STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335028	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prestige Nursing Care & Rehab Center	3400 -26 Cannon Place Bronx, NY 10463

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, record review, and interviews, the facility failed to ensure that residents' right to a safe, homelike environment was maintained. This was evident in two (2) shower rooms observed during the Environmental Task. Specifically, two (2) clear overhead lighting fixture coverings in the Six (6) [NAME] unit shower room were observed to be cracked or had broken circular areas, and the faucet on a sink in the Four (4) East unit was loose and became partially detached from the sink's base when used. The findings include:The facility policy and procedure titled, Homelike Environment, reviewed 01/2026, documented it is the policy of the facility to create and sustain a home-like environment that supports each residents' physical, emotional, and psychosocial well-being. The facility will respect resident preferences, encourage individuality, and promote autonomy while maintaining a safe and sanitary environment. The facility will maintain a clean, comfortable, and safe environment. Efforts will be made to reduce institutional appearance and maintain appropriate lighting. All efforts to create a home-like environment must comply with Life Safety Codes and facility policy and procedures. Environmental rounds will be conducted routinely to identify and correct hazards. The facility policy and procedure titled, Routine Maintenance, reviewed 01/2026, documented all essential mechanical, electrical, structural, resident care equipment and resident furnishings will be maintained in a safe operating condition. The Director of Maintenance is responsible for maintaining a schedule to ensure timely monitoring, repair and maintenance. If the maintenance director or any staff member feels the work is out of scope and they are unsure how to safely and effectively perform a duty, it should be brought to the attention of the Administrator, and an outside professional can be contacted. Routine monitoring, repair and maintenance services will be performed on, but not limited to the electrical systems, equipment, appliances, outlets, plumbing, drainage, sinks, toilets, repair of interior walls, floors and ceiling tilesOn 04/13/2026 at 10:31 AM, an observation of the Six (6) [NAME] unit shower room was performed. Two (2) of three (3) clear overhead light coverings were observed to be in disrepair: one (1) was cracked and one (1) was broken revealing two (2) circular holes. On 04/13/2026 at 11:40 AM, a tour of the Four (4) East unit shower room was performed with Maintenance Worker #2. A faucet was observed to be loose and became partially detached from the base of the sink when in use.The unit Maintenance Department Repair Log entry dated 03/06/2026 documented a request for repair for the bathroom ceiling tiles. On 04/13/2026 at 10:49 AM, an interview was conducted with Maintenance Worker #1 who stated that they were supposed to repair the ceiling tiles and lights in the Six (6) [NAME] unit shower room one week ago. Maintenance Worker #1 acknowledged the entry in the repair logbook was dated 03/06/2026 and further stated that the repair was delayed because the work had to be completed after hours when residents would not be using the shower. On 04/13/2026 at 11:40 AM, an interview was conducted with Maintenance Worker #2 who stated that they were not made aware of the loose faucet in the Four (4) East unit shower room. Maintenance Worker #2 also stated that today they were following up on the repairs that are documented in the floor's maintenance logbook. After touring the shower room with the surveyor, Maintenance Worker #2 stated the faucet would be logged and addressed for repair. On 04/13/2026 at 11:21 AM, an interview was conducted with the Director of (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Housekeeping, who stated that they are aware of the Comptroller's recent assessment in February 2026, and that the report of observations identified needed repairs. The Director of Housekeeping also stated that they repaired all items listed on the Comptroller's Report that was provided to the facility. The Director of Housekeeping also stated the equipment for repair of the ceiling lights in the Six (6) [NAME] unit shower room had come in but that the repair must be scheduled at night. On 04/16/2026 at 10:26 AM, an interview was conducted with the facility Administrator who stated that an unannounced visit to inspect the physical environment of the facility by the Comptroller's Office occurred in February 2026. The Comptroller performed an exit presentation which included a verbal report of the identified issues. The Administrator stated that all needed repairs identified by the Comptroller were completed in February and March 2026. The Administrator stated they conducted environmental rounds to ensure the completion of repairs. The Administrator also stated that on rounds they did not notice the need for repair of the Six (6) [NAME] shower room light fixtures or the Four (4) East shower room faucet that was identified in the Comptroller's Report. The facility Administrator further stated the loose faucet base is normal wear and tear and the supplies needed to repair the lights on Six (6) East were delivered earlier this month, but the repair was not completed prior to the surveyor's observations. 