

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335005	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2026
NAME OF PROVIDER OR SUPPLIER Briarcliff Manor Center for Rehab and Nursing Care		STREET ADDRESS, CITY, STATE, ZIP CODE 620 Sleepy Hollow Road Briarcliff Manor, NY 10510	
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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and observations conducted during survey the facility failed to ensure residents receive services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain for 1 of 5 residents reviewed for antibiotics. Specifically, Resident #5 was determined to have a urinary tract infection on 4/13/26, refused antibiotics in all forms and there was no documented follow up. Resident was admitted to hospital on [DATE] with a urinary tract infection. The findings include: Resident #5 was admitted to facility with the following diagnoses including: Non-Alzheimer's Dementia, Bipolar, and Schizophrenia. The 1/19/2026 Annual Minimum Data Set (resident assessment) documented Resident #5 had moderate impairment in cognition. It documented Resident #5 was always continent of bowel and bladder and needed supervision for toileting. The 4/13/2026 urine test documented Resident #5 had a urinary tract infection. The 4/14/26 Physician Order documented Cipro (antibiotic) 500 milligram by mouth every 12 hours for 7 days for urinary tract infection. The April 2026 Medication Administration Record documented the 4/14/26 Physician Order Cipro 500 milligram by mouth every 12 hours for 7 days for urinary tract infection, 4 out of 5 doses refused. The April 2026 Medication Administration Record documented dextrose 5% and 0.45% sodium chloride intravenous solution: infuse 70 cc per hour by intravenous route every shift was documented refused on 4/16/2026. The 4/16/26 Nursing Note written by Registered Nurse Unit Manager #2 at 10:18 PM documented resident continues to refuse all medications. Resident #5 was previously on Cipro 500 mg by mouth twice daily for 7 days for urinary tract infection; however resident remains non compliant with all medications by mouth. Nurse Practitioner #1 was made aware. New orders received for ceftriaxone 1 gram daily for 7 days. Designated Representative #1 was made aware. The 4/16/26 Medical Note written by Nurse Practitioner #1 documented Resident #5 seen for follow up for urinary tract infection. It further documented Resident #5 has been refusing oral medications including antibiotics. The 4/17/26 Physician Order documented Ceftriaxone (antibiotic) 1 gram solution for injection intramuscular 1 time daily for 7 days for urinary tract infection. The April 2026 Medication Administration Record documented the 4/17/26 Physician Order Ceftriaxone 1 gram solution for injection intramuscular 1 time daily for 7 days for urinary tract infection, 6 out of 6 doses refused. Resident #5 refused 10 out of 11 doses of antibiotic medications via intravenous, intramuscular and oral forms. The 4/20/2026 Medical Note written by Nurse Practitioner #1 documented resident seen for follow up dementia and urinary tract infection. Resident #5 had a history of dementia and selective mutism and was seen for follow up of urinary tract infection and cognitive status. Resident #5 remained minimally interactive at baseline with limited ability to report symptoms. Resident #5 continued on Ceftriaxone intravenous for a confirmed positive urinary tract infection (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
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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with E. coli (Escherichia coli, bacteria in the colon). Previously noted medication noncompliance with refusal of oral antibiotics; currently tolerating intravenous therapy. The documented plan was to continue close monitoring of infection response, hydration status, and cognitive baseline. The 4/20/26 Medical Note written by Nurse Practitioner #1 documented Resident #5 seen for follow up for urinary tract infection. It documented resident refused Ceftriaxone. Previously noted for medication non compliance with refusal of oral antibiotics, currently tolerating intravenous therapy. It documented to continue to use intravenous route for antibiotics The 4/22/26 at 2:24 PM Nursing note and 4/23/26 at 2:34 PM Nursing note written by Licensed Practical Nurse #44 documented Resident #5 refused all medications during this tour. It documented Nurse Practitioner #1 was notified of medication refusals. The 4/23/26 Care Plan meeting note documented interdisciplinary team met with Designated Representative #1 to discuss patient's progress thus far. Per nursing, Resident #5 refused medication in all routes. The 4/26/2026 Nursing note documented despite encouragement and reapproach 3 times, resident refused for IV line to be inserted. Physician #1 was made aware and placed an order for intravenous fluids and intravenous antibiotics to be discontinued. Resident to start on intramuscular ceftriaxone. There was no documented evidence of follow up related to Resident #5 refusals to take any form of antibiotics for their urinary tract infection. The 6/07/2026 Nursing note documented Next of Kin #1 called 911 when they visited Resident #5 and requested the resident be transferred to the emergency room for further evaluation. The Next of Kin #1 reported the resident experienced a decline in mental health. Emergency