code has been previously waived. The results of the current survey and the review of the facility's previously submitted justification reaffirm correction would pose an undue hardship. Adequate safeguards remain in place to protect the residents, staff and visitors.

Continuation of the waiver for items 1 and 2 is recommended.

Include your request for renewal of the waiver, or a plan of correction, in the space provided on this form.

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K 017	Continued From page 2 [10NYCRR 415.29(a)(2), 711.2(a)(1); 1997 LSC: 13-3.6.2.1]	K 017		
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observations conducted during the Life Safety Code inspection, it was determined that the facility did not properly maintain smoke barrier walls on two of seven resident units (South 1 and 3). The issue was related to openings into smoke barrier walls that compromised the fire resistance rating of these walls. This was a pattern of no actual harm with the potential for more than minimal harm that is not immediate jeopardy. The finding is: On January 30, 2007, between the hours of 9:45 a.m. and 12:15 p.m. and 1:35 p.m. and 3:00 p.m., the building was evaluated for compliance with the Life Safety Code. The Director of Environmental Services, Director of Maintenance, and maintenance staff accompanied the surveyors. When smoke barrier walls were	K 025		3/6/07

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K 025	Continued From page 3 viewed above ceiling tiles, openings into these walls were observed. Examples include, but are not limited to, the following: 1. In the nursing office of the South 3 unit, between rooms #320 and #309, there was a gap approximately 1/2 inch x 24 inches between the sheetrock and the duct. There were gaps approximately 1-inch x 8 inches and 1/2 inch x 6 feet between the sheetrock and roof deck. 2. In room #120 of the South 1 unit, there was an approximately 3 inch x 3 inch gap in the sheetrock and the deck. [10NYCRR 415.29(a)(2), 711.2(a)(1); 1997 LSC: 13-3.7.3, 6-3.2, 6-3.6]	K 025		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: On January 29, 2007, between the hours of 9:02 a.m. and 1:00 p.m., the building was evaluated for compliance with the Life Safety Code. The Director of Maintenance and Environmental	K 029		3/6/07

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K 029	Continued From page 4 Services Director accompanied the surveyors. The following conditions were found. The laundry, and rooms over 50 square feet whose contents include significant amounts of combustible materials, are required to be protected as hazardous areas against the spread of smoke and fire from these rooms. Doors shall be self-closing to these hazardous areas. When such rooms were examined, the following was observed: 1. The South Wing basement laundry room doors are held open by magnetic holders, which are connected to the fire alarm system. When the door to the clean linen side of the laundry room was released from the magnetic holder, the door did not positively latch closed. When the door to the dirty linen side of the laundry room was released from the magnetic holder, the door hit the door frame and disabled the door from fully closing and latching. 2. The North Wing office supply room on the first floor, which is approximately 60 square feet, has a significant amount of combustible materials being stored in it. When the office supply room was inspected, the door to the room lacked a self-closing device. [10NYCRR 415.29(a)(2), 711.2(a)(1); 1997 LSC: 13-3.2.1]	K 029		
K 033 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from	K 033		3/6/07

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K 033	Continued From page 5 other parts of the building. 8.2.5.2, 19.3.1.1 This STANDARD is not met as evidenced by: On January 30, 2007, the portions of the building above the suspended ceiling tile system were examined for compliance with the applicable standards. The inspection was performed in the presence of the Director of Maintenance (DOM), Environmental Services Director, and maintenance person. The following situations were present. 1. The South Wing stairwell C2 doors are equipped with electro-magnetic locking devices. When the electro-magnetic locking devices were released and the surveyor applied pressure to the doors, they did not remain positively latched. 2. The stairwell doors going into the loading dock area are equipped with electro-magnetic locking devices. The DOM told the surveyor that the electro-magnetic devices are not energized during the day for access to the rear of the building. When the surveyor applied pressure on the right side door from the corridor side, it opened and was not positively latched. 3. The stairwell door to the Administration area is held open by a magnetic holder connected to the fire alarm system. When the surveyor pulled the door from the magnetic holder, it closed but did not positively latch. The inability of the stairwell doors to latch compromised the fire and smoke resistance of	K 033		

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K 033	Continued From page 6	K 033		

the stairway.

In addition:

4. The West Wing stairway at the south end of the wing serves as the means of egress from the small basement space. The stairway discharges onto the first floor of the West Wing, not going directly outdoors. The discharge area in the building is four feet away from an exit door directly to the outdoors, but the interior discharge area is not separated from the rest of the building by the accepted separation methods. Also, an air transfer grill that is used for the ventilation of the area compromises the stairway enclosure at the basement level.

5. The east stairway serving the North 2 Unit also serves the basement maintenance area. At the basement, an air transfer grill that is used for ventilating the area compromises that stairway enclosure.

Regarding items 4 and 5, this requirement of the Life Safety Code has been previously waived. The results of the current survey and review of the facility's previously submitted justification reaffirm correction would pose an undue hardship. Adequate safeguards remain in place to protect the residents, staff, and visitors.

Continuation of the waiver is recommended.

Include your request for renewal of the waiver, or a plan of correction, in the space provided on this form.