10 New York Code Rules and Regulations 415.5(h)(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 review and staff interviews, the facility failed to ensure that a person-centered comprehensive care plan was developed and implemented to address the residents' medical, physical, mental, and psychosocial needs. This was evident for one (1) resident (Resident #60) reviewed for Dental out of a total sample of 38 residents; specifically, a person-centered comprehensive care plan was not developed and implemented to address the resident's dental care needs. Additionally, a comprehensive care plan was not developed and implemented for Resident #73's use of plastic utensils in the resident's Activity of Daily Living or Behavior care plans.The findings include: The facility policy and procedure titled, Comprehensive Person-Centered Care Planning, dated 11/28/2017, last revised 01/2026, stated that a comprehensive, person-centered care plan for each resident is developed within (7) days of completion of the resident assessment. The care plan is based on the resident's comprehensive assessment and is developed by Care Planning/Interdisciplinary Team members. The facility policy and procedure titled, Mealtime Assistance, with review date of 07/2025, documented residents will receive assistance with meals in a manner that meets the individual needs of each resident. Residents who are assessed as suicidal ideation, behaviors, hoarders or infection control purposes may be assigned disposable tableware and cutlery. All devises will be placed in the care plan and certified nursing assistant accountability. Resident #60 was admitted to the facility on [DATE] with diagnoses that included anemia, renal insufficiency, renal failure, and malnutrition. The Quarterly Minimum Data Set, dated [DATE] documented that Resident #60 has intact cognitive status and is independent of staff for most activities of daily living. The Minimum Data Set assessment also documented that Resident #60 had no concerns with swallowing and oral/dental status. The Comprehensive Care Plan for Dental Care dated 10/30/2025 documented that Resident #60 has actual impairment. Monitoring/Evaluation notes for Dental Care plan dated 11/06/2025 documented that Resident #60 is partially edentulous with full upper and partial lower dentures, functions well, clean and treat symptomatically. On 04/09/2026 at 10:30 AM, Resident #60 was interviewed and stated that they have a lot of missing teeth and had never seen the dentist since admission. Resident #60 stated that they have been requesting the staff to see the dentist since admission. Resident #60 stated that the facility has not helped with appointments to see the dentist yet. On 04/09/2026 at 12:17 PM, during a dining room observation, Resident #60 was observed eating lunch, noted with only one upper front tooth and a lot of missing bottom teeth; resident was noted to be having difficulty chewing the chopped meat served. When approached during lunch, the resident expressed difficulty to eat. Resident #60 further stated that it would have been easier if they had dentures and they had been waiting for so long to see the dentist. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There is no documented evidence that a person-centered comprehensive care plan was developed and implemented to address Resident #60's dental care. On 04/15/2026 at 11:10 AM, Registered Nurse #1 was interviewed and stated that they just started on the unit about three (3) weeks ago. Registered Nurse #1 stated that they are not sure if Resident #60 has dentures and they don't know the last time Resident #60 was seen by the dentist. Registered Nurse #1 further stated that it is the Registered Nursing Supervisor's responsibility to initiate the residents' comprehensive care plans upon admission. On 04/16/2026 at 8:58, AM The Assistant Director of Nursing was interviewed and stated that the Night Nursing Supervisor that was responsible for reviewing the comprehensive care plan stated that they just copied and pasted the dental note on Resident #60's care plan and that it was not appropriate to do so. The Assistant Director of Nursing stated that the care plan documented for Resident #60 did not address the resident's plan of care as Resident #60 did not apparently have dentures as documented in the comprehensive care plan in place. On 04/16/2026 at 9:37 AM, Registered Nurse #3 was interviewed and stated that they just realized that the current Dental Care comprehensive care plan in place did not address Resident #60's dental problem. Registered Nurse #3 stated that the review of resident's care plan is assigned to night shift supervisor and they have not been checking to see if it is appropriate for