Medical Services contacted receiving hospital and proceeded with transfer. The 6/10/26 Hospital Discharge Paperwork documented Resident #5 was admitted to hospital for evaluation of altered mental status, agitation, poor oral intake and reported weight loss. Initial evaluation was notable for findings consistent with a urinary tract infection. During an interview on 7/13/2026 at 12:31 PM, Registered Nurse Unit Manager #2 Registered Nurse Unit Manager #2 stated the 4/13/2026 urinalysis documented the resident was positive for a urinary tract infection. They stated the resident was prescribed antibiotics and refused to take them. They further stated the physician was informed and hospitalization was discussed with the physician, however, they were unable to find documented evidence. Registered Nurse Unit Manager #2 reviewed the hospital records and acknowledged that Resident #5 had diagnosis of urinary tract infection. During an interview on 7/14/2026 at 9:54 AM, Physician #1 stated they were not informed by the nursing staff that the resident did not take the injectable antibiotic. They stated Nurse Practitioner #1 may have been informed but it was not communicated to them and they relied on the nursing staff to inform them. They stated they found out after the resident was hospitalized that they still had a urinary tract infection. Physician #1 acknowledged they did not follow up on antibiotic refusals and stated if they would have been aware of the refusals they would have repeated the urine sample. During an interview on 7/14/2026 at 12:41 PM, the Psychiatrist stated they were also never informed that the resident had a urinary tract infection, which could contribute to the resident's altered mental status. 10 NYCRR 415.12(d)(1)		

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. Based on record review, interviews, and observations conducted during a survey, the facility failed to ensure a resident was provided with the necessary services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care for 1 of 5 residents reviewed for behavioral health. Specifically, Resident #5 refused 144 out of 178 doses of antipsychotic medications from March 2026 to June 2026 that contributed to symptoms of catatonia (withdrawal, intermittent mutism and posturing), weight loss, urinary tract infection and admission to hospital on 6/7/26. Findings include: Resident #5 was admitted to facility with the following diagnoses including: Non-Alzheimer's Dementia, Bipolar, and Schizophrenia. The 1/19/2026 Annual Minimum Data Set (resident assessment) documented Resident #5 had moderate impairment in cognition. It documented the resident sometimes felt lonely or isolated from those around them and received antipsychotics on a routine basis. The 11/27/2023 Psychoactive Medication Care Plan documented resident was at risk for side effects related to psychoactive medications. The documented interventions were to: administer medications as ordered by the physician, monitor for behaviors, monitor response to medications, notify physician if medications are refused because medications are ineffective in not taken regularly. The 3/18/24 physician order documented Fluphenazine (antipsychotic medication) 5 milligram/milliliter (liquid) give 2 milligrams by mouth 2 times a day for schizophrenia. The 3/11/26 physician documented Fluphenazine 1 milligram give 2 tablets, 2 times a day for catatonic schizophrenia. The 3/18/26 physician order documented Fluphenazine decanoate 25 milligram injection every 2 weeks for schizophrenia. The 4/07/2026 Psychiatric Consult documented a follow up with Resident #5 for medication nonadherence and features of catatonia including withdrawal, intermittent mutism and posturing. Due to a medication noncompliance Fluphenazine decanoate, an antipsychotic medication was initiated and administered on 4/2/2026. Resident #5 continued to present with catatonic features, including withdrawal, minimal engagement. Per nursing, appetite has improved and sleep remains normal. The plan documented to continue Fluphenazine decanoate for schizoaffective disorder to target symptoms of medication nonadherence, catatonic features, decreased oral intake, impaired functioning from baseline. The 4/20/2026 Medical Note written by Nurse Practitioner #1 documented resident seen for follow up dementia and urinary tract infection. Resident #5 had a history of dementia and selective mutism and was seen for follow up of urinary tract infection and cognitive status. Resident #5 remained minimally interactive at baseline with limited ability to report symptoms. Oral intake remained variable. Neuro consult was reviewed and recommendations included supportive care and delirium precautions. The plan was to initiate Donepezil (memory enhancement medication) 5 milligram at bedtime as recommended by neurology. Resident #5 continued on Ceftriaxone intravenous for a confirmed positive urinary tract infection with E. coli (Escherichia coli, bacteria in the colon). Previously noted medication noncompliance with refusal of oral antibiotics; currently tolerating intravenous therapy. No acute changes reported. Continue plan, neurology recommendations implemented with initiation of Donepezil. Continue close monitoring of infection response, hydration status, and cognitive baseline. The 4/20/26 Medical note written by Physician # 1 documented the resident was seen on 4/17/26 and was stable. The note did not document resident's continued refusal of antipsychotic medications. The 4/21/2026 Psychiatric Consult documented the resident was seen for medication nonadherence and catatonia. If symptoms worsen or new concerning features emerge, please transfer resident to a higher level of care for further (continued on next page)		

