STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335014	A. Building B. Wing	08/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Schenectady Center for Rehabilitation and Nursing	526 Altamont Ave Schenectady, NY 12303

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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. F725 Based on observation, interviews, and record review during the recertification and abbreviated survey (Case #s:), the facility did not ensure provision of sufficient nursing staff to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident throughout the facility. Specifically, the facility's minimum staffing levels were not met on multiple shifts and multiple units between 8/04/2025 and 8/17/2025. Additionally, there were multiple residents and family complaints regarding the lack of sufficient staffing, resulting in staff's timely response to call lights and not providing scheduled showers and treatments both during initial resident and family interviews and Resident Council, and complaints made through the complaint department of the New York State Department of Health nursing home complaint hotline. This is evidenced by: The Facility Assessment, dated 1/2025, documented the average daily census was 237 full beds, with a maximum bed count of 240. Under section titled Staffing Plan, documented ?based on your resident population and their needs for care and support, describe your general approach to staffing to ensure that you have sufficient staff to meet the needs of the residents at any given time. Examples of two different ways to look at your staffing plan are provided in the tables below. Choose a methodology that works best for your organization. You may elect to use one or both tables below or choose your own methodology. It may be helpful to review specific staffing references in the regulation regarding the facility assessment (see attachment 1). For a discussion on how to determine sufficient staffing, see attachment 2, section 7.b.' The facility's Facility Assessment, Attachment 2, section 7.b., documented ?do we need to make any changes in staffing? Based on resident number, acuity, and diagnoses of resident population and our current level of staffing, do we have sufficient nursing staff (nurses and CNAs) with the appropriate competencies and skills? How do we determine if we have sufficient staffing? Consider the following: Gather input from residents, family members, and/or resident representatives, CNAs, licensed nurses providing direct care, and the local long-term care ombudsman about how well the current staffing plan has been working and any concerns, and make sure to consider this information when developing the staffing plan. Calculate the type of staff and the amount of staff time needed to meet residents' daily needs, preferences, and routines in order to help each resident attain or maintain the highest practicable physical, mental, and psychosocial well-being. Review expectations for minimum staffing requirements at the federal and state level. Federal law requires nursing homes to have sufficient staff to meet the needs of residents, to use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. S483.35(b)(1), and must designate a licensed nurse to serve as a charge nurse on each tour of duty (S483.35(a)(2). However, there is no current federal requirement for specific nursing home staffing levels. Review comparative data (at the nursing home, state and national level) available on the staff measure on Nursing Home Compare. Ask how do we compare, and if we have different HRPD from other homes, the state, and nation, why? What might that mean and how might it inform our staffing plan? Note that the Nursing Home Compare staffing rating takes into account differences in the levels of residents' care needs in each nursing home. For example, a nursing home with residents that have more health problems would be expected to have more nursing staff than a nursing home (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	where the residents need less health care.' The staffing requirements were broken down in number needed or average or range as follows: Licensed nursed providing direct care: Day shift: 1-3 Registered Nurses, 1-12 Licensed Practical Nurses Evening shift: 0-1 Registered Nurse Supervisor and 1-12 Licensed Practical Nurses Night shift: 0-1 Registered Nurse Supervisor and 1-6 Licensed Practical Nurses Nurse Aides Day shift: 6-20 Certified Nurse Aides Evening shift: 6-20 Certified Nurse Aides Night shift: 2-6 Certified Nurse Aides The sheets provided for 8/04/2025, 8/05/2025, 8/06/2025, 8/07/2025, and 8/12/2025 all included the number of staff required and the number of staff scheduled but not the total census. The sheets provided 8/08/2025, 8/09/2025, 8/10/2025, 8/11/2025, 8/13/2025, 8/15/2025, 8/16/2025, and 8/17/2025 included only the number of staff scheduled, not the number required but listed the total census as 240 every day. Staffing sheets provided by the facility indicated the following staffing shortages: 8/04/2025 6:30 AM - 2:30 PM documented that 13 nurses were required and 10 were scheduled. 2:30 PM - 10:30 PM documented that 24 Certified Nurse Aides were required and 21 were scheduled. 8/05/2025 6:30 AM - 2:30 PM documented that 12 nurses were required and 10 were scheduled. 6:30 AM - 2:30 PM documented that 27 Certified Nurse Aides were required and 26 were scheduled. 2:30 PM - 10:30 PM documented that 12 nurses were required and 9 (nine) were scheduled. 8/08/2025 6:30 AM - 2:30 PM documented that 27 Certified Nurse Aides were scheduled. 2:30 PM - 10:30 PM documented that 21 Certified Nurse Aides were scheduled. 8/09/2025 6:30 AM - 2:30 PM documented that 11 nurses were scheduled. 6:30 AM - 2:30 PM documented that 21 Certified Nurse Aides were scheduled. 2:30 PM - 10:30 PM documented 21 Certified Nurse Aides were scheduled. 8/10/2025 6:30 AM - 2:30 PM documented that 9 (nine) nurses were scheduled. 6:30 AM - 2:30 PM documented 20 Certified Nurse Aides were scheduled. 2:20 PM - 10:30 PM 12 nurses were scheduled. 2:30 PM - 10:30 PM 18.5 Certified Nurse Aides were scheduled, the 0.5 due to a Certified Nurse Aide coming in at 6:30 PM. 8/11/2025 6:30 AM - 2:30 PM documented that 11 nurses were scheduled. 2:20 PM - 10:30 PM 11.4 nurses were scheduled, the 0.4 due to 1(one) nurse coming in late and 1(one) nurse leaving early. 8/12/2025 6:30 AM - 2:30 PM documented that 13 nurses were required, and 12 nurses were scheduled. 2:20 PM - 10:30 PM documented that 12 nurses were required and 10.5 were scheduled, the 0.5 due to 1(one) nurse coming in late. 8/13/2025 6:30 AM - 2:30 PM documented that 11.8 nurses were scheduled, 0.8 due to 1 (one) nurse leaving early. 8/16/2025 6:30 AM - 2:30 PM documented that 9 nurses were scheduled. 6:30 AM - 2:30 PM documented that 25 Certified Nurse Aides were scheduled. 2:30 PM - 10:30 PM documented 20.9 Certified Nurse Aides were scheduled, with multiple Certified Nurse Aides coming and going outside the regular shift time. 2:20 PM - 10:30 PM 10 nurses were scheduled. 8/17/2025 6:30 AM - 2:30 PM documented that 9 (nine) nurses were scheduled. 6:30 AM - 2:30 PM documented that 25 Certified Nurse Aides were scheduled. 2:30 PM - 10:30 PM documented 19.4 Certified Nurse Aides were scheduled, with multiple Certified Nurse Aides coming and going outside the regular shift time. 2:20 PM - 10:30 PM 9.8 nurses were scheduled, with one nurse leaving early. Of the 14 complaints brought on survey, 9 of the complaints were related to complaints regarding staffing levels being unsatisfactory for resident care, and long call bell times. During an observation on 8/07/2025 at 10:55, a call bell was noted to alarm for over 10 minutes. During an observation on 8/07/2025 at 11:18 AM, Resident #8's (eight) call light was observed on. The unit secretary answered the light, resident needed to be changed, needed to be changed and was not changed until 11:53 AM, after the resident put their call light on again at 11:52 AM. During an observation on 8/08/2025^ at 12:41 PM, call bells for rooms 108A^ and 127 were noted to alarm for over 15 minutes. During an observation on 8/14/2025 at 10:37 AM, 3 (three) staff members were noted to be gathered around the nursing unit desk while multiple call bells were ringing.^ During an observation on 8/14/2025 at 11:00 AM, two (2) staff members were seen at a staff desk. One was on their phone, and one was tucked behind a doorway, sitting on their phone. During a surveyor-led Resident Council meeting on 8/11/2025 at 10:00 AM, when asked do you get the help and care you need without waiting a long time? Does the staff respond to your call light timely? The responses were the following: That's an (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	iffy sometimes. They're talking on the phone while giving them care. It's our time they're wasting when on the phone. On phones rather than answering their needs. They think they can do both. Too many times, they're understaffed. Staffing was bad all the time. Staffing hasn't gotten better. Resident #84 stated sometimes they waited over an hour, sometimes an hour and half at times. ˆ There was a lack of staffing especially on the weekend. Sunday 8/10/2025 they had 1(one) nurse on each unit upstairs. 3 (three) aides per unit. Staffing affects all the shifts. That's not unusual; that's the sad part. ˆ During an interview on 8/14/2025ˆ at 11:50 AM, Resident #5 (five) stated they have had to wait 2 (two) hours for the light to be answered and weekends are worse.ˆ During a phone interview on 8/14/2025 at 9:56 AM, Staffing Coordinator #1(one) stated that staff fluctuated. There were good months and bad months. Staffing Coordinator #1(one) stated they overstaff every unit because the amount of call-outs received made making sure there was adequate coverage difficult. Staffing Coordinator stated a Certified Nurse Aide class had just graduated, and once they were certified, they would join the staff, but in the meantime, they were all on the units and were supposed to be assisting in ways they could, such as changing bed linens, answering call bells, and retrieving supplies for staff as needed. Staffing Coordinator #1(one) stated that they worked closely with Administrator #1(one) and Director of Nursing #1(one), as well as corporate. Staffing Coordinator #1(one) stated that even though they schedule more people than required, once they explained their logic to the administration, they stopped getting spoken to for overstaffing. When discussing resident complaints of long call bell times and inefficient care, Staffing Coordinator #1 (one) stated they thought that the work ethic of the staff was more of a problem than the number of people they scheduled, stating it was about quality more than quantity. Staffing Coordinator #1 (one)stated they sometimes worked the floor as a Certified Nurse Aide and could work with 6 (six) staff or 3 (three) staff and it was possible that 3 (three) staff would get more done because they worked harder than 6 (six) would. Staffing Coordinator #1(one) stated that they could use more staff, but those staff needed to be good at their job, just having numbers doesn't mean the job will get done. During an interview on 8/14/2025 at 10:32 AM, Licensed Practical Nurse #11 stated that the rehab unit usually had 2 (two) nurses and Certified Nurse Aides were usually well stocked, but some of the Certified Nurse Aides were not great at their job, which made their job harder. During an interview on 8/14/2025 at 10:47 AM, Certified Nurse Aide #8 (eight) stated that sometimes other aides will look for them to go to specific rooms they're assigned to and not help in rooms that are not. Certified Nurse Aide #8 (eight) stated that it wasn't how they worked. They go in whatever room requires help, regardless of the assignment.ˆ During an interview on 8/14/2025 at 10:51 AM, Registered Nurse #1 stated that there were 2 (two) Certified Nurse Aides on their side and the other half of the unit had the same amount. During an interview on 8/14/2025 at 10:53 AM, Licensed Practical Nurse #1(one) stated that usually there were 4 (four) Certified Nurse Aides and 2 (two) Licensed Practical Nurses per unit and that it was sufficient, but it depended on the quality of the Certified Nurse Aide. Licensed Practical Nurse #1(one) stated they don't see staff hanging out on their shift. Nor did they come to work in the morning and find residents soiled from the night before. During an interview on 8/14/2025 at 11:07 AM, Licensed Practical Nurse #12 stated that 4 (four) Certified Nurse Aides and 2 (two) nurses per unit were the usual staffing. How well that works out is hit or miss. There should be enough staff. During an interview on 8/14/2025 at 11:13 AM, Certified Nurse Aide #3 (three) stated that since May 2025, there have been 4 (four) Certified Nurse Aides and 2 (two) nurses per unit. Sometimes, when residents with behavior issues get worked up, they need extra hands. Certified Nurse Aide #3 (three) stated they worked as a team; every resident was their resident and couldn't speak to every Certified Nurse Aide, thinking the way they did. During an interview on 8/18/2025 at 10:08 AM, Resident #104 stated that the previous day, Sunday day shift on 8/17/25, only 2 (two) aides and 1 (one) nurse were on the unit, and as a result, not everyone got up. ˆ During an interview on 8/18/2025 at 10:12 AM, Resident #84 stated that Sunday was very low-staffed. Resident #83 stated that they got up at 5 AM while the night staff was still there for fear that they would not get (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	help during the day. Surveyor observation of the unit made evident that only 1 (one) Certified Nurse Aide was on the unit until 10 AM, and the second Certified Nurse Aide came on. The only nurse on the unit was noted to be working a double shift that had started on the night shift. During an interview on 8/18/2025 at 12:20 PM, Director of Nursing #1(one) stated that call bells should be answered within 15 to 20 minutes. Half an hour might be appropriate depending on what was happening on the floor. There were high call times after breakfast when people were getting up and during evening care. Director of Nursing #1(one) stated that when they round, they did not see people on their cell phones or hanging out. When asked why the Facility Assessment gave ranges as wide as 6-20 Certified Nurse Aides as a plan, the Director of Nursing stated that Administrator #1(one) wrote it with input from them and Staffing Coordinator #1(one). Director of Nursing #1(one) stated that there would never be just 6 (six) Certified Nurse Aides on during the day. During an interview on 8/19/2025 at 10:47 AM, Administrator #1(one) stated that facilities were allowed to use ranges in the facility assessments. If there were (six) 6 Certified Nurse Aides on during the day, that would be considered an all hands-on deck time and everyone would be on the units helping. Physical therapy would get people out of bed and Administrator #1 (one) would answer call bells, stating he had answered a call bell that day. Administrator #1(one) stated that the facility was in a good location and staffing was better than it was in the winter. Compared to other facilities, Administrator #1(one) stated they believed they were doing a good job.