the resident's problem. On 04/16/2026 at 9:46 AM, The Director of Nursing was interviewed and stated that the nurse on the unit is responsible for ensuring that there is a person-centered comprehensive care plan for all residents. The Director of Nursing also stated that care plan is initiated upon admission by the admission nurse and developed over fourteen (14) days until the care plan meetings. The Interdisciplinary Team is expected to go over the care plans to ensure that the care plan is addressing resident's needs. The Director of Nursing further stated that the night nurse that entered the information for Resident #60's Dental care plan admitted entering wrong information on the resident. Resident #73 was admitted to the facility on [DATE], with diagnoses that included seizure disorder, dementia and traumatic brain injury. The Quarterly Minimum Data Set assessment, dated 03/21/2026, documented that Resident #73 had severely impaired cognitive function for daily decision making with behavioral symptoms of rejection of care and wandering. The Minimum Data Set assessment also documented that Resident #73 required supervision or touching assistance for eating, all personal care needs, all activities of daily living and mobility. On 04/13/2026 at 12:00 PM, during a dining observation, Resident #73 was observed eating in their room using plastic cutlery. The tray ticket documented, plastic utensils no knife. On 04/14/2026 at 12:08 PM, during a dining observation, Resident #73 was observed eating in their room using plastic cutlery. The tray ticket documented, plastic utensils no knife. The Care Plan Activity Report titled, Activities of Daily Living: Self Care Performance Deficit- Eating, effective 08/06/2024 and last reviewed 03/19/2026, did not document plastic utensils as an intervention for use by Resident #73. The Certified Nursing Assistant Documentation History Detail, Category for Eating, dated (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	03/16/2026-04/16/2026 did not document that plastic utensils were used by Resident #73. There is no documented evidence that a person-centered Comprehensive Care Plan and Certified Nursing Assistant Accountability record were developed and implemented for Resident #73's use of plastic utensils. On 04/16/2026 at 11:36 AM, an interview was conducted with the Director of Nursing who stated plastic utensils are recommended for use for residents who have behavioral issues including suicidal ideation, homicidal ideation, and threatening behaviors. The interdisciplinary team, including nursing, identifies the behaviors and the Registered Nurse on the floor or the Nurse Manager documents the intervention for use of the utensils in the Activities of Daily Living or Behavior Care Plan. The Director of Nursing also stated that the care plan needs to be updated quarterly by the nurse manager. Once entered in the care plan, the task of using plastic utensils is forwarded to the Certified Nursing Assistant Accountability so that they are aware of the need for use and possible assistance. Resident #73's Activities of Daily Living and Behavior Care Plans were reviewed in the electronic medical record with the Director of Nursing who stated that neither the care plans, nor the accountability sheets documented Resident #73's use of plastic utensils. The Director of Nursing further stated that the nurse manager should have reviewed the record quarterly to ensure the care plan documented the use of plastic utensils. On 04/16/2026 at 11:50 PM, an interview was conducted with Registered Nurse #6 who stated that Resident #73 gets agitated, they have a history of verbally threatening staff and there was a determination made that the resident should not have access to metal silverware. Registered Nurse #6 also stated that after those behaviors are noticed, the social worker is notified, along with the nursing supervisor, and the dietician. A decision is made by the team for use of plastic utensils, and the nurse manager enters the intervention of utilizing plastic utensils in the activities of daily living care plan and updates them quarterly. Care Plans were reviewed in the electronic medical record with Registered Nurse #6 who further stated plastic cutlery with no knife should be documented on the care plans but is not. On 04/16/2026 at 12:41 PM, an interview was performed with Registered Nurse #7, the nurse manager, who stated they spoke with the facility dietician approximately two (2) weeks prior. Registered Nurse #7 stated that residents are provided plastic utensils and no knife if they have suicidal ideation, homicidal ideation, and or threatening behaviors. Once the behavior has been determined, an intervention should be placed on the Activities of Daily Living care plan and updated every ninety (90) days. Registered Nurse #7 further stated that the nurse manager does not have to always enter the intervention or update the care plan, but any nurse on the unit could have done that; Registered Nurse #7 recognized the care plan was not completed. 