NEW YORK STATE OF OPPORTUNITY. | Department of Health

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Executive Deputy Commissioner

February 10,2021

Ms. Anne Gallese
Kirkhaven
254 Alexander Street
Rochester, NY 14607-2591

Facility: **Kirkhaven**
Medicare Provider #: **33-5668**
Type of Survey: **Focused Infection Control COVID-19 Survey**
Event ID #: **0H6N11**
Survey Exit Date: **01/22/2021**

Dear Ms.Gallese:

On 01/22/2021 a Focused Infection Control COVID-19 Survey was completed to determine if your facility was in compliance with Federal and State requirements related to maintaining an infection prevention and control program to prevent the development and transmission of COVID-19.

All Federal and State program requirements were in substantial compliance.

Survey reports and the Nursing Home Survey Profile must be made available to residents and their representatives in a place that is readily accessible and in a manner that allows review without the need to ask nursing home staff for these documents. If necessary, a notice of the place where they are available is to be posted in a public place. Survey reports become disclosable immediately after being made available to the facility and must remain accessible until you receive the results of a new recertification survey. To protect resident confidentiality, do not post the resident roster.

If you have any questions you may contact Lori Grow at 585-423-8020.

Sincerely,

Gale L. Ajavon

Gale L. Ajavon
WRO RAO LTC Program Manager
Division of Nursing Home and ICF/IID Surveillance

GLA/rj
Enclosure

cc: Dianna Leach, Ombudsman Program Coordinator
Maury Meredith, Centers for Medicare and Medicaid Services
Bureau of Surveillance and Quality Assurance
profcred@health.ny.gov

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335668	A. BUILDING _____ B. WING _____	01/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KIRKHAVEN	254 ALEXANDER STREET ROCHESTER, NY 14607

(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) COMPLETE DATE
F 000	INITIAL COMMENTS An Infection Control COVID-19 Focus Survey was conducted at Kirkhaven on 01/22/21 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. No deficiencies were cited as a result of this survey.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/10/2021

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 the 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.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.