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observations, record review, and interviews during a recertification survey, the facility did not ensure that drug records were in order; and that an account of all controlled drugs was maintained and periodically reconciled on six (6)(Birch, Willow, Oak, Elm, Maple, and Cedar) of (6) six units reviewed. Specifically, the shift-to-shift staff signature form for controlled drugs, titled Shift Count, did not consistently include the signatures of staff members at each shift change, validating the correct narcotic count. This is evidenced by: The policy and procedure titled Narcotic Count, dated 8/2018, documented the on-coming and the off-going nurses assigned to the medication cart would be responsible for ensuring the accuracy of the controlled drug count. A review of the shift-to-shift reconciliation of narcotics forms on Birch unit medication cart #1(one) for 8/1/2025-8/13/2025 documented missing signatures for the following dates: 8/1/2025 off-going nurse signature at 10:30 PM and 8/6/2025 off-going nurse signature at 6:30 AM. There were no entries for 8/5/2025 other than signatures at 6:30 AM. A review of the shift-to-shift reconciliation of narcotics forms on Birch unit medication cart #2 (two) for 81/2025-8/13/2025 documented missing signatures for the following dates: 8/2/2025 on-coming nurse signature for an unknown time, 8/3/2025 off-going nurse signature at 6:30 AM, 8/4/2025 on-coming nurse signature at 2:30 PM, and 8/6/2025 on-coming nurse signature at 2:30 PM. A review of the shift-to-shift reconciliation of narcotics forms on [NAME] unit medication cart #1(one) for 81/2025-8/13/2025 documented missing signatures for the following dates: 8/1/2025 on-coming nurse signature at 10:30 PM, 8/2/2025 off-going nurse signature at 6:30 AM, 8/7/2025 on-coming nurse signature at 2:30 PM, 8/8/2025 off-going nurse signature at 2:30 PM, 8/9/2025 on-coming nurse signature for unknown time, and 8/9/2025 off-going nurse signature at 10:30 PM. A review of the shift-to-shift reconciliation of narcotics forms on [NAME] unit medication cart #2 (two) for 8/1/2025-8/13/2025 documented missing signatures for the following dates: 8/2/2025 on-coming nurse signature at 6:30 AM, 8/2/2025 off-going nurse signature at 2:30 PM, 8/3/2025 on-coming nurse signature at 6:30 AM, 8/3/2025 off-going nurse signature at 2:30, 8/3/2024 off-going nurse signature at 10:30 PM, 8/4/2025 on-coming nurse and off-going nurse signatures at 6:30 AM, 84/2025 off-going nurse signature at 2:30 PM, 8/5/2025 on-coming and off-going nurse signatures at 6:30 AM, 8/5/2025 off-going nurse signature at 2:30 PM, 8/8/2025 on-coming nurse signature at 10:30 PM, 8/9/2025 off-going nurse signature at 7:25 AM, 8/10/2025 on-coming nurse signature at 6:30 AM, and 8/10/2025 off-going nurse signature at 2:30 PM. A review of the shift-to-shift reconciliation of narcotics forms on Oak unit medication cart #1(one) for 81/2025-8/13/2025 documented missing signatures for the following dates: 8/1/2025 on-coming and off-going nurse signatures at 6:30 AM, 8/1/2025 off-going nurse signature at 2:30 PM, 8/7/2025 on-coming nurse signature at 2:30 PM, 8/7/2025 on-coming and off-going nurse signature at 10:30 PM, 8/11/2025 off-going nurse signature at 6:30 AM, 8/11/2025 on-coming nurse signature 10:30 PM, 8/12/2025 off-going nurse signature at 6:30 AM, and 8/12/2025 off-going nurse signature at 6:30 AM. A review of the shift-to-shift reconciliation of narcotics forms on Oak unit medication cart #2 (two) for 8/1/2025-8/13/2025 documented missing signatures for the following dates: 8/7/2025 on-coming nurse signature at 10:30 PM, 8/8/2025 off-going nurse signature at 6:30 AM, 8/10/2025 off-going nurse signature at 10:30 PM, 8/11/2025 off-going nurse signature at 6:30 AM, 8/12/2025 on-coming nurse signature at 10:30 PM, and 8/13/2025 off-going nurse signature at 6:30 AM. A review of the shift-to-shift reconciliation of narcotics forms on Elm unit medication cart #1(one) for 8/1/2025 - 8/12/2025 documented missing signatures for the following dates: 8/1/2025 on-coming nurse signature at 6:30 AM, 8/1/2025 off-going nurse signature at 2:30 PM, 8/1/2025 on-coming nurse signature at 10:30 PM, 8/2/2025 on-coming nurse signature at 10:30 PM, 8/3/2025 on-coming nurse signature at 6:30 AM, 8/3/2025 off-going nurse signature at 2:30 PM, 8/5/2025 on-coming and off-going nurse signatures at 6:30 AM, 8/5/2025 off-going nurse signature at 2:30 PM, 8/7/2025 off-going nurse signature at 2:30 PM, (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	8/10/2025 on-coming nurse at 10:30 PM, and 8/11/2025 off-going nurse signature at 6:30 AM. A review of the shift-to-shift reconciliation of narcotics forms on Maple unit medication car #1(one) for 8/1/2025 - 8/12/2025 documented missing signatures for the following dates: 8/3/2025 off-going nurse signature for 6:30 AM, 8/7/2025 on-coming and off-going nurse signatures at 2:30 PM, 8/7/2025 off-going nurse signature for 10:30 PM 8/9/2025 on-coming nurse signature at 6:30 AM, 8/9/2025 on-coming and off-going nurse signatures at 2:30 PM, 8/9/2025 off-going nurse signature at 10:30 PM, 8/11/2025 on-coming nurse signature for 10:30 AM, 8/12/2025 off-going nurse signature at 6:30 AM, and 8/12/2025 on-coming nurse signature at 2:30 PM. A review of the shift-to-shift reconciliation of narcotics forms on Cedar unit medication cart #2(two) for 8/1/2025-8/13/2025 documented missing signatures for the following dates: 8/1/2025 on-coming nurse signature at 2:30 PM, 8/1/2025 off-going nurse signature at 10:30 PM, 8/2/2025 on-coming and off-going nurse signatures at 6:30 AM, 8/2/2025 on-coming and off-going nurse signatures at 2:30 PM, 8/2/2025 off-going nurse signature at 10:30 PM, 8/3/2025 off-going nurse signature at 6:30 AM, 8/3/2025 on-coming nurse signature at 2:30 PM, 8/3/2025 off-going nurse signature at 10:30 PM, 8/5/2025 on-coming nurse signature at 6:30 AM, 8/5/2025 off-going nurse signature at 2:30 PM, 8/7/2025 off-going nurse signature at 6:30 AM, 8/7/2025 on-coming nurse signature at 2:30 PM, 8/7/2025 off-going nurse signature at 10:30 PM, 8/8/2025 on-coming nurse signature at 2:30 PM, 8/8/2025 off-going signature at 10:30 PM, 8/9/2025 on-coming nurse signature at 10:30 PM, 8/10/2025 off-going nurse signature at 6:30 AM, 8/12/2025 on-coming nurse signature at 10:50 PM, and 8/13/2025 off-going nurse signature at 6:30 AM. During an interview on 8/12/2025 at 10:06 AM, Licensed Practical Nurse #3 (three) stated there was no excuse not to sign the shift-to-shift narcotic count sheets. If a nurse was alone on the unit, the supervisor should come to assist with the count. During an interview on 8/13/2025 at 8:27 AM, Registered Nurse #1(one) stated the narcotic book should be signed shift to shift and there shouldn't be any blanks. During an interview on 8/13/2025 at 9:01 AM, Licensed Practical Nurse #9(nine) stated there should not be any blanks on the shift-to-shift narcotic count sheet and it should be signed by both nurses at the time of the count. During an interview on 8/13/2025 at 9:15 AM, Registered Nurse #3 (three) stated the shift-to-shift sheets should be signed shift to shift when the count occurred. During an interview on 8/18/2025 at 12:20 PM, Director of Nursing #1 (one) acknowledged that shift to shift narcotic sheets were not being signed as directed and the nurses were currently being educated on the importance of that. 10 New York Codes, Rules, and Regulations 415.18(b)(3)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on record review and interview during the recertification survey, the facility did not ensure a policy was developed for the monthly medication regimen review that included time frames for the different steps in the process. Specifically, the policy did not include time frames for the different steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This is evidenced by: The policy and procedure titled Medication Regimen Reviews (MRR) dated 7/19/2019 with no review or revision dates stated if the situation was serious enough to present a risk to a person's life, health, or safety, the Consultant Pharmacist would contact the Physician directly to report the information to the Physician. There was no time frames included to state when this contact would happen. During an interview on 8/12/2025 at 2:16 PM, Director of Nursing #1(one) stated the Medication Regimen Review policy should have time frames for steps in the process. In an email dated 8/18/2025 at 1:41 PM, Administrator #1(one) wrote the medication regimen review policy was the most up to date policy the facility was using. 10 New York Codes, Rules, and Regulations 415.18(c)(2)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews conducted during the recertification survey, the facility did not ensure drugs and biologicals were labeled and stored in accordance with professional standards of practice for two (2) (Cedar unit Side #2, [NAME] unit Side #1,) of six (6) medication carts and two (2) (Elm unit #1 and #2 medication rooms) of six (6) medication rooms reviewed. Specifically, (a.) (1) (one) bottle of purified protein derivative (PPD) solution had no open and or expiration date; (b.) an opened insulin pen had no open and or expiration date; (c.) one (1) unopened insulin pen was stored improperly; (e.) stock medications in medication rooms had expired; (f.) opened stock medications were not dated; (g.) a resident specific medication was not dated and (h.) a medication cup with unidentified medication was found in the medication cart. This is evidenced by: During an observation on [DATE] at 9:45 AM, Cedar Unit Side #2 (two) medication cart had over-the-counter medications that were not labeled with the date opened. A resident-specific medication bottle was not labeled with the date opened. An insulin glargine pen that had not been opened was in the medication cart and not in the refrigerator per the manufacturer's instruction. A medication cup was found in the top drawer with unidentified medication. During an observation on [DATE] at 8:30 AM, the [NAME] unit Side #1(one) medication cart had over-the-counter medications that were not labeled with the date open. One insulin pen was found without an open or expiration date. During an observation on [DATE] at 12:30 PM, a bottle of over-the-counter ear drops was found to be expired in the Elm unit medication room [ROOM NUMBER](one). A bottle of Tuberculin PPD Solution 5 units per 0.1 milliliter was found opened but not dated or initialed, and a box of over-the-counter acid reducer pills was found expired in the Elm unit medication room [ROOM NUMBER] (two). During an interview on [DATE] at 9:45 AM, Licensed Practical Nurse #10 stated they did not know who the cup of medication was for or why it was in the cup. During an interview on [DATE] at 8:30 AM, Registered Nurse #1(one) stated that insulin bottles and pens should be dated as soon as they were opened. They did not know why that insulin pen was not dated. 10 New York Codes, Rules, and Regulations 415.18(d)

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	335014	A. Building B. Wing	08/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Schenectady Center for Rehabilitation and Nursing	526 Altamont Ave Schenectady, NY 12303

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. F804 Based on observation and interviews conducted during a recertification survey and abbreviated survey (Case #NY00596012), the facility did not ensure residents were provided food and drink that was palatable, flavorful, at an appetizing temperature for two (2) of two (2) meals reviewed (Lunch meals on 8/14/2025 and 8/15/2025). Specifically, food was not served at a palatable and appetizing temperature during the lunch meal on 8/14/2025 and 8/15/2025. This is evidenced by: During an observation on 8/11/2025 at 11:51 AM, meal trays were prepped by Dietary Aides in the unit kitchenette. During an interview on 8/07/2025 at 11:18 AM, Resident #239 stated the food was terrible, so they bought their own food. During an interview on 8/7/2025 at 11:35 AM, Resident #157 stated the food was not good and the only food items they ate were the macaroni salad and meatloaf. During an interview on 8/08/2025 at 10:05 AM, Resident #3 (three) stated the food was institutional at best. Food was only warm if a resident ate in the dining room. If a resident had to wait to get food, it was usually cold. During an interview on 8/08/2025 at 10:22 AM, Resident #103 stated they were the last room to receive their meal, and the food was cold before they got it. They stated what was on the meal ticket was not always what was provided. If they did not like what was served, they might get a peanut butter and jelly sandwich, egg salad, or tuna salad sandwich. During an interview on 8/13/2025 at 8:37 AM, Registered Nurse #1(one) stated that staff usually passed meal trays to residents in the dining room who could feed themselves first, and the residents who needed to be fed were served last, so they could give them the assistance they needed to eat. During a meal tray sampling on 8/14/2025 at 12:01 PM, Resident #5's(five) lunch tray was tested, and a replacement tray was provided. The lunch tray was tested for taste and temperature, and the results were as follows: coffee 127.8 degrees, mandarin oranges 48.7 degrees, Salisbury steak was lukewarm at 114.6 degrees, mashed potatoes 134.2 degrees, wheat bread 102.7 degrees, chicken noodle soup 134.4 degrees, and tossed salad 54.9 degrees. ˆ During a meal tray sampling on 8/14/2025 at 12:06 PM, Resident #149's lunch tray was tested, and a replacement tray was provided. The lunch tray was tested for taste and temperature, and the results were as follows: coffee 127.8 degrees, creamer 72.5 degrees, water 37.4 degrees, Salisbury steak was lukewarm at 115.5 degrees, mashed potatoes 143.7 degrees, seasoned spinach 116.1 degrees, and banana (fresh fruit) 72.7 degrees. (not in sample) During a meal tray sampling on 8/15/2025 at 12:13 PM, Resident #239's lunch tray was tested, and a replacement tray was provided. The lunch tray was tested for taste and temperature and the results were as follows: hot water 117.5 degrees, water 39.4 degrees, macaroni and cheese casserole 139.6 degrees, large tossed salad with tomato, cucumber, and onion 68.4 degrees, fruit cocktail 68.8 degrees, and yellow squash 122.2 degrees. The yellow squash was not served in a bowl as was indicated the meal ticket. During an interview on 8/18/2025 at 12:10 PM, Nutritionist #2(two) stated if they were made aware that a resident's food was cold, they would speak with the Food Service Director about the specific resident. They would also offer the residents to eat in the dining room because the food is served faster there. They stated it would be a collective effort on the team. They would also speak to the nursing staff to see if they are getting food out on time. Nutritionist #2(two) stated they have received complaints here and there about the food served not matching the meal ticket. They stated that when a complaint like that was made, dietary staff would investigate who served the food, speak to the staff involved, and corrective action would be taken if needed. Nutritionist #2(two) stated the facility offered a variety of decent alternatives if a resident did not like what was served. They stated, they did not receive many complaints about the variety of foods offered. They always had an alternate hot meal available, and staff or residents could always call the kitchen to change a menu item. During an interview on 8/18/2025 at 11:35 AM, Food Service Director #1(one) stated they were new to the facility and had only been working in the role for 2 (two) weeks and were still learning. They stated that the Dietary Aides built the trays based on the meal tickets and then the Certified Nurse Aides passed the meal trays to the residents. They stated the Certified (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Nurse Aides passed trays to the residents who ate in the dining room first, and then they would pass out trays to the residents who ate in their rooms. Food Service Director #1(one) stated they had not received any complaints about the food being cold, just that there was a limited variety of food choices offered. They stated the kitchen checked food temperatures before it was placed in the hot box and brought to the units. The food was then switched to the steam table on the unit. They stated that staff could use the stove on the unit to heat up plates, and staff should call the kitchen if a resident reported that the food was cold. Food Service Director #1(one) stated they had not received any complaints about the Salisbury steak served on 8/14/2025 being cold. They further stated if the steak was cold, it was an error in how quickly the food was delivered to the residents. 10 New York Code of Rules and Regulations 415.14(d)(1)(2)^^