10 New York Code, Rules and Regulations 415.11(c)(1)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observation, record review, and interviews, the facility failed to act upon the recommendations documented in the drug regimen review for one (1) (Resident # 347) of five (5) residents reviewed for unnecessary medications out of 38 total sampled residents. Specifically, the irregularity noted in the drug regimen review for Resident #347, dated 02/09/2026, was to consider a gradual dose reduction of Olanzapine five (5) milligrams; the physician did not document a rationale for not changing the medication order in the resident's medical record.The findings are:The facility policy and procedure titled, Drug Regimen Review, last revised January 2026, documented that the consultant pharmacist shall perform medication regimen reviews for each resident at least monthly. They shall provide written documentation of all recommendations and submit it to the facility for the attending prescriber or designee's review and response. The prescriber or designee shall act upon the Drug Regimen Review findings/recommendations in a timely manner of seven to fourteen (7-14) days or less. They shall document on the drug regimen review form whether they agree or disagree with the recommendation and provide a brief clinical rationale. Resident # 347 was admitted to the facility with diagnoses that include non-Alzheimer's dementia, depression, and psychotic disorder. The quarterly Minimum Data Set (MDS) assessment, dated 01/06/2026, documented Resident #347's cognition as severely impaired and noted they receive antipsychotic and antidepressant medications. A physician's order for Resident #347 dated 04/13/2026 included Olanzapine (Zyprexa) five (5) milligram tablet: give one tablet by oral route once daily in the evening for Psychosis.A medication regimen review report dated 02/09/2026 documented that Resident #347 is currently receiving Olanzapine five (5mg) once daily. The report noted that the most recent psychiatry consult recommended a gradual dose reduction from five (5) milligrams daily to two and a half (2.5) milligrams daily for seven (7) days, two and a half (2.5) milligrams every other day for seven (7) days, and then to be discontinued.The attending physician's response dated 02/11/2026 documented agree, will do.A review of the physician orders dated 02/11/2026 to 4/15/2026 evidenced no documentation that the order was changed to reflect the recommendation.A review of Resident #347's medical progress notes had no documentation that action had been taken to address the recommendation.On 04/15/2026 at 9:59 AM, Psychiatric Nurse Practitioner #1 was interviewed and stated that they saw Resident #347. The resident was drowsy, so they recommended a gradual dose reduction for the Olanzapine. The recommendation was not carried out, and it was beyond their control.On 04/15/2026 at 11:30 AM, Attending Physician #1 was interviewed and stated that the pharmacy consultant recommended a gradual dose reduction of the Olanzapine from five (5) milligrams to two and a half (2.5) milligrams; they agreed with the recommendation. Attending Physician #1 stated that the order was not changed after they spoke to the staff who said that resident was aggressive and refused care. The order was not changed, and no follow-up note was added.On 04/16/2026 at 10:24 AM, the Medical Director was interviewed and stated that when the pharmacy reviews the medications and makes a recommendation, it is up to the clinician to accept or decline it. If they choose not to accept, they must write the reason for their disagreement with the recommendation. If they agree with the recommendation, they must do so. If they do not do it, it must be documented.On 04/16/2026 at 1:24 PM, the Director of Nursing was interviewed and stated that when the pharmacy consultant entered their documentation into the chart, the chart was flagged for the doctor's response. The doctor is responsible for accepting or declining the recommendation. They must provide the reason if they do not accept the recommendation. If they accept, they must follow through, just as with a psychiatrist's recommendation. Upon review of the electronic medical record, the Director of Nursing stated there was no documentation in Resident #347's chart as to why the recommendation was not followed. 10 New York Codes, Rules and Regulations 415.18 (c)(2)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff interviews, the facility did not ensure that the resident's drug regimen is free from unnecessary drugs. This was evident for one (1) resident (Resident #131) out of a total sample of thirty-eight (38) residents. Specifically, Resident #131 was ordered Morphine fifteen (15) milligram extended-release tablets to be given with frequency of as needed, which is not an adequate indication or duration for its use. The findings include: The facility's policy titled, Pain Assessment and Management, last reviewed 01/2026, documented that residents admitted on pain medication regimens will have their pain medications continued uninterrupted after evaluation by the medical provider. Staff will assess the