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	evaluation. The 4/23/26 Care Plan meeting note documented interdisciplinary team met with Designated Representative #1 to discuss patient's progress thus far. Per nursing, resident was refusing medication in all routes. There was no documented evidence hospitalization was discussed to psychiatrically stabilize resident if symptoms worsen as recommended by psychiatrist in their notes on 4/21/2026. The 4/25/26 Medical note written by Physician #1 documented resident still refusing fluphenazine despite all attempts. It further documented they spoke to Resident #5 about taking medication and the resident agreed. The plan was to follow up with psychiatry. The March, April and May 2026 Medication Administration Records documented 144 refusals out of 178 doses of antipsychotic medications. Nurse Practitioner #1 documented they were made aware of antipsychotic medication refusals on 3/17/26, 4/7/26, 4/14/26, 4/16/26, 4/20/26 and 4/21/26. The 5/05/2026 Psychiatric Consult documented the resident was seen for medication nonadherence and catatonia. If symptoms worsen or new concerning features emerge, please transfer resident to a higher level of care for further evaluation. The 5/19/26 at 3:02 PM Nursing note documented Resident #5 refused all medications. The 5/13/26 Medical Note written by Nurse Practitioner #1 documented per nursing report Resident #5 refused all medications this tour. Medication review notable for intermittent refusal of oral medications including fluphenazine (antipsychotic) by mouth per medication administration record review. The plan was to continue behavioral redirection and encouragement; Monitor psychiatric status and medication adherence closely. The 5/27/26 at 2:37 PM Nursing note documented Resident #5 refused all medications. The 5/27/26 Medical note written by Nurse Practitioner #5 documented per nursing report Resident #5 refused all medications this tour. The plan was to provide education and reassurance as tolerated, Re-approach later and administer medications if resident agrees, document refusal and notify provider/family. The 6/07/2026 Nursing note documented Next of Kin #1 called 911 when they visited Resident #5 and requested the resident be transferred to the emergency room for further evaluation. The Next of Kin #1 reported the resident experienced a decline in mental health. Emergency Medical Services contacted receiving hospital and proceeded with transfer. The 6/10/26 Hospital Discharge Paperwork documented Resident #5 was admitted to hospital for evaluation of altered mental status, agitation, urinary tract infection, poor oral intake and reported weight loss. During an interview on 7/13/2026 at 12:31 PM, Registered Nurse Unit Manager #2 stated Resident #5 took one (1) or two (2) of the antipsychotic medication injections and stated the physician was informed of the refusal. They further stated the physician was informed and hospitalization was discussed with the physician, however, they were unable to find documented evidence. During a follow up interview on 7/14/2026 at 11:16 AM Designated Representative #1 stated they were not asked about sending Resident #5 to the hospital for psychiatric evaluation to stabilize the resident. They stated they would have agreed to send the resident to the hospital. During an interview on 7/14/2026 at 12:41 PM, the Psychiatrist stated when they held the fluphenazine due to abnormal labs, mild catatonia happened (withdrawal, intermittent mutism and posturing). Psychiatrist stated holding the antipsychotic medication may have contributed to catatonia, but it was very mild. The Psychiatrist stated the resident had some improvement, after medication was restarted, and did not see any concerns. In March, Resident #5 started to refuse any form of oral antipsychotic medication (fluphenazine), so a long-acting injection (fluphenazine) was ordered. They stated the resident was improving in April; the resident was talking more and engaging but they were unaware the resident was not taking the long-acting antipsychotic injection. The Psychiatrist stated there was no discussion with the interdisciplinary team about hospitalization for psychiatric stabilization. If they had been aware the long-acting antipsychotic injectable medication was not being taken regularly they would have sent Resident #5 out to the hospital within a month to stabilize (continued on next page)		

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident's medication. They further stated when the resident did not take their antipsychotic medication it would cause psychiatric decompensation. The psychiatrist stated they were also not informed that the resident had a urinary tract infection, which could have contributed to altered mental status. During a follow up interview on 7/24/2026 at 12:27 PM, Physician #1 stated they had discussions about hospitalization to psychiatrically stabilize the resident, but Resident #5 and Designated Representative #1 refused. Physician #1 was unable to find documented evidence of these conversations. ^ 10 NYCRR 415.12(f)(1)		