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews conducted during recertification and abbreviated (Case #s: 2578580, 2576246, 596027, 2566657, 596028, 594500, 596019, 596018, 596016, 596012, 596015, 59600, 596011, 596005) surveys, the facility did not ensure residents received treatment and care in accordance with professional standards of practice for (seven) 7 of 35 residents reviewed. Specifically, (a) for Resident #14, medication was not administered per physician orders. Specifically, (b) for Resident #35, medication was not administered per physician orders. Specifically, (c) for Resident #103, medication was not administered per physician orders. Specifically, (d) for Resident #177, medication was not administered per physician orders.^^^Specifically, (e) for Resident #146, weekly weights were not obtained per physician orders. Specifically, (f) for Residents #157 and #199, physician orders were not obtained to check for nor was documentation recorded for skin integrity for residents with hard ridged neck braces. This is evidenced by:^^ ^Resident #14 Resident #14 was admitted to the facility on [DATE] with diagnoses including unspecified dementia with unspecified severity and with other behavioral disturbance (a degenerative memory loss condition that can cause behavioral disturbances), anxiety disorders (uncontrolled anxiety), and peripheral vascular disease (lack of blood flow to the hands and feet). The Minimum Data Set (an assessment tool) dated 5/02/2025 documented the resident sometimes understood others, sometimes could be understood, and was severely cognitively impaired.^^ A Physician order created 8/22/2024 at 7:01 PM documented an order for Levothyroxine Sodium Oral Tablet 100 micrograms to be given 1 tablet by mouth one time a day for hypothyroidism.^ The Medication Administration Record for July 2025 documented the medication was scheduled for 9:00 AM and administered at that time.^^ A facility provided document stating meal delivery times to each unit provided evidence that breakfast was scheduled to be delivered to all the units between 7:45 AM and 8:00 AM.^^ The Levothyroxine (thyroid hormone replacement medication) manufacturer's recommendations document to only take the medication with water on an empty stomach and wait at least 30 minutes before consuming food.^^ During an interview on 8/12/2025 at 9:26 AM, Licensed Practical Nurse #3 (three) stated that if they had seen an order for the thyroid hormone replacement medication to be given at 9 AM, they would speak with the medical provider to change the times so it could be given by the night shift as that medication needed to be given on an empty stomach.^ During an interview on 8/18/2025 at 12:20 PM, Director of Nursing #1(one) stated that when it came to the time of medications being administered, they deferred to the medical provider.^^ During an interview on 8/18/2025 at 2:02 PM, Medical Director #1(one) stated medications like a thyroid hormone replacement medication don't need to be given at(six) 6 AM. There was a false impression as to when those medications need to be taken, and they just need to be given a few hours before a meal. The example given was to administer at (four) 4 PM because that would be a few hours before dinner or at bedtime. Additionally, Medical Director #1(one) stated that a thyroid hormone replacement medication would be taken anytime because the dose could be adjusted if the timing made the medication less effective. The example given was that the Medical Director #1(one) took all their medications at dinner because that was when their spouse gave it to them. Medical Director #1(one) stated that people should not be woken up for medications if it can be helped. It should be by preference, just before a meal.^Medical Director #1(one) stated they tried to cater to resident timing not the ideal time and they educated the resident and families about the misconceptions regarding timing of medications to make it easiest for the resident.^ ^Resident #146 Policy titled, Physician Orders and created 10/2015 and last revised 02/2020, documented it was the policy of the facility to secure physician orders for care and services for residents as required by state and federal law. Physician orders will be dated and signed according to the state and federal guidelines. Physician orders would include the medication and/or treatment and a correlating medical diagnosis or reason. Policy titled, Food and Nutrition Services and created (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11/2017 and last revised 2/19/2025, documented a nutritional assessment, including current nutritional status and risk factors for malnutrition, shall be conducted for each resident. Components of the nutritional assessment included weight status and anthropometric data and current height and weight. Resident #146 was admitted to the facility with diagnoses of type 2 diabetes mellitus (a chronic condition that happens when a person has persistently high blood sugar levels), lymphedema (tissue swelling caused by an accumulation of protein-rich fluid that is usually drained through the body's lymphatic system), and urinary tract infection. The Minimum Data Set (an assessment tool) dated 7/20/2025, documented that the resident could be understood, understood others, and had intact cognition. A review of Resident #146's Comprehensive Care Plan for Nutritional Problem or Potential Nutritional Problem Related to Medical Diagnosis, Medicine Usage, Therapeutic Diet, Skin Alterations, Edema, Obesity, initiated 7/14/2025, documented as a goal that Resident #146 would receive adequate nutrition and hydration without any unplanned significant weight changes by next review. Interventions included the following weights as the physician ordered and report significant weight changes to the medical provider and Interdisciplinary Team for input. Physician order dated 7/13/2025 documented weigh on admission/readmission x1 (one time), then weekly x4 (four times), then monthly. Review of Treatment Administration Record for July and August, 2025 documented Resident #146 was weighed on 7/14/2025, 7/16/2025, 7/23/2025, 7/30/2025 and 8/06/2025. Review of Weight Summary Report in Resident #146's electronic medical record documented a weight for 7/13/2025 only. There were no documented weights for 7/14/2025, 7/16/2025, 7/23/2025, 7/30/2025, or 8/6/2025. During an interview on 8/14/2025 at 11:33AM, Certified Nurse Aide #7 (seven) stated that the nurses told them what residents needed to be weighed on their shift. They were given a sheet of paper with the names of residents who need to be weighed. They weighed the resident and wrote the weight down on that sheet of paper. After they weighed the residents, they gave the paper back to the nurse. They stated they do not enter the weight into the resident's electronic medical record. During an interview on 8/14/2025 at 12:16 PM, Licensed Practical Nurse #2(two) stated the nurse manager sent out a list of residents that needed to be weighed. Licensed Practical Nurse #2 (two) told the Certified Nurse Aides which residents needed to be weighed, and they followed up with them after lunch to see if they were weighed or not. The nurse on the medicine cart was responsible for putting the resident's weight into the resident's electronic medical record. Licensed Practical Nurse #2 (two) stated the Medication Administration Record indicated when the residents were supposed to be weighed. Licensed Practical Nurse # 2(two)stated Resident #146 had a weight entered into their electronic medical record on 7/13/2025, and there were no other documented weights for this resident. During an interview on 8/14/2025 at 12:45, Licensed Practical Nurse # 1(one) stated weights for residents newly admitted to the facility were taken weekly. The Licensed Practical Nurses were notified by the electronic medical record that a weight was needed for a resident. The Licensed Practical Nurses had the Certified Nurse Aides obtain the weights, and the Licensed Practical Nurses entered the weight into the electronic medical record of the resident. They stated there was one weight documented for Resident #146 on 7/13/2025. There were no other documented weights for this resident. They stated they would have expected to have seen three or four more documented weights for this resident, and they did not know why there were not more documented weights for Resident #146. During an interview on 8/15/2025 at 10:01 AM, Nutritionist #1(one) stated the weights for residents newly admitted to the facility are obtained the first four weeks they are in the facility. The nurse on the cart directed the Certified Nurse Aides to obtain the weights and that most of the time, they give the weight to the Nurse Manager to be entered into the electronic medical record. They stated they check every morning to see if weights were done, and if not, they reminded the staff or mentioned it in morning report that weights were needed for residents. They stated weights were not always obtained in a timely fashion and some weeks were better than others. They stated for Resident #146, weekly weights were not completed as ordered by the physician. They stated they spoke with the unit manager about it, and the unit manager thought (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #146 refused to have their weight taken, but the refusal was not documented. They stated this does not happen often and it was unfortunate timing. During an interview on 8/18/2025, Director of Nursing #1(one) stated weights of residents were obtained upon admission/readmission to facility, weekly, and with dietary recommendations. They stated that weekly weights for Resident #146 as ordered by the physician were not completed. Resident #157^ Resident #157 was admitted to the facility with the diagnoses of nondisplaced fracture of first cervical vertebra (a break in a neck bone where the pieces remain in the normal anatomical position), fracture of manubrium (a break in the upper part of the sternum), and fracture of fourth lumbar vertebra (a break in the spine in the lower back). The Minimum Data Set (an assessment tool) dated 8/5/2025 documented the resident could understand others, was understood by others, and was severely cognitively impaired.^^ The policy and procedure titled Appliances - Sprints, Braces, Slings last revised 4/2019, stated skin integrity should be checked.^ The policy and procedure titled Skin and Pressure Injury Prevention last revised 6/27/2024, stated for residents with a removable medical device, the skin should be monitored for potential pressure injury development.^ During an observation on 8/7/2025 at 11:43 AM, Resident #157 was noted to be wearing a Miami J collar (a brace used to support neck bones and ligaments and reduce any movement that may cause further damage to the cervical spine).^^ The Physician's Order dated 7/29/2025 documented Miami J collar (a brace used to support neck bones and ligaments and reduce any movement that may cause further damage to the cervical spine) on at all times every shift.^^ A review of the Medication Administration Record and Treatment Administration Record for July 2025 and August 2025 did not show documentation to check the skin integrity under the Miami J collar (a brace used to support neck bones and ligaments and reduce any movement that may cause further damage to the cervical spine).^^^^^^^ During an interview on 8/18/2025 at 1:17 PM, Director of Nursing #1(one) stated there should be an order to check the skin under the Miami J collar (a brace used to support neck bones and ligaments and reduce any movement that may cause further damage to the cervical spine) and did not know why there was not an order for this before 8/15/2025.^^