effectiveness of medication in managing the pain by evaluating the dosage and administration intervals.Resident #131 was admitted to the facility with diagnoses that include chronic obstructive pulmonary disease, renal insufficiency, and obstructive uropathy.The Quarterly Minimum Data Set, dated [DATE], documented the resident's cognition as intact. Additional documentation noted the resident did not receive scheduled pain medication regiment, but received PRN pain medication. The Quarterly Minimum Data Set, dated [DATE], documented the resident's cognition as intact. Additional documentation noted the resident had no behavioral symptoms, no pain, took an anticonvulsant, and that Resident #131 participates in assessment and goal setting. The resident did not receive scheduled pain medication and did not receive PRN pain medication.The physician's order originally ordered 03/07/2026 and last renewed on 04/09/2026, documented Morphine extended-release (ER) 15 milligram tablet, give one (1) tablet (fifteen (15) milligram) by oral route every twelve (12) hours as needed.The Medication Administration Record for April 2026 revealed that Resident #131 received Morphine extended-release (ER) fifteen (15) milligram tablet on 04/07/2026 at 5:30 AM, 04/08/2026 at 5:00 AM, 04/13/2026 at 5:00 AM and 04/14/2026 at 7:52 AM.The Comprehensive Care Plan titled Pain, effective 11/05/2024, documented an etiology of primary generalized osteoarthritis. Goals included the resident will have decreased complaints of pain in 90 days. Interventions include administering medications as ordered by Medical Doctor.A Nurse Practitioner monthly progress note dated 04/13/2026 documented a follow up on chronic conditions, no falls, infections or emergency department visits during the last interim. Documentation included that Resident #131 was refusing meds, labs and medical care. Nurse Practitioner note also documented that received Morphine extended-release (ER) fifteen (15) milligram tablet every twelve (12) hours by an outside pain management specialist, however, the patient is non-compliant with the scheduled regimen and requests that the medication be administered on a as needed basis, stating they don't need medication all the time. Additionally, the patient is expected to follow up monthly with the outside pain management specialist but has been non-compliant with scheduled appointments.On 04/15/2026 at 10:47 AM, Nurse Practitioner #2 was interviewed and stated that they are Resident #131's primary provider and that Resident #131 complains of chronic pain. Nurse Practitioner #2 stated that Resident #131 has been receiving Morphine and that the pain management consultant ordered a standing dose for Resident#131, but Resident #131 wanted the medication as needed. Nurse Practitioner #2 stated that Resident #131refuses to go to the pain management consultation.On 04/16/2026 at 12:49 PM, Nurse Practitioner #2 further stated that they spoke to the pain management doctor previously, and that they are trying to wean Resident #131 from the medication, so the Morphine 15mg is ordered for 30 days only. Then Resident #131 would go back to the pain doctor, and they would reevaluate the medication.On 04/15/2026 at 11:07 AM, Registered Nurse #9 was interviewed and stated that they monitor the residents and give the medications, and if there were any significant changes, they would report it to their Charge Nurse. Registered Nurse #9 stated that Resident #131 chooses what they want to take and if the medication is generic, they refuse. Registered Nurse #9 stated that the resident states when they need pain medication.On 04/16/2026 at 12:22 PM, the attending Medical Doctor was interviewed and stated that although Resident #131 is (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indirectly under their care, Resident#131 does not want to be examined by a male doctor. For this reason, they are seen by Nurse Practitioner #2, who is under the medical doctor's supervision. The attending Medical Doctor stated that Resident #131's chronic back pain has been a problem, and a major point of contention for Resident #131 is that their pain has not been managed by the pain consultant. Resident #131 wants what they want, and they do not trust the clinicians in the building, so they follow up with an outside pain management physician to reduce the pain. The attending Medical Doctor stated that they should have given the Morphine immediate-release (IR) instead of the Morphine extended-release (ER) if it was to be given on as needed basis. On 04/16/2026 at 1:51 PM, the Director of Nursing was interviewed and stated that Resident#131 has behaviors, dictates their care and that they are non-compliant with their care. The Director of Nursing stated that they were was not aware Resident#131 was receiving Morphine extended-release on an as needed basis. On 04/16/2026 at 2:16 PM, the Medical Director was interviewed and stated that Resident#131 has suffered from pain for a long time and that the Morphine extended-release works for the resident. The Medical Director stated that the resident has reactions to short-term medications. The Medical Director also stated that Resident #131 has not complained of pain and that this regimen has worked for them. The Medical Director stated that residents who experience pain can determine what is best for them and know how to manage it. The Medical Director further stated that Resident #131 has had bad experiences with other medications, and therefore care should be tailored so that their pain is managed and to satisfy their needs. 