[10NYCRR 415.29(a)(2), 711.2(a)(1); 1997 LSC: 13-3.1.1, 6-2.4.2]

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K 038 SS=B	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: On January 30, 2007, the portions of the building below the suspended ceiling tile system were examined for compliance with the applicable standards. The inspection was performed in the presence of the Director of Maintenance, Environmental Services Director, and maintenance person. The following situation was present: The exit door serving the Auditorium and the Physical Therapy/Occupational Therapy area discharges into a yard. The yard has a fence with a padlocked gate to provide a secure outdoors environment for residents with dementia. The fence and gate do not allow rapid and easy access to the nearby street. [10NYCRR 415.29(a)(2), 711.2(a)(1); 1997 LSC: 13-2.7, 5-7.1] This requirement of the Life Safety Code has been previously waived. The results of the current survey and the review of the facility's previously submitted justification reaffirm correction would pose an undue hardship. Adequate safeguards remain in place to protect the residents, staff, and visitors. Continuation of the waiver is recommended.	K 038		3/7/07

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K 038	Continued From page 8 Include your request for renewal of the waiver, or a plan of correction, in the space provided on this form.	K 038		
K 052 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on record review and staff interview conducted during the Life Safety Code inspection, it was determined that the facility did not properly maintain and test the fire alarm system. The issue was related to testing frequencies of the fire alarm batteries. This resulted in no actual harm with potential for minimal harm that is widespread, and is evidenced by: The fire alarm system must have a maintenance and testing program complying with applicable requirements of NFPA 72, the National Fire Alarm Code , 1999 Edition. Among the requirements of NFPA 72 are the following: The batteries of the fire alarm system must have a load voltage test performed semi-annually,	K 052		3/6/07

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K 052	Continued From page 9 unless the batteries are of the dry cell type, for which the test must be done monthly. [7-3.2] On January 31, 2007, between the hours of 12:30 p.m. and 1:57 p.m., the records of the maintenance and testing of the fire alarm system were examined. The records indicated that the annual testing of the fire alarm system, along with the load voltage test for the fire alarm batteries, was done on 9/22/06. The Director of Maintenance explained that he is aware that the fire alarm batteries are required to have a load voltage test on a semi-annual basis, and that was not done. There was no documentation that the load voltage test for the fire alarm batteries was done on a six month basis. [10NYCRR 415.29(a)(2), 711.2(a)(1); 1997 LSC: 12-6.3.4.1, 7-6.1.4, 7-6.1]	K 052		
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5	K 056		3/7/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335082	A. BUILDING 01 - MAIN BUILDING B. WING	02/01/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SHORE WINDS	425 BEACH AVENUE ROCHESTER, NY 14612

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 056	Continued From page 10 This STANDARD is not met as evidenced by: Based on record review and staff interviews conducted during the Life Safety Code inspection, it was determined that the facility did not properly maintain the automatic sprinkler system. This resulted in no actual harm with potential for more than minimal harm that is widespread, and is evidenced by the following: On January 31, 2007, at approximately 12:40 p.m., the facilities automatic sprinkler system was evaluated for compliance with the Life Safety Code. The Director of Maintenance (DOM) provided records of the quarterly testing of the automatic sprinkler system. The quarterly reports dated 3/7/06, 6/12/06, 9/21/06, and 12/12/06 revealed the following: Each report indicated that the water flow pressures for the automatic sprinkler were low at 15 pounds (lbs.), 15 lbs., 15 lbs., and 22 lbs., respectively. There were notes from the testing contractor that the low pressures should be addressed. The DOM could not provide records that the low pressure to the automatic sprinkler system had been addressed. The facility did not ensure that the automatic sprinkler system was properly maintained. [10NYCRR 415.29(a)(2), 711.2(a)(1); 1997 LSC: 13-3.5]	K 056		
K 070 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8	K 070		3/6/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335082	A. BUILDING 01 - MAIN BUILDING B. WING	02/01/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SHORE WINDS	425 BEACH AVENUE ROCHESTER, NY 14612

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 070	Continued From page 11 This STANDARD is not met as evidenced by: Based on observations conducted during the Life Safety Code inspection, it was determined that the facility had portable space heating devices in use that exceeded 212 degrees Fahrenheit (*F). This resulted in a pattern of no actual harm with potential for more than minimal harm, and is evidenced by the following: On January 30, 2007, at approximately 1:30 p.m., portable space heating devices were observed in the West Wing 1 dining room. There were two element type portable space heaters, one radiator oil filled type portable space heater, and one baseboard type heater. The surface temperatures of the heating devices were checked with an infra red mini temp device. The electrical element type and radiator oil filled type portable space heaters were found to have surface heat temperatures of approximately 400 *F and 230 *F, respectively. The one baseboard type portable space heater had a surface heat temperature of approximately 186 *F. It was determined that none of the portable space heaters can be used in the facility except the baseboard type portable space heater, which can only be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 *F. (100 degrees Celsius). [10NYCRR 415.29(a); 1997 LSC: 13-7.7]	K 070		
K 130 SS=E	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786	K 130		3/6/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335082	A. BUILDING 01 - MAIN BUILDING B. WING ______	02/01/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SHORE WINDS	425 BEACH AVENUE ROCHESTER, NY 14612

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 130	Continued From page 12	K 130		

This STANDARD is not met as evidenced by:
Based on observations conducted during the Life Safety Code inspection, it was determined that Alcohol Based Hand Rub (ABHR) dispensers were not properly mounted. Specifically, these dispensers were mounted and located near electrical fixtures. This resulted in a pattern of no actual harm with potential for more than minimal harm that is evidenced by the following:

On January 29, 2007, between the hours of 9:02 a.m. and 1:00 p.m., it was observed that ABHR dispensers were mounted and located on walls adjacent to and/or above electrical fixtures on the North, South, and West Wings.