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on record review and interviews conducted during the recertification survey, the facility did not ensure each resident was treated with respect and dignity, and care in a manner and in an environment that promoted maintenance or enhancement of their quality of life for two (2) (Resident #68 and #100) of thirty-five (35) residents reviewed. Specifically, (a.) Resident #100 did not receive showers as scheduled, or when requested for July and August 2025. On or about 8/1/2025, Resident Representative #1 was approached by Certified Nurse Aide # 1 to bring in toiletries for Resident #100 such as soap, deodorant, and shampoo, because Resident #100 had an odor ; (b.) On 8/08 /2025, staff did not respond to Resident #68 yelling out for help during mid-morning and then again at lunch time. This is evidenced by: The facility's policy and procedure titled, Quality of Life/Dignity, revised 5/28/2024, documented the following: Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. 1. Residents shall be treated with dignity and respect at all times. 2. Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth. 13. Demeaning practices and standards of care that compromise dignity is prohibited. Staff shall promote dignity and assist residents as needed by: b. Promptly responding to the resident's request for toileting assistance; and other needs. 14. Staff shall treat cognitively impaired residents with dignity and sensitivity; for example: a. Addressing the underlying motives or root causes for behavior; and b. Not challenging or contradicting the resident's beliefs or statement. Resident #100 was admitted to the facility with a diagnosis of unspecified dementia (a decline in cognitive function, impacting memory, thinking, language, and judgment); cerebral infarction (the death of brain tissue (necrosis) due to insufficient blood supply), and depression unspecified (significant distress or impairment in daily life). The Minimum Data Set (an assessment tool) dated 07/21/2025 documented the resident's cognition could not be assessed, but they were usually able to be understood and understood by others. Resident #100's Comprehensive Care Plan titled, Activities of Daily Living, dated 7/15/2025, documented resident required assistance with Activities of Daily Living related to Dementia, Fracture, and Limited Mobility. Interventions included: Encourage the resident to use the bell to call for assistance. Monitor for changes in status, notify the interdisciplinary team as needed. Skin Inspection: monitor for redness, open areas, scratches, cuts, bruises, and report changes to the Nurse. Record Review of Certified Nurse Aide documentation revealed that in June of 2025, Resident received two (2) showers, on 6/26/2025 and 6/29/2025. July 2025 documented showers on 7/8/2025 and 7/24/2025. August 2025 documented a shower on 8/08/2025. All other dates within the three (3) months were marked ?Not Applicable.' During an interview on 08/08/2025 at 10:30 AM, Resident Representative #1 stated Resident #100 had not had a shower in ?a very long time.' They could not recall when the last shower was given, and they visited the resident daily. Resident Representative #1 stated they were approached by Certified Nurse Aide #1 to bring in toiletries for Resident #100, such as soap, deodorant, and shampoo, because Resident #100 had an odor. During an interview at 11:00 AM, Registered Nurse #5 stated Resident#100's shower day was Tuesday. However, they were unable to generate the certified nurse aid documentation on showers for this resident. During an interview at 11:05 AM, Director of Nursing #1 provided certified nurse aide documentation for August 2025, for Resident #100 shower schedule, which indicated Non-Applicable. The Director of Nursing stated the entries were erroneous. The Director of Nursing was asked to provide documentation of the last shower for resident #100, who then retrieved July dates showing blanks and Non-Applicable for the month of July. Upon request via Health Commerce, the Director of Nursing submitted documentation as mentioned above for June, July, and August 2025. During an interview on 08/18/2025 at 01:22 PM, Director of Nursing #1 stated that nursing staff retrieved resident toiletries from the supply room. Staff are not permitted to ask family to bring in supplies unless the resident has a special order. Per Resident Rights, it is (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unacceptable for staff to tell a resident that they smell. During an interview on 08/19/2025 at 10:48 AM, Administrator #1 stated that customer service training is provided for all staff is at least annually. They also stated no one should be telling residents they smell. Resident #68 was admitted to the facility with a diagnosis of Hemiplegia (paralysis of one side of the body. and hemiparesis (weakness on one side of the body) following a stroke affecting right dominant side; Dysarthria (a speech disorder characterized by difficulty in articulating words and producing clear speech), and diabetes mellitus type 2 (a chronic condition where the body either doesn't produce enough insulin or can't properly use the insulin it produces, leading to high blood sugar levels). The Minimum Data Set (an assessment tool) dated 07/05/2025 documented the resident's cognition could to be assessed, but they were usually able to be understood by others. Resident #68's Comprehensive Care Plan titled behaviors, dated 6/29/2025, documented resident exhibits behavior symptoms such as attempts to self-transfer without asking for assistance, refusals, yelling, and being combative with care and feeding. Interventions included: Acknowledge the resident's feelings/encourage to express their feelings. Check for toileting need, provide toileting/incontinence care as indicated Resident #68's Comprehensive Care Plan titled mobility, dated 6/29/2025, documented resident required assistance with self-care and mobility related to aging process, medical diagnoses, post-cerebral vascular accident (stroke); weakness. Interventions included: Encourage resident to participate to the fullest extent possible with each interaction. Monitor for changes in status, notify interdisciplinary team as needed. During an observation on 08/08/2025 at 10:20 AM and at 12:40 PM, Resident #68 yelled out for help. At 10:20 AM, Licensed Practical Nurse # 5, Certified Nurse Aide #1, # 3 and #4 were seen on Cedar Unit and did not respond to Resident #68. At 12:40 PM, Certified Nurse Aides #3 and #4 were observed walking by Resident #68's room and did not respond to their call for help. Certified Nurse Aides #1 and #2 and Licensed Practical Nurse # 5 were present in dining room then at the nurse's station response to resident calling for help. At 12:40 PM, writer responded to resident #68 and asked what they needed. Resident #68 was observed sitting behind a drawn curtain, alone in room, lights off, in wheelchair on a Hoyer-Lift Pad, leaning halfway over right side; food was strewn on floor, lunch tray was 40% consumed. The resident appeared disheveled, unshaven, fingernails were long with food or dirt underneath. Resident #68 stated they wanted to be put back to bed. Writer notified certified nurse aide #3, who then entered resident #68's room, left and returned with certified nurse aide #1 for assistance. During an interview on 08/08/2025 at 11:00 AM, Resident Representative #1 stated that earlier that day, they asked Certified Nurse Aide #1 to assist another resident (Resident #168) to the bathroom. They stated Certified Nurse Aide #4 told them it was not their resident, they needed to find resident #168's aide, and they walked by the unanswered call light. In total, four (4) staff members walked by an unanswered call light. Resident Representative #1 stated that this is a common occurrence at this facility. During an interview on 08/08/2025 at 11:20 AM, the Licensed Practical Nurse stated that all nursing staff should answer any call light regardless of who the resident is assigned to. During an interview on 08/08/2025 at 13:00 PM, Certified Nurse Aide #4 stated they would toilet any resident regardless of who the resident is assigned to. During an interview on 08/18/2025 at 12:23 PM, Director of Nursing #1 stated that during high care times, such as morning care, residents wait up to 15-20 minutes, and at times up to 30 minutes to have call lights answered. It depends on the situation and on what is feasible at the time. Director of Nursing #1 stated they had adequate care during high call times (i.e., after breakfast or evening care). New York Codes, Rules, and Regulations Title 10 S415.5(a)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews conducted during recertification and abbreviated (Case #s: 2578580, 2576246, 596027, 2566657, 596028, 594500, 596019, 596018, 596016, 596012, 596015, 596007, 596011, 596005) surveys, the facility did not ensure residents were free from neglect for one (1) (Resident #253) of thirty-five (35) residents reviewed for neglect. Specifically, Resident #253 was admitted to the facility on [DATE] with NPO status (nothing by mouth) and received nutrition/hydration via a gastrostomy tube (G-tube, a feeding tube inserted through the abdomen into the stomach. It is used to deliver nutrition, fluids, and medications when a person is unable to eat or drink adequately on their own.) Tube feedings (a way to provide nutrition and hydration) were not initiated until the following day the resident was admitted to the facility (6/24/2025) at 10:00 AM. This is evidenced by: The facility policy titled, Abuse, created 9/2012, last revised 7/18/2025, documented that the facility prohibits the mistreatment, neglect, and abuse of residents/patients. The policy defined neglect as failure of the facility, its employees, or service providers to provide goods and services necessary to avoid physical harm, pain, mental anguish, or distress. The facility policy titled, Enteral Feedings, created/2015, last revised 2/2023, documented it was the policy of the facility to provide enteral nutrition therapy to residents unable to obtain nutrition orally, when such therapy is ordered by the physician and not clinically contraindicated. The first step in the procedure was to verify the physician's order. Resident #253 was admitted to the facility with diagnoses of pneumonia (infection that inflames air sacs in one or both lungs, which may fill with fluid), dysphagia (difficulty swallowing) following cerebral infarction (a condition where brain tissue dies due to lack of blood flow) and encephalopathy (any diffuse disease of the brain that alters brain function or structure). There was no completed Minimum Data Set (an assessment tool) for this resident as they were discharged to the hospital the day after they were admitted to the facility. The Comprehensive Care Plan with focus, Resident requires tube feeding related to tube feeding with dysphagia and, initiated 6/24/2025, documented as an intervention for Resident #253: Administer tube feeding and water flushes per Registered Dietician/Licensed Dietician and Doctor of Medicine orders. The discharge summary from the hospital documented that Resident #253 was discharged on 6/23/2025. Resident #253 had a PEG-tube (percutaneous endoscopic gastrostomy tube) (a feeding tube placed through the abdominal wall and into the stomach to provide food, water, and medicine) at baseline due to dysphagia. Patient Resident #253 was resumed with PEG-tube feedings, and was tolerating them well. Diet upon discharge from hospital was PEG tube feeding through Vital 1.5 [brand name] nutritional formula, currently at a rate of 65 milliliters an hour. The facility provided documentation that Resident #253 was admitted to the facility on [DATE] at 3:23 PM. Progress note from the provider the facility with Date of Service as 6/23/2025. The resident #253 was transferred from the hospital to the facility on 6/23/2025. They had a G-feeding tube. Were to continue tube feeds. Monitor for aspiration. Nursing Progress Note by Registered Nurse #4 (four)dated 6/23/2025, documented Resident #253 had swallowing problems. The Resident had an enteral tube,. Tthey were not to receive food, water, or medication by mouth, NPO. They had an Enteral Feed Order: (see physician orders),. Rand the resident tolerated the enteral feed well. Review of physician order dated 6/24/2025 documented enteral tube: Vital 1.5, may also use Peptamin 1.5, a different and comparable brand of nutritional feeding formula via enteral tube at a rate of 65 milliliters/hour to begin at 10:00 AM for a total volume of 1560 milliliters to be delivered. There were no physician orders for enteral tube feeding to be administered on 6/23/2025. Review of Medication Administration Record for June, 6/2025 documented Enteral tube (Vital 1.5, may also use Peptamen 1.5) via enteral tube nutritional feeding formula administration at a rate of 65 milliliters to begin at 10:00 AM for a total volume of 1560 milliliters to be delivered one time a day for neurogenic dysphagia, was administered on (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/24/2025 at 10:00 AM. There was no documentation on the Medication Administration Record that tube feedings were completed on 6/23/2025. In reviewing Resident #253's medical record, it was not documented that the provider was notified that Resident #253's tube feeding was not initiated on the date of admission, 6/23/2025. During an interview on 8/18/2025 at 10:38 AM, Nutritionist #1 (one) stated they reviewed the hospital paperwork to see what the hospital provided for a the resident that required tube feeding. They liked to review this information before the resident was admitted to the facility, so they knew what kind of tube feeding to provide and if there were other nutritional findings. They checked to see if they had the kind of tube feeding used for a resident in the facility. If they did not have it, they asked the hospital to send extra tube feeding supplies and they would rush order the supplies that were needed from their supplier. They stated they may switch brands of tube feedings as there may be an equivalent substitute. Nutritionist #1(one) stated if the resident who required tube feeding was admitted when they were not in the building, the nurses knew how to put the orders into the electronic medical record system, and they had access to the supply room so they could get the tube feeding formula. Nutritionist #1(one) stated Resident #253 was admitted on [DATE] and was discharged to the hospital on 6/24/2025. Because of the timing of their admission and discharge, Nutritionist #1one did not get a chance to assess Resident #253. They stated Resident #253 was on a continuous tube feed at a rate of 65 milliliters per hour. They stated it was likely that their tube feeding was stopped at the hospital when Resident #253 was transported to the facility for admission. If a tube feeding was to be continuous, it meant that it was to run continuously until the amount to be delivered was administered to the resident. They stated there was a physician order for Resident #253's tube feeding to begin on 6/24/2025 at 10:00 AM and if someone was admitted to the facility on a continuous tube feeding and they receive most of the tube feeding during the day, they like to start the tube feeding in the morning to get them on a consistent schedule. They stated they may do a one-time order to have the tube feeding running for a shorter period if the resident did not have orders for the tube feeding to begin until the next day, but for Resident #253 there was not a one-time order to provide tube feeding on 6/23/2025. During an interview on 8/18/2025 at 1:53 PM, Registered Nurse #4 (four stated they completed an admission assessment when a resident was first admitted to the facility. They stated they documented in Resident #253's comprehensive care path note that Resident #253 was admitted to the facility with an enteral tube and they tolerated the enteral feed well. They could not remember if the tube feeding was running when they completed the assessment. They stated the first order for the enteral feeding was on 6/24/2025, but there ?must have been something running because they were not going to not feed Resident #253 for 24 hours.' Registered Nurse #4 (four) stated they did not see an order to provide tube feeding for Resident #253 on the date of admission, 6/23/2025 when they reviewed the resident's orders at the time of this interview. During an interview on 8/18/2025 at 12:23 PM, Director of Nursing #1(one) stated they assumed if a resident that required tube feeding was admitted to the facility in the afternoon, an order for their tube feeding would be put into the electronic medical record and it would be initiated at the time indicated on the order. They stated they would expect to see the tube feeding initiated within an hour of admission. If a resident's continuous tube feed order was not initiated until the next day, they would expect the provider to be notified so the provider could advise them what to do. Director of Nursing #1(one) stated Resident #253 had an order for tube feedings that were initiated on 6/24/2025. They said it should have been started before 6/24/2025. During an interview on 8/18/2025 at 2:31 PM Medical Director #1(one) stated when a resident was on a continuous tube feeding, it was ideal to start the tube feeding when it was due and available. If a tube feeding was not administered until the day after a resident requiring tube feeding was admitted , they would look at what would be the ?consequences, what would be the ill-effect if it was not available until the morning'. They stated it was not ideal