10 New York Code Rules and Regulations 415.12(l)(1)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews, the facility failed to ensure that food was stored in accordance with professional standards for food service safety. This was evident for three (3) of five (5) kitchen refrigerators that were observed during the initial kitchen tour. Specifically, walk-in refrigerator #1 was observed to contain unlabeled and undated cups of almond milk, walk-in refrigerator #2 was observed to contain outdated cooked food and undated defrosting food, and the kitchen pantry refrigerator contained four (4) ounce fruit and pudding cups that were undated and/or outdated.The findings include: The facility policy and procedure titled, Food Storage, with review date of 10/2025, documented that all use by dates will function as safety dates and all frozen food will be stored in a solid state. All perishable food will be dated by a staff member and stored immediately upon receival. Best by or best if used by dates are a suggestion for when the food item will be at its best quality. The facility standard is to treat this as the expiration date.The facility policy and procedure titled, Pantry Refrigerators, with review date of 01/2026, documented that any food placed in the pantry refrigerator must be labeled and dated. All food is discarded after seventy-two (72) hours or if there is no date. No exceptions.On 04/09/2026 at 9:11 AM, an initial kitchen observation was carried out with the Food Service Director. The findings included:Walk-in refrigerator #1 was observed to contain two (2) unlabeled, undated eight (8) ounce Styrofoam cups of almond milk.Walk-in refrigerator #2 was observed to contain one (1) metal pan covered in aluminum foil containing cooked ground chicken dated 04/02/2026, one (1) metal pan covered in plastic wrap containing mixed vegetables dated 04/02/2026, and a one (1) gallon container of whole eggs in citric acid defrosted without a defrost date.The kitchen pantry refrigerator was observed to contain one (1) four (4) ounce fruit cup dated 03/31/2026, one (1) four (4) ounce fruit cup dated 04/05/2026, one (1) four (4) ounce fruit cup labeled with an illegible date, one (1) four (4) ounce fruit cup undated, and one (1) four (4) ounce chocolate pudding cup dated 04/04/2026. On 04/09/2026 at 9:30 AM, an immediate interview was conducted with the Director of Food Service who stated when prepared or cooked food is placed in the refrigerator the items should be labeled with the preparation date. The cooked food should be served within three (3) days or discarded. The cooked chicken and vegetables dated 04/02/2026 should have been discarded if not served by 04/05/2026. The Director of Food Service also stated the prepared fruit cups should also be served or discarded within three (3) days. The Director of Food Service stated they did not know that defrosting food items had to be labeled with the defrost date. The Director of Food Service further stated that they, along with the dietary supervisor, perform daily rounds of all refrigerated food items, but they must have misread the date on the cooked food items. The Director of Food Service further stated that a dietary supervisor called out and they could not perform rounds that day.On 04/09/2026 at 9:35 AM, an interview was conducted with Dietary Aide #1 who stated that they were very busy and did not notice the outdated fruit cups stored in the pantry refrigerator. Dietary Aide #1 further stated that the fruit cups should have been discarded within 3 days. On 04/13/2026 at 3:23 PM, an interview was conducted with Dietary [NAME] #1 who stated that the chicken stored in the refrigerator was cooked on 04/07/2026. The vegetables are raw and both the vegetables and cooked ground chicken were labeled on 04/07/2026 for use on 04/09/2026 because foods that are prepared can be stored for seventy-two (72) hours. Dietary [NAME] #1 also stated that the chicken and vegetables were labeled 04/07/2026 but admitted the number seven (7) could be mistaken for the number two (2). Dietary [NAME] #1 also stated that they are responsible for food preparation and storage, and all stored food items should be clearly dated. Also, frozen food that is placed in the refrigerator for defrost should be clearly labeled with the date it was placed in the refrigerator. Dietary [NAME] #1 further stated any item opened, stored, defrosting or perishable must be discarded within seventy-two (72) hours and that the Food Service Director or anyone assigned to perform rounds is responsible to discard the food items daily. 10 New York Codes Rules and Regulations 415.14(h)