These conditions were found, but not limited to, the following areas or rooms:

1. In the South wing of the building, ABHR dispensers were mounted in resident bathrooms above and/or adjacent to electrical light switches in resident sleeping rooms #314, #316, #322, #324, #328, #230, #229, #220, #210, and the staff lounge.

2. In the North wing of the building, ABHR dispensers were mounted in resident bathrooms above and/or adjacent to electrical light switches in resident sleeping rooms #205 and #201.

3. In the West wing of the building, ABHR dispensers were mounted in resident bathrooms above and/or adjacent to electrical light switches in resident sleeping rooms #205 and #211.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335082	A. BUILDING 01 - MAIN BUILDING B. WING	02/01/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SHORE WINDS	425 BEACH AVENUE ROCHESTER, NY 14612

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 130	Continued From page 13 The positioning of this flammable substance above or adjacent to ignition sources increases the risk of fire. [10NYCRR 415.29(a)(2), 711.2(a)(1); 1997 LSC: 6-4.3.1, 6-4.3.2]	K 130		
K 141 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Non-smoking and no smoking signs in areas where oxygen is used or stored are in accordance with 19.3.2.4, NFPA 99, 8.6.4.2. This STANDARD is not met as evidenced by: Based on observations conducted during the Life Safety code inspection, it was determined that the facility did not have precautionary signs posted where oxygen was used. This resulted in a pattern of no actual harm, with potential for more than minimal harm, and is evidenced by the following: On January 29, 2007, between the hours of 9:02 a.m. and 1:00 p.m., it was observed on the South wing that resident sleeping rooms #208 and #227 had oxygen in use, and there was no signage stating, "No smoking/oxygen in use." On the North wing the Physical Therapy room and on the West wing resident room #205 had oxygen in use, and there was no signage stating, "No smoking/oxygen in use." The main entrances and entrances from the outdoor smoking area doors lacked no smoking signs adjacent to doorways or to building walls. [10NYCRR 415.29(a)(2), 711.2(a)(1); 1997 LSC: 13-3.2.4; NFPA 99, 8.6.4.2]	K 141		3/5/07
K 144	NFPA 101 LIFE SAFETY CODE STANDARD	K 144		3/6/07

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335082	A. BUILDING **01 - MAIN BUILDING** B. WING	**02/01/2007**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SHORE WINDS	**425 BEACH AVENUE** **ROCHESTER, NY 14612**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 144 SS=C	Continued From page 14 Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on record review conducted during the Life Safety Code inspection, it was determined that the facility did not conduct the required tests of the emergency generator. This resulted in no actual harm with potential for minimal harm that is widespread. The finding is: On January 31, 2007, the records of the testing of the emergency electric power generator were examined with the Director of Maintenance. The following conditions were present: The monthly load tests of 30 minutes for the facility's generator were not done for the following months: January 2006, February 2006, March 2006, April 2006, and June 2006. [NFPA 110 Standard for Emergency and Standby Power Systems 1999 Edition: 6-4.3] [10NYCRR 415.29(a)(2), 711.2(a)(1); 1997 LSC: 13-5.1, 7-1.3]	K 144		

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
335082	A. Building B. Wing	3/7/2007

Name of Facility	Street Address, City, State, Zip Code
THE SHORE WINDS	425 BEACH AVENUE ROCHESTER, NY 14612

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0253 Reg. # 483.15(h)(2) LSC	02/22/2007	ID Prefix F0281 Reg. # 483.20(k)(3)(i) LSC	02/22/2007	ID Prefix F0311 Reg. # 483.25(a)(2) LSC	02/22/2007
ID Prefix F0314 Reg. # 483.25(c) LSC	02/22/2007	ID Prefix F0315 Reg. # 483.25(d) LSC	02/22/2007	ID Prefix F0322 Reg. # 483.25(g)(2) LSC	02/23/2007
ID Prefix F0323 Reg. # 483.25(h)(1) LSC	02/21/2007	ID Prefix F0324 Reg. # 483.25(h)(2) LSC	02/20/2007	ID Prefix F0333 Reg. # 483.25(m)(2) LSC	02/23/2007
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:
2/1/2007

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335082	A. BUILDING **01 - MAIN BUILDING** B. WING	R **03/07/2007**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SHORE WINDS	**425 BEACH AVENUE** **ROCHESTER, NY 14612**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS	{K 000}		

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.