that the tube feeding was not started until 10:00 AM on 6/24/2025, but it was acceptable. They stated they should have been notified the tube feeding was not started on 6/23/2025, but they could not remember if they were notified. During an interview on 8/19/2025 at (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11:03 AM, Licensed Practical Nurse # 7(seven) stated newly admitted residents were assessed by a Registered Nurse shortly after they arrived at the facility, not the next day. If a new resident arrived at the facility at 8:00 PM, a Registered Nurse working the overnight shift would complete the assessment. After the assessment, the provider was contacted, and orders were reviewed with them. The diet order, which included tube feedings, was written the day the resident was admitted to the facility. Unless there was an order for the tube feeding to be held, it should be started the same day the resident was admitted to the facility. During an interview on 8/19/2025 at 11:16 AM, Licensed Practical Nurse #1(one) stated when a resident was admitted to the facility, a Registered Nurse completed an admission assessment. The orders for the resident were reviewed with the on-call provider, approved and entered into the electronic medical record. The Registered Nurse should document the orders were reviewed with the provider, and if there were any changes to the orders, they should be put in the note as well. Licensed Practical Nurse #1(one) did not recall Resident #253 and stated they were in a training the day they were admitted to the facility. They did not know why the orders for the tube feeding for Resident #253 were not initiated on 6/23/2025, the date Resident #253 was admitted to the facility.New York Codes, Rules, and Regulations Title 10 S415.4(b)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interviews during the recertification survey, the facility did not ensure that each resident's drug regimen was free from chemical restraints. This was identified for 1 (one) of 1 (one) residents reviewed for unnecessary medications. Specifically, Resident # 14 was ordered Buspirone 7.5 milligrams twice a day for anxiety, Seroquel 50 milligrams twice a day for antipsychotic, Seroquel 25 milligrams daily at bedtime for antipsychotic, oxycodone 5 milligrams three times a day for severe pain, and OxyContin 5 milligrams every 12 hours for severe pain. There was no evidence that a gradual dose reduction was attempted, and Resident #14 was observed to be lethargic-looking when observed during the day. This is evidenced by: A facility policy Psychotropic Medication - Gradual Dose Reduction dated 2/2020, documented that after medications were ordered for a resident, the staff and practitioner shall seek an appropriate dose and duration for each medication that also minimized the risk of adverse consequences. Resident #14 medications, including antipsychotics, shall receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Under Procedure, the following was documented: (1) Periodically, the staff and practitioner would review the continued relevance of each resident's psychotropic medications; (2) The Attending Physician and staff would identify target symptoms / behaviors for which a resident was receiving various medications. The staff would monitor for improvement in those target symptoms / behaviors and provide the Physician with that information; (3) The staff and practitioner would consider tapering of medications as one approach to finding an optimal dose or determining whether continued use of a medication was benefiting the resident. (4) The staff and practitioner would consider tapering under certain circumstances, including when: (a) The resident's clinical condition had improved or stabilized; (b) Non-pharmacological interventions, including behavioral interventions, had been effective in reducing symptoms; or (c) A resident's condition had not responded to treatment or had declined despite treatment; (6) Residents who used antipsychotic drugs shall receive gradual dose reductions, unless clinically contraindicated, in an effort to discontinue the use of such drugs. Pertinent behavioral interventions would also be attempted. (Behavioral interventions refer to non-pharmacological attempts to influence an individual's behavior, including environmental alterations and staff approaches to care.); (7) Within the first year after a resident was admitted on an antipsychotic medication or after the resident had been started on an antipsychotic medication, the staff and practitioner shall attempt a Gradual Dose Reduction in two separate quarters (with at least one month between the attempts), unless clinically contraindicated. After the first year, the facility shall attempt a Gradual Dose Reduction at least annually, unless clinically contraindicated; (10) Attempted tapering of sedatives and hypnotics shall be considered as a way to demonstrate whether the resident was benefiting from a medication or might benefit from a lower or less frequent dose. Tapering shall be done consistent with the following: (a) For as long as a resident remained on a sedative/hypnotic that was used routinely and beyond the manufacturer's recommendations for duration of use, the physician shall attempt to taper the medication at least quarterly unless clinically contraindicated. Clinically contraindicated means: (1) The continued use was in accordance with relevant current standards of practice and the physician had documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder; or (2) The resident's target symptoms returned or worsened after the most recent attempt at tapering the dose within the facility and the physician had documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder. Resident # 14 was admitted to the facility on [DATE] with diagnoses (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	including unspecified dementia, unspecified severity, with other behavioral disturbance (a degenerative memory loss condition that can cause behavioral disturbances), anxiety disorders (uncontrolled anxiety), and peripheral vascular disease (lack of blood flow to the hands and feet). The Minimum Data Set (an assessment tool) dated 5/2/2025 documented the resident sometimes understood others, sometimes could be understood that and was severely cognitively impaired. A Physician Order dated 5/9/2025 documented oxycodone oral tablet 5 milligrams, give 1(one) tablet by mouth every 12 hours as needed for pain. A Physician Order dated 8/13/2025 documented oxycodone oral tablet 5 milligrams, give 5 milligrams by mouth three times a day for pain. A Physician Order dated 5/08/2025 documented Seroquel oral tablet 25 milligrams, give 1(one) tablet by mouth at bedtime for antipsychotic. A Physician Order dated 5/08/2025 documented Seroquel oral tablet 50 milligrams, give 1(one) tablet by mouth two times a day for antipsychotic. Give 1(one) tab at lunch time and 1 (one) tab at 4 PM. A Team meeting note dated 5/8/2025 at 9:45 AM, created by Nutritionist #1(one), documented: the team meeting was attended by nursing, social services, rehabilitation/therapy, dietary, primary care physician/medical provider, recreation/activities, administration, Minimum Data Set coordinator; Resident not appropriate to attend; psychiatry notes. The Team Interdisciplinary Team meeting summary is as follows: Reduce Seroquel to 25 milligrams daily,. Monitor labs, encourage exercise, and follow up in 8 (eight) weeks or as needed. A Provider note dated 6/1/2025 at 7:26 PM by Nurse Practitioner #1(one) documented Resident #14's adult child reported that the resident had a past history of hallucinations and paranoid delusions, and that Seroquel has helped these behaviors. Resident #14 was noted to be stable at the time of the note;, the provider was in agreement with the family member, and Resident #14 was not appropriate for Gradual Dose Reduction at that time due to risk of increased hallucinations and paranoia that could affect their overall health;. Continue 50 milligrams twice daily as they continued to be stable. For Resident #14's dementia with behavioral disturbances, the note documented the resident was stable;. No noted behaviors since admission; and Continue Seroquel 50 milligrams twice daily for now. A Provider note dated 6/24/2025 at 7:32 AM by Nurse Practitioner #1(one) documented Resident #14 was stable, had a history of behaviors related to her dementia, had a history of hallucinations and paranoid delusions and a history of depression; no noted behaviors since admission; and Continue Seroquel 50 milligrams twice daily for now. A Psychiatric tele-health provider note dated 7/03/2025 at 9:15 AM documented that Resident #14's adult child reported that the resident had a past history of hallucinations and paranoid delusions, and that Seroquel has helped these behaviors. Resident #14 was noted to be stable at the time of the note;, the provider was in agreement with the family member and Resident #14 was not appropriate for Gradual Dose Reduction at that time due to risk of increased hallucinations and paranoia that could affect their overall health;. Continue 50 milligrams twice daily as they continued to be stable. For Resident #14's dementia with behavioral disturbances, the note documented the resident was stable; No noted behaviors since admission; and Continue Seroquel 50 milligrams twice daily for now. A facility provided document titled Psychotropic Listing Report dated 7/01/2025 through 7/31/2025 documented: Resident #14's Seroquel dose was 50 milligrams on 10/27/2023, reviewed for gradual dose reductions on 4/2024 and 10/2024. On 08/2025, the dose was increased 50 milligrams twice a day and 25 milligrams at bedtime; the next Gradual Dose Reduction was due 5/2026; and the reason listed for the last Gradual Dose Reduction on 5/8/2025 was contraindicated. A facility provided document titled Medication Regimen Review dated 4/30/2024 documented: the resident had an active order for Seroquel 50 milligrams twice a day since 10/27/2023; they were due for a 6-month Gradual Dose Reduction assessment; the Gradual Dose Reduction contraindicated reason checked on the form was this resident would not tolerate a Gradual Dose Reduction because their current dose was maintaining function and Gradual Dose Reduction would likely cause a decline in function manifested by self-inflected injuries. The Treatment Administration Record for May 2025 documented monitored resident behaviors on 5/8, 5/9, 5/10, 5/11, 5/12, and 5/13. All other dates contained an X. The behaviors that were documented were (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented as none. There was no documented evidence that behaviors were monitored on the Treatment Administration Record for 6/2025. The Treatment Administration Record for 7/2025 documented monitored resident behaviors on 7/16 through 7/31. All other dates contained an X. The behaviors that were documented were documented as none, improved, or unchanged. The Treatment Administration Record for 8/2025 documented monitored resident behaviors on all the dates up to 8/14. The behaviors that were documented were documented as none, or not applicable. During an observation on 8/08/2025 at 10:30 AM, Resident #14 was observed to be sitting in their wheelchair, leaning forward, appearing to be asleep. During an observation on 8/12/2025 at 10:20 AM, Resident #14 was observed to be sitting in their wheelchair, again looking like they were asleep, and leaning over in their wheelchair. During observations on 8/15/2025 at 10:45 AM, Resident #14 was observed sitting, hunched over in their wheelchair, complaining that their leg hurt. A staff member stated to Resident #14 that they had just given them pain medication and they had to give it a few minutes to work. Resident #14 stated ?oh' and then appeared to fall asleep in their wheelchair in the hallway. During an interview on 8/15/2025 at 10:56 AM, Licensed Practical Nurse #6 (six) stated that they did not believe Resident #14 had behaviors other than to refuse care on occasion.ˆ ˆ During an interview on 8/15/2025 at 10:58 AM, Minimum Data Set Coordinator #1(one), serving as temporary Nurse Manager for the unit, stated that behaviors were documented in the Treatment Administration Record. While looking for Gradual Dose Reduction attempts, they stated it looked like in Spring of 2025 there had been an attempt at a Gradual Dose Reduction, but the resident decompensated. When asked if Resident #14's medications were cut off or reduced, Minimum Data Set Coordinator #1(one) stated that on 5/8/2025 the Interdisciplinary Team recommended lowering the dose to 25 mg twice a day. They could not find any documented evidence that dose was lowered, just times changed.ˆMinimum Data Set Coordinator #1(one) stated that Neurology had written a note that said the dose should not be changed, just the time of administration, because Resident #14 would get more confused at night. During an interview on 8/18/2025 at 12:20 PM, Director of Nursing #1(one) stated that there has been issues with Certified Nurse Aide documentation. Missing documentation was more likely due to the staff not doing the document versus not doing the tasks an d referenced the ?didn't happen if you didn't write it down' adage.ˆWhen asked specifically about Resident #14's medications and Gradual Dose Reductions, Director of Nursing #1(one) stated they would have to check, however, they never returned or offered further information. ˆ During an interview on 8/18/2025 at 2:02 PM, Medical Director #1one stated that they have a monthly meeting with each unit to discuss Gradual Dose Reductions. They stated they did not know each resident specifically. Medical Director #1(one) stated that they looked at what medications were prescribed for and how the resident was behaving. Education on the side effects of medications needs to be discussed among all the staff. Medical Director #1(one) referenced how diabetes medications can have off-label uses and had to adjust other diabetes medications to account for the side effects. Polypharmacy could be complicated, and they needed to consider how torturous the Gradual Dose Reduction would be for the resident. In terms of Resident #14 and their level of sedation observed, Medical Director #1(one) stated that Seroquel wasn't always sedating. The person eventually developed a tolerance, and if narcotics were added to the picture, the sedation was probably the narcotics, and the resident was in pain, so they needed the narcotics.ˆMedical Director #1(one) stated they looked for quality of life for the residents. New York Codes, Rules, and Regulations Title 10 S415.4(d)(1)(vii)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews during the recertification survey, the facility did not ensure that each resident was screened for a mental disorder or intellectual disability prior to admission for 2 (Resident #s 185 and 218) of 35 residents reviewed. Specifically, the Preadmission Screening and Resident Review was incorrect for Resident #185 and incomplete for Resident #218. This is evidenced by: The facility Policy titled, Preadmission Screening and Resident Review /Screens, dated 12/2019, documented every admission to the facility would have a completed Level 1 Screen prior to admission to ensure the resident was appropriate for admission to the facility. Residents with identified serious mental illness or intellectual disability would have a completed Level II Preadmission Screening and Resident Review prior to admission, if indicated on their Level 1 Screen. The facility would protect the rights of nursing homes residents with mental illness and /or intellectual disabilities by ensuring the identification and delivery of specialized developmental and mental health services as needed. Additionally, if a resident was identified as having a mental illness and/or intellectual disability on their admission Level 1 Screen and met the criteria for an initial exemption from requiring a Level II Preadmission Screening and Resident Review according to state regulations, but no longer meets the criteria for that exemption, a Level 1 Screen and Level II Preadmission Screening and Resident Review evaluation would be completed within the appropriate state-determined timeframe. Resident #185 Resident #185 was admitted to the facility with diagnoses of unspecified dementia, unspecified severity, with other behavioral disturbance (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking), post-traumatic stress disorder, unspecified (a mental health condition caused by an extremely stressful or terrifying event), and cerebral infarction, unspecified (a type of stroke where brain tissue death occurs due to lack of blood supply). The Minimum Data Set (an assessment tool) dated 6/15/2025 documented that the resident was sometimes understood, sometimes able to understand others, and was minimally cognitively compromised. The Preadmission Screening and Resident Review dated 6/07/2024 for Resident #185 documented under 22, does this person have a dementia diagnosis documented in the medical record, the answer was no. Under #23, does this person have a serious mental illness, the answer was no. During an observation on 8/07/2025 at 12:36 PM, ˆResident #185 was observed in the dining room at dining room table. With use of their IPAD, the resident transcribed they were the governor of New York State.ˆ ˆ During an observation on 8/08/2025 at 1:34 PM, Resident #185 was observed wandering about unit tearful and grunting and was not using their IPAD. Resident #218 Resident #218 was admitted to the facility with diagnoses of major depressive disorder, recurrent, moderate (a mental condition characterized by a persistently depressed mood and long-term loss of pleasure or interest in life), atrial fibrillation (a heart rhythm disorder where the heart's upper chambers beat irregularly and often too fast), and acute kidney failure (a sudden and rapid loss of kidney's ability to filter waste and maintain proper fluid and electrolyte balance). The Minimum Data Set, dated [DATE] documented that the resident was able to understand others, be understood and was cognitively intact. The Preadmission Screening and Resident Review dated 6/07/2024 for Resident #218 documented under #21, reason for Residential Health Care Facility, no reason was documented under #23, does this person have a serious mental illness, the answer was no. During general observations on 8/08/2025 at 10:00 AM, Resident #218 was noted to be in bed, disheveled and appeared to be sleeping. A behavioral health note dated 7/29/21025 at 9:46 AM, documented that Resident #218 continued to self-isolate in their room, not wanting to leave despite encouragement from everyone, including their spouse. During an interview on 8/18/2025 10:31 AM, Regional Director of Social Work #1(one) stated that a serious mental illness, by itself, does not trigger a Level II screen. Dementia would rule out a need for a Level II screen. A significant change or a hospitalization for mental health reasons would trigger a Level II screen. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regional Director of Social Work #1(one) stated that Resident #185 was monitored by psychiatry at the facility, and it was indeterminable if their current presentation was due to their mental illness, or their history of drug use. Refusals of care would not be considered symptoms of mental illness, and the staff would use nonpharmacological ways to counter the refusals. Regional Director of Social Work #1(one) explained that the screeners have to follow the manual which give specific examples of what conditions that would trigger a Level II screen. When asked about the blank section of Resident #218 screen documenting the reason the resident required the facility housing, Director of Social Work #1(one) stated they would need to look at it. Two hours later, Regional Director of Social Work #1(one) stated they had contacted the hospital that performed Resident #218's Preadmission Screening and Resident Review, and that they had a completed screen on file, had sent it to the facility upon their request that day, and they had uploaded it to the system. A review of the updated screen had the missing section checked off. 10 New York Code of Rules and Regulations 415.14(d)(1)(2)^^

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews, the facility did not ensure the development and implementation of comprehensive person-centered care plans, that included measurable objectives and timeframes to meet the resident's medical, nursing, and mental and psychosocial needs for five(5) (Resident #s 35, 48, 146, 157, and 199) of 35 residents reviewed for comprehensive care plans. Specifically, (a.) for Resident #35 there was no documented evidence that there was a care plan in place related to the known contracture of Resident #35's right hand; (b.) for Resident #48, there was no comprehensive care plan addressing the use of oxygen, (c.) for Resident #146, on their care pan with the focus of nutrition problem or potential nutrition problem related to medical diagnosis, medicine usage, therapeutic diet, skin alterations, edema, obesity, a documented intervention was to follow weights as ordered. This intervention was not completed as ordered by the provider; and (d.) for Residents #157 and #199, the comprehensive care plans did not address the use of a Miami J collar. This is evidenced by: The policy and procedure titled Care Plans - Comprehensive, last reviewed 8/2/2024, stated that a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs would be developed and implemented for each resident. Resident #35 Resident #35 was admitted to the facility with the diagnoses of unspecified dementia (a degenerative neurological disease characterized by memory loss and general decline in mental ability), moderate protein-calorie malnutrition (malnutrition created by a diet deficient in both protein and calories), and weakness. The Minimum Data Set (an assessment tool) dated 7/28/2025, documented the resident was usually able to understand others, usually able to be understood, and was significantly cognitively impaired. Resident #35's comprehensive care plan for activities of daily living, dated 2/16/2023, documented the levels of assistance Resident #35 required for activities of daily living, but did not document anything regarding care specific to the contracted hand. Resident #35's comprehensive care plan for impaired skin integrity dated 2/16/2023 documented preventing the resident from scratching and keeping hands and body parts from excessive moisture, keeping fingernails short. There was no documented evidence that there was a care plan area related specifically to the resident's right hand contracture. During an observation and interview on 8/07/2025 at 10:53 AM, Resident #35 was noted to have a right-hand contracture and long fingernails on both hands. Family Member #2 who was visiting with Resident #35, explained that Resident #35's hand had been contracted for years. Upon examination of Resident's 35 right hand and assessment of their range of motion, a dark area was noted on the inside of the resident's hand, approximately where the resident's fingernails rested. Family Member #2 stated they did not know what was on the resident's hand. Family Member #2 called Family #3 who had attended the care plan meeting on 8/06/2025 and asked if there had been any conversation regarding Resident #35's contracted hand. Family Member #3 stated there had not been. Licensed Practical Nurse #6 was informed of the findings when the interview concluded. Licensed Practical Nurse #6 stated they were not aware of any issues with the resident's hand, but they would look at it and respond as needed. A facility skin monitoring assessment dated [DATE] at 10:43 AM documented that a new skin alteration was noted on Resident #35's right hand, described as contracture with small deep tissue injury noted. A facility nursing alert note dated 8/12/2025 at 11:15 AM documented that the resident had a newly identified skin alteration according to point-of-care documentation. Area assessed, doesn't appear to be open; however, some moisture noted, betadine orders in place to dry up moisture, and physical therapy evaluation for possible palm guard. A general nursing progress note dated 8/12/2025 at 11:49 AM documented that Resident #35 had a history of severe contraction of the hand. Palm opens with mild pain, and the resident is resistant to care and assessment of the area. Palm appears non-discolored with no breaks in skin. There is a buildup of (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dead skin cells in the palm, and occupational therapy is in to assess, soak the hand, and provide recommendations. Floor Nurse (Licensed Practical Nurse #6) did cut and file nails at the time. The Nurse Practitioner was made aware. Recommends occupational therapy assessment for the palm guard. During an interview on 8/18/2025 at 12:20 PM Director of Nursing #1 stated that usually when physical conditions were creating new issues, physical and occupational therapy were consulted. Resident #35's hand was cleaned really well, and they determined there was no wound. Occupation therapy was working with Resident #35. Director of Nursing stated that checking Resident #35's hand should have been on the list of tasks, but it was not and there was no order to do so. Resident #48 Resident #48 was admitted to the facility with the diagnoses of acute infarction of intestine (a serious condition where the blood supply to the small intestine is suddenly blocked, leading to tissue death), hypertension (a condition in which the force of the blood against the artery walls is too high), and hypoxemia (a condition where there is low oxygen in the blood). The Minimum Data Set (an assessment tool), dated 7/31/2025, documented that the resident could be understood, understand others, and was cognitively intact. During observations on 8/8/2025 at 10:34 AM and 8/11/2025 at 1:34 PM, Resident #48 was on oxygen via a nasal cannula at two (2) liters per minute. The tubing had no date on it to reflect when the tubing had been changed. The Physician's Order dated 7/25/2025 stated wean supplemental oxygen as tolerated by the resident from two liters per minute continuous to one liter per minute down to room air to maintain oxygen saturation greater than 90%. A review of the resident's comprehensive care plans, both current and resolved, documented no comprehensive care plans addressing the use of oxygen. Resident #157 Resident #157 was admitted to the facility with the diagnoses of nondisplaced fracture of the first cervical vertebra (a break in a neck bone where the pieces remain in the normal anatomical position), fracture of manubrium (a break in the upper part of the sternum), and fracture of fourth lumbar vertebra (a break in the spine in the lower back). The Minimum Data Set (an assessment tool) dated 8/5/2025 documented the resident could understand others, was understood by others, and was severely cognitively impaired.^^ During an observation on 8/7/2025 at 11:43 AM, Resident #157 was noted to be wearing a Miami J collar (a brace used to support neck bones and ligaments and reduce any movement that may cause further damage to the cervical spine).^^ The Physician's Order dated 7/29/2025 documented a Miami J collar on at all times every shift.^^ The comprehensive care plan At risk for impaired skin integrity related to weakness, history of ulceration, impaired mobility, incontinence did not address the use of the Miami J collar as a skin integrity risk. During an interview on 8/18/2025 at 1:17 PM, Director of Nursing #1 stated there should be a care plan to address every medication, treated condition, and braces and splints. They stated the comprehensive care plans should be person-centered to address the resident's needs. 10 New York Codes, Rules, and Regulations 415.11(c)(1)

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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. Based on observations, record review, and interviews conducted during the recertification and abbreviated surveys (NY00596011; NY00596018; NY00594500), the facility did not ensure residents who were unable to carry out activities of daily living received the necessary services to maintain grooming and personal hygiene for three (3) of nine (9) residents (Resident #100, #218 and #250) reviewed. Specifically, (a.) Resident #100 was not showered per the facility schedule and as requested. (b.) Resident #'s 218 and 250 were not provided toileting checks or care in accordance with their plan of care. This is evidenced by: The facility's Policy and Procedure titled Activities of Daily Living Care and Support, revised 2/28/2025, documented: 1. ADL Activities of Daily Living care and support will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the resident's assessed needs, personal preferences, and individualized plan of care, that includes but is not limited to supervision and assistance with: a. Hygiene (bathing, dressing, grooming, and oral care); b. Mobility (transfer and ambulation, including walking); c. Elimination (toileting), transfers, and incontinent care. d. Dining (meals and snacks); and e. Communication (speech, language, and any functional communication systems). 2. The resident's bath or shower will be scheduled as per the resident's preference and assessed needs at a minimum of weekly, as needed, and may include a bed bath on non-shower days. Nail care should be provided as needed for the resident. Residents with certain medical conditions may require a licensed nurse to perform. 5. Oral care/denture care and teeth brushing will be provided with care and as needed. 6. Facial hair will be groomed as per the resident's preference and/or assessed needs. 7. Hair care should be provided to the resident as per the resident's preference and/or assessed needs or by appointment at hair hairdresser's or barber;. 8. Toileting/Perineal care/Incontinence care will be provided with care and as needed. Resident #100 Resident #100 was admitted to the facility with a diagnosis of unspecified dementia (a decline in cognitive function, impacting memory, thinking, language, and judgment); cerebral infarction (the death of brain tissue (necrosis) due to insufficient blood supply);, and depression unspecified (significant distress or impairment in daily life). The Minimum Data Set (an assessment tool) dated 7/21/2025 documented the resident's cognition could to be assessed, but they were usually able to be understood and understood by others. Resident #100's Comprehensive Care Plan titled Activities of Daily Living, dated 7/15/2025, documented resident requires assistance with Activities of Daily Living related to Dementia, Fracture, and Limited Mobility. Interventions: Encourage the resident to use the bell to call for assistance. Monitor for changes in status, notify interdisciplinary team as needed. Skin Inspection: monitor for redness, open areas, scratches, cuts, bruises, and report changes to the Nurse. Record Review of Certified Nurse Aide documentation, documented in June of 2025 resident received two (s) showers on 6/26/2025 and 6/29/2025, respectively. In July 2025, documented showers were given on 7/08/2025, 7/24/2025, and for August, on 8/08/2025. Not applicable were documented on 7/17/2025, 7/20/2025, 7/22/2025, 7/29/2025, 7/31/2025, 8/5/2025, and 8/07/2025. During an interview on 08/08/2025 at 10:30 AM, Resident Representative #1(one) stated Resident #100 had not had a shower in a very long time. They could not recall when the last shower was given, and they visit daily. During an interview on 08/08/2025 at 11:00 AM, Registered Nurse #5(five), stated resident #100's shower day is Tuesday. However, they were unable to generate the certified nurse aid documentation on showers for this resident. During an interview on 08/08/2025 at 11:00 AM, Certified Nurse Aide #5 (five) was asked to provide documentation for Resident #100's last shower. They were unable to retrieve or show any documentation for Resident #100's last shower. During an interview on 08/08/2025 at 11:05 AM, Director of Nursing #1(one) provided certified nurse aide documentation for August 2025, for resident #100's shower schedule, which indicated Non-Applicable. Director of Nursing #1(one) stated the entries were erroneous. Director of Nursing #1(one) was asked to provide documentation of the last shower for Resident #100. Director of Nursing #1(one) then retrieved the July dates showing blanks (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and Non-Applicable for July. Upon request via Health Commerce, Director of Nursing #1(one) submitted documentation as mentioned above for June, July, and August 2025. During an interview on 08/15/2025 at 11:32 AM, Certified Nurse Aide #3 (three) stated that every resident has one shower per week. They have a scheduled shower day. If a resident refuses a shower, they will go back later and offer a shower again. If the resident continues to refuse, the certified nurse aide will notify the nurse. The nurse will also offer a shower and document any refusals. During an interview on 08/15/2025 at 11:37 AM, Registered Nurse #5 (five) stated they cannot say that resident #100 received a shower in between the dates of 07/17/25 and 08/07/2025. If the resident were refusing showers, there should be documentation that the resident refused their showers. There was no documented evidence about resident #100 refusing showers in their progress notes. If the resident were refusing showers, they would attempt a different time, day, and care provider, and try to get the family involved. Resident #218 Resident #218 was admitted to the facility with diagnoses of atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), hypertension (a condition where the force of blood against the artery walls is consistently too high), and acute kidney failure (a sudden or rapid decrease in kidney function). The Minimum Data Set (an assessment tool) dated 5/23/2025, documented that the resident was cognitively intact, could be understood, and could understand others. During general observations on 8/08/2025 at 10:00 AM, Resident #218 was noted to be in bed, disheveled, and appeared to be sleeping.ˆ A complaint received by the Department of Health on 8/11/2025, documented Resident #218 had to wait over an hour and a half to get changed after they soiled themselves. Resident #218's comprehensive care plan for assistance with self-care and mobility dated 5/28/2024, documented that the resident required a substantial 1 one-assist from staff members to personal care, showering or bathing, a two-assist from staff to roll left to right in bed, and a mechanical lift for transfers. Resident #218 was documented to have Monday as their shower day The Comprehensive Care Plan for Bowel Incontinence dated 5/28/2024, documented: Resident #218 had bowel incontinence related to medication side effects. Resident #218's incontinence would be managed daily in a timely manner. Interventions included checking the resident every 2 to 4 hours as tolerated during waking hours and assisting with toileting as needed. A review of the Documentation Survey Report for July 2025 for Resident #218 documented an intervention/task titled Care Provided. Each day and shift was recorded if care was provided. Care included tasks such as toileting, hygiene, and toilet transfer. During the month of July 2025, there was no documentation to support that care was provided to Resident #218 on 7/12/2025 evening shift (2:30 PM to 10:30 PM), 7/13/2025 night shift (10:30 PM to 6:30 AM), 7/26/2025 evening and night shift, and both 7/27/2025 and 7/28/2025 evening shift. During an interview on 8/18/2025 at 10:46 AM, Licensed Practical Nurse #8(eight) reviewed Resident #218's Documentation Survey Report for July 2025. They stated the dates/times where there was no recorded documentation, that the task was probably done, but the staff forgot to document it. They stated no lack of documentation meant that it was not done. Licensed Practical Nurse #8(eight) stated documentation was reviewed every morning. They were writing up a couple of nurses for missing documentation. Resident #250 Resident #250 was admitted to the facility with diagnoses of cellulitis of the left lower limb (a common bacterial skin infection that causes redness, swelling, and warmth), sepsis (a life-threatening illness caused by the body's extreme response to an infection), and acute kidney failure (a sudden or rapid decrease in kidney function). The Minimum Data Set (an assessment tool) dated 4/03/2025, documented that the resident was cognitively intact, could be understood, and could understand others. A complaint received by the Department of Health on 4/10/2025 documented that Resident #250 was admitted to the facility for rehabilitation after a hospitalization. The complainant stated Resident #250 should have been assisted to the bathroom every 2 to 4 hours, but was not. Resident #250 was not allowed to use the bathroom on their own. The complainant stated it took staff 30 minutes or more to respond to the call bell when the resident had to use the bathroom. The Comprehensive Care Plan for Self-Care and Mobility dated 4/05/2025, documented Resident #250 required assistance with (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	self-care and mobility related to impaired balance and limited mobility. Interventions included toileting hygiene: partial assist of 1 staff (Helper completes less than half the activity. Help uses their own strength to lift or hold the resident's body, arm, or legs. The Comprehensive Care Plan for Bladder Incontinence dated 4/9/2025, documented that Resident #250 was at risk for bladder incontinence related to debility. Interventions included checking and providing toileting care every 2 to 4 hours as tolerated. A review of the Documentation Survey Report for April 2025 for Resident #250 documented an intervention/task with a description of urinary toileting care every 2 to 4 hours as indicated and as tolerated during waking hours and as needed. Each day and shift was recorded if care was provided. During April 2025, there was no documented evidence that Resident #250 received toileting care on 4/01/2025 day shift (6:30 AM to 2:30 PM), 4/09/2025 night shift, 4/10/2025 day shift, 4/11/2025 day and evening shift, 4/13/2025 evening shift, 4/17/2025 day shift, 4/22/2025 day shift, 4/25/2025 evening shift, 4/26/2025 night shift, 4/28/2025 day shift, 4/29/2025 day shift, and 4/30/2025 night shift. During an interview on 8/12/2025 at 3:49 PM, Certified Nurse Aide #5(five) stated that many of the residents on their assignment are on a toileting schedule of every 2 to 4 hours because it is a rehabilitation unit. They assisted one resident at a time, going from one to the next. Certified Nurse Aide #5(five) stated they usually completed their documentation after the first round, after dinner. and then after the last round. When asked if they're ever short-handed, Certified Nurse Aide #5(five) said, We'll, yeah. They stated there was only one occasion where they did not have time to document after a morning when it was really busy. During an interview on 8/14/2025 at 11:48 AM, Certified Nurse Aide #6(six) stated that when they come into work, they assist the residents who get up first. They stated they completed the check and changes after breakfast trays were picked up, and then again after lunch. They provided frequent checks. Certified Nurse Aide #6(six) stated the residents probably did not urinate every 2 hours. They would frequently go around and ask residents if they needed anything. During an interview on 8/18/2025 at 12:25 PM, Director of Nursing #1(one) reviewed Resident #250's Documentation Survey Report for July 2025. For the dates/times where there was no recorded documentation or a blank space, they stated if it was not documented, then it was not done. They stated it was probably done, but was not documented. They have had some issues with documentation, and reviewed documentation every day. New York Codes, Rules, and Regulations Title 10 S415.12(a)(3)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on observation, record review, and interviews conducted during the recertification survey, the facility did not ensure ongoing provision of programs to support each resident and their choices of activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of one (1) (Resident #8) of three (3) residents reviewed. Specifically, Resident #8 (eight) did not consistently participate in meaningful, accommodating activities to maintain their highest practicable quality of life. This is evidenced by: The Policy titled Activity Programs, last revised 5/2019, documented the facility must provide, based on the comprehensive assessment, care plan, and the preferences of each resident, an ongoing program to support residents in their choices of activities, both facility sponsored group, individual activities, and independent activities designed to meet the interests of and support the physical, mental, and psychosocial wellbeing of each resident. The activity program consisted of individual, small and large group activities designed to meet the needs and interests of each resident. Resident #8 (eight) was admitted to the facility with diagnoses of cerebral infarction (the death of brain tissue due to insufficient blood supply), chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), and anxiety disorder (a common mental health condition characterized by excessive and persistent worry, fear, and nervousness). The Minimum Data Set (an assessment tool) dated 7/22/2025, documented that the resident was cognitively intact, could be understood and could understand others. The Comprehensive Care Plan for Activities dated 3/01/2025 documented Resident #8 (eight) was able to make recreation and leisure preferences known. Interests included watching television, reading on kindle, family/friend visits, listen to classic rock, and attend food socials. Interventions included: assist resident in finding programs of interest; provide resident with independent leisure supplies. The Comprehensive Care Plan for Level II(two) Preadmission Screening and Resident Review evaluation dated 6/02/2025 documented Resident #8 (eight) had a level II(two) evaluation related to mental illness, major depressive disorder, and generalized anxiety. Interventions included: provide the following services as recommended on the Level II Preadmission Screening and Resident Review evaluation, recreational group and activities. A recreation progress note dated 7/21/2025 at 9:11 AM, documented Resident #8 (eight) enjoyed independent activities such as watching television, talking on the phone, snack cart, traveling hospitality, manicures, and pet/family visits. They enjoyed going to food socials off the unit. Staff would continue to encourage Resident #8(eight) to attend activities and respect all of their decisions. During an observation on 8/07/2025 at 11:18 AM, Resident #8(eight) was lying in bed with the television on. There was a phone and tablet observed on the resident's nightstand. There were no additional activity items noted in the resident's room. During an interview on 8/07/2025 at 11:18 AM, Resident #8 (eight) stated they had gone to a couple activities, but sadly they watched television most of the time. They received visits from their son. They stated they did not get out of bed often because they did not like using the mechanical lift. During an interview on 8/15/2025 at 11:37 AM, Resident #8 (eight) stated that activity staff have not really brought them anything to do, and they have not received any one-to-one visits. They stated activity staff would come around to do nails, give out snacks, and brought around animals, which they liked, but they only stayed for a few minutes at a time. A review of the Multi-Month Participation Report dated 1/01/2025 to 8/31/2025 documented Resident #8 (eight): did not participate or receive activities for the month of July, received 2 activities for the month of August as of 8/18/2020, a pet visit on one occasion, and snack cart on one occasion. During an interview on 8/12/2025 at 10:06 AM, Licensed Practical Nurse #3 (three) stated activity staff provided one-to-one visits to residents that did not attend group activities in the Adirondack Room. They further stated that one-to-one activities were not offered at the same time as activities in the Adirondack room because staff needed to supervise the residents in the Adirondack room. During an interview on 8/13/2025 at 12:24 PM, Registered Nurse #1(one) stated activity staff would come around with a snack cart and animal visits for residents that typically (continued on next page)

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	335014	A. Building B. Wing	08/19/2025

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Schenectady Center for Rehabilitation and Nursing	526 Altamont Ave Schenectady, NY 12303

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stayed in their room. They had not observed any one-to-one visits offered. During an interview on 8/14/2025 at 12:20 PM, Registered Nurse #2(two) stated they were pretty sure that residents who spent most of their time in their room were offered activities, such as word searches. They stated that activity staff always invited residents to attend activities. Registered Nurse #2 (two) stated activity staff came around and painted nails or offered baked goods and snacks to residents that preferred to stay in their rooms. ^ During an interview on 8/18/2025 at 10:51 AM, Director of Activities #1(one) stated that when they did an assessment of a resident and discovered that a resident preferred to stay in their room, activity staff would ask the resident if they would like word searches, crossword puzzles, a radio, or other activities to do in their room and the activities would be provided. Director of Activities #1(one) stated they were working to create busy boxes for each of the rehabilitation units, which included sketch books, markers, word searches, and other individual activity items. They stated the facility had a library and puzzles available to residents that did not go to group activities. The activity department provided pet visits and a hospitality cart weekly which included various activities to pass out to residents such as playing cards and word searches. Director of Activities #1(one) stated their staff always encouraged and offered residents to attend activities. They stated they have a healthy one-to-one program, and that each unit had a dedicated activity staff member. Director of Activities #1(one) stated they have explained the importance of documenting one-to-one visits to their staff, but they might not always document a visit. Their staff documented at the end of every day who went to an activity, which included one-to-one visits. Director of Activities #1(one) stated that Resident #8(eight) had accepted things off the snack cart and hospitality cart when they reviewed the residents record. When questioned if Resident #8 (eight) was provided a radio to listen to classic rock music, since their care plan indicated that they enjoyed classic rock, Activities Director #1(one) stated that the resident's son was supposed to bring in a radio. New York Codes, Rules, and Regulations Title 10 S483.24

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview during the recertification survey, the facility did not ensure residents at risk for pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote wound healing, and prevent new ulcers from developing for 1(one) of 6 (six) residents (Resident #35) reviewed for Pressure Ulcers. Specifically, for Resident #35 there was no documented evidence that preventative measures were taken to prevent skin breakdown due to their hand contracture. The is evidenced by: The facility policy titled Contracture Prevention dated 8/2020, documented that each resident must be assessed for need of contracture prevention procedures on admission and as needed. Additionally, hand rolls may be placed in any hand that the resident cannot move. These can be commercial rolls or wash clothes rolled up and should be removed daily during care. The hand should be cleaned and dried thoroughly and observed for any reddened or broken areas prior to reapplication of the hand rolls. The facility policy titled Skin and Pressure Injury Prevention dated 6/27/2024, documented the facility would assess residents for risk in the development of pressure injuries and implement preventative measures in accordance with current standards of practice. Additionally, staff would inspect the skin when performing or assisting with personal care of activities of daily living and identify any signs of developing pressure injuries (i.e. non-blanchable erythema. For darkly pigmented skin, inspect for changes in skin tone, temperature, and consistency. Once the assessment was conducted and risk factors were identified and characterized, a resident-centered care plan shall be developed to address the modifiable risks for pressure injuries and skin protection interventions. Resident #35 Resident #35 was admitted to the facility with the diagnoses of unspecified dementia (a degenerative neurological disease characterized by memory loss and general decline in mental ability), moderate protein calories malnutrition (malnutrition created by a diet deficient in both protein and calories), and weakness. The Minimum Data Set (an assessment tool) dated 7/28/2025, documented the resident was usually able to understand others, usually able to be understood and was significantly cognitively impaired. Resident #35's comprehensive care plan for activities of daily living dated 2/16/2023 documented skin inspection, monitor for redness, open areas, scratches, cuts, bruises and report changes to the nurse. Resident #35's comprehensive care plan for impaired skin integrity dated 2/16/2023 documented prevent the resident from scratching and keep hands and body parts from excessive moisture, keep fingernails short. There was no documented evidence that there was a care plan area related specifically to the resident's right hand contracture. During an observation and interview on 8/07/2025 at 10:53 AM, Resident #35 was noted to have a right-hand contracture and long fingernails on both hands. Family Member #2 (two) who was visiting with Resident #35, explained that Resident #35's hand had been contracted for years. Upon examination of the Resident's 35 right hand and assessment of their range of motion, a dark area was noted on the inside of the resident's hand, approximately where the resident's fingernails rested. Family Member #2 (two) stated they did not know what was on the resident's hand. Family Member #2 (two) called Family #3 (three) who had attended the care plan meeting on 8/06/2025 and asked if there had been any conversation regarding Resident #35's contracted hand. Family Member #3 (three) stated there had not been. Licensed Practical Nurse #6 (six) was informed of the findings when the interview concluded. Licensed Practical Nurse #6 (six) stated they were not aware of any issues with the resident's hand, but they would look at it and respond as needed. ^ A facility skin monitoring assessment dated [DATE] at 10:43 AM documented that a new skin alteration was noted on Resident #35's right hand described as contracture with small deep tissue injury noted. A facility nursing alert note dated 8/12/2025 at 11:15 AM documented the resident had a newly identified skin alteration according to point of care documentation. Area assessed, doesn't appear to be open, however some moisture noted, betadine orders in place to dry up moisture and physical therapy evaluation for (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	possible palm guard. A general nursing progress note dated 8/12/2025 at 11:49 AM documented Resident #35 had history of severe contraction of the hand. Palm opens with mild pain, and the resident is resistant to care and assessment of the area. Palm appears non-discolored with no breaks in skin. There is a buildup of dead skin cells in the palm, and occupational therapy is in to assess, will soak the hand, and provide recommendations. Floor Nurse (Licensed Practical Nurse #6) did cut and file nails at the time. The Nurse Practitioner was made aware. Recommends an occupational therapy assessment for a palm guard. During an interview on 8/12/2025 at 10:06 AM, Licensed Practical Nurse #3 (three) stated that they had been made aware of Resident #35's hand that day. They stated it looked like moisture, and they were going to get an order to apply betadine and protect their skin with a rolled-up cloth. Licensed Practical Nurse #3 (three) stated that Resident #35 was sometimes non-compliant with their activities of daily living. Additionally, Licensed Practical Nurse #3 (three) would discuss with therapy to get a hand carrot and with wound care for the best plan. Licensed Practical Nurse #3 (three) stated they would encourage Resident #35 to let the staff cut their fingernails, and if they refused, a reapproach would occur when the family members visited. During an interview on 8/18/2025 at 12:20 PM Director of Nursing #1(one) stated that usually when physical conditions were creating new issues, physical and occupational therapy were consulted. Resident #35's hand was cleaned really well, and they determined there was no wound. Occupation therapy was working with Resident #35. Director of Nursing #1 (one) stated that checking Resident #35's hand should have been on the list of tasks, but it was not and there was no order to do so.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews conducted during the recertification survey, the facility did not ensure that each resident received the necessary respiratory care and services that are in accordance with professional standards of practice, the resident's care plan and the resident's choice, for (two) 2 (Residents #48 and #163) of 3 (three) residents reviewed for oxygen administration. Specifically, a) Resident #48, the oxygen tubing was not dated and labeled to reflect when the tubing was changed; b) Resident # 163, nebulizer tubing was not dated and labeled to reflect when the tubing was changed, and the nebulizer mask was not stored per facility policy (in a plastic bag with the resident's name on it) when not in use. Resident #48 Resident #48 was admitted to the facility with the diagnoses of acute infarction of the intestine, hypertension, and hypoxemia. The Minimum Data Set (an assessment tool), dated 7/31/2025, documented that the resident could be understood by others and was cognitively intact. Facility policy titled, Oxygen Therapy, last revised 9/2022, stated oxygen cannula tubing was to be changed weekly and as needed. During observations on 8/8/2025 at 10:34 AM and 8/11/2025 at 1:34 PM, Resident #48 was on oxygen via nasal cannula at two (2) liters per minute. The tubing had no date on it to reflect when the tubing had been changed. The Physician's Order dated 7/25/2025 stated to wean supplemental oxygen as tolerated by the resident from two (2) liters per minute continuous to one (1) liter per minute down to room air to maintain oxygen saturation greater than 90%. The July 2025 Medication Administration Record and Treatment Administration Record did not document an order to change the tubing per the facility policy. The August 2025 Medication Administration Record and Treatment Administration Record did not document an order to change the tubing per the facility policy. A review of the progress notes from 7/25/2025 to 8/18/2025 showed no documentation for oxygen tubing change. During an interview on 8/8/2025 at 10:40 AM, Licensed Practical Nurse #4 (four) stated the tubing should be changed, and oxygen tubing was generally changed on the overnight shift. During an interview on 8/12/2025 at 2:16 PM, Director of Nursing #1(one) stated a new policy dated 8/13/2025 was in place, stating the tubing would be changed when soiled or as needed. During an interview on 8/19/2025 at 10:50 AM, Administrator #1(one) stated that a policy was in effect until a new one replaced it. Resident #163 Resident #163 was admitted to the facility with the diagnoses of type 2 (two) diabetes mellitus (a chronic condition that happens when a person has persistently high blood sugar levels), hyperlipidemia (a condition in which there are high levels of fat particles in the blood), and gastrointestinal hemorrhage (bleeding anywhere in the digestive tract). The Minimum Data Set, dated [DATE], documented the resident could be understood and understand others and had severely impaired cognition for daily living decisions. Facility Policy titled, Nebulizer Medication/COVID-19, created 11/2016 last revised 1/2021, stated the purpose of the procedure was to safely and aseptically administer aerosolized particles of medication into the resident's airway. Nebulizer treatments would be given by licensed nursing staff or respiratory therapists, as directed, using proper technique and universal precautions. The procedure for administering nebulizer medications included: Administer therapy until the medication is gone. When treatment is complete, turn off the nebulizer and disconnect the T-piece, mouthpiece, and medication cup. Rinse and disinfect the nebulizer equipment. Wash pieces with warm soapy water. Allow to air dry on a paper towel. When the equipment was completely dry, store it in a plastic bag with the resident's name and the date on it. Change equipment and tubing every seven days, or according to facility protocol. During an observation on 8/08/2025 at 10:24 AM, Resident # 163 was lying in bed. A nebulizer (a machine that changes liquid medicine into fine droplets in aerosol or mist form that are inhaled through a mouthpiece or mask) was on the nightstand. The mask was stored on top of the nightstand. It was not stored in a plastic bag. The tubing for the nebulizer was not labeled with a date. Resident #163 stated they used the nebulizer to receive a breathing treatment that was given to them by the nurse. They (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated the last time they used it was yesterday evening. During an observation on 8/12/2025 at 2:47 PM, the nebulizer in Resident #163's room was on the nightstand. The mask was stored on top of the nightstand. It was not stored in a plastic bag. The tubing for the nebulizer was not labeled with a date. During an observation on 8/14/2025 at 11:32 AM, the nebulizer in Resident #163's room was on the nightstand. The mask was stored on top of the nightstand. It was not stored in a plastic bag. There was an empty plastic bag noted to be on the nightstand. The tubing for the nebulizer was not labeled with a date. During an observation on 8/15/2025 at 12:12 PM, the nebulizer in Resident #163's room was on the nightstand. The mask was stored on top of the nightstand. It was not stored in a plastic bag. There was an empty plastic bag noted to be on the nightstand, The tubing for the nebulizer was not labeled with a date. A review of medical orders dated 6/06/2025, documented the resident was to receive ipratropium-albuterol solution 0.5-2.5 (3) MG/3ML. Route of administration was inhale orally. Frequency was two (2) times a day, every day at 8:00 AM and 7:00 PM. There were no medical orders regarding when the nebulizer tubing should be changed. A review of the Medication Administration Record dated August 2025, documented that ipratropium-albuterol solution 0.5-2.5 (3) MG/3ML was administered via inhalation orally at 8:00 AM and 7:00 PM. A review of the Treatment Administration Record dated August 2025 did not document the changing of the nebulizer tubing. During an interview on 8/14/2025 at 12:16 PM, Licensed Practical Nurse #2 two Stated Resident #163 received ipratropium-albuterol via a nebulizer machine. They stated the mask was stored in a plastic bag. During an interview on 8/14/2025 at 12:45 PM and on 8/15/2025 at 12:21 PM, Licensed Practical Nurse #1(one) stated masks for nebulizers should be stored in a plastic bag after use. They stated they went through all resident rooms that had nebulizers and made sure there were bags in the rooms to store the nebulizer masks in. They stated the tubing for nebulizers was changed as needed, such as if it was soiled or compromised. They stated there was no physician order for Resident #163 to change their nebulizer tubing. An order should have been written as an as-needed order to change the nebulizer tubing, but it was not written. They did not know when the nebulizer tubing for Resident #163 was last changed, and they were not aware of how the changing of the tubing was tracked. During an interview on 8/15/2025 at 12:16 PM, Registered Nurse #1(one) stated the tubing for nebulizers was changed on the night shift, but they were unsure how often the tubing was changed. They stated the masks for nebulizers were stored in a plastic bag. They stated they just went into Resident #163's room, and the nebulizer mask was not stored in a plastic bag, so they put it in a plastic bag. During an interview on 8/18/2025 at 12:23 PM, Director of Nursing #1(one) stated it was part of the facility's process to store masks for nebulizers in a bag for infection control purposes. The tubing for nebulizers should be changed as needed and when it is soiled. They stated there was no date on the tubing that indicated when it was changed, and there was no schedule for changing the tubing, but it should have been documented in the medical record when it was changed. New York Codes, Rules, and Regulations Title 10 S415.12(k)(3)