STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335110	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evergreen Commons Rehabilitation and Nursing Ctr	1070 Luther Road East Greenbush, NY 12061

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 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 observations, interviews, and record review conducted during an abbreviated survey (Case #2653623), the facility did not ensure resident's right to free from neglect for 1 (one) (Resident #5) of 4 (four) residents reviewed for abuse and neglect. Specifically, Resident #5's care plan for At Risk for Falls documented an intervention to encourage the resident to wear proper footwear/non- skid socks and the resident was found on the floor after a fall without proper footwear or non- skid socks on. The facility policy Freedom from Abuse, Neglect, and Exploitation last reviewed 10/2025, documented the purpose was to ensure residents of the facility were free from abuse, neglect, or exploitation. Neglect was defined as the failure of the facility, it's employees or service providers to provide goods and services to a resident that were necessary to avoid physical harm, pain, mental anguish or emotional distress. All incidents of potential abuse, neglect, or exploitation would be investigated. Resident #5 was admitted to the facility with diagnoses of dementia (a group of conditions that cause a progressive decline in cognitive abilities), fracture of left femur (break in the thigh bone), and acute gastric ulcer with hemorrhage (sudden and severe bleeding from an ulcer in the stomach lining). The Minimum data Set (an assessment tool) dated 8/22/2025, documented Resident #5 had severe cognitive impairments, could be understand, but rarely/never understand others. Resident #5's care plan At risk for falls documented interventions that included bilateral floor mats, encourage resident to wear proper footwear/non-skid socks, Physical Therapy or Occupational Therapy evaluation and participation to build strength and endurance as needed, provide call bell, and frequently used articles within resident's reach, maintain bed in lowest position while in bed, perimeter mattress, and early get up. Resident #5's care plan Activities of Daily Living/Mobility documented the resident was dependent with a mechanical lift assist of 2 (two) for sit-to-chair transfer. It was documented that Resident #5 was dependent with 1 assist to put on and take off their footwear. A nursing progress note/assessment dated [DATE] at 4:56 AM, written by Registered Nurse #2, documented Resident #5 was observed face down, lying on the floor next to their bed, with feces noted in the resident's anal area. Neurological checks were within normal limits, Resident #5 denied pain, and there was no pain observed in all four of the resident's extremities. Some nursing interventions included: neurological checks initiated, moved closer to nurse's station, non-slip footwear, call bell within reach, bedside mat in place, bed in lowest position and bed locked, and frequent toileting. An Accident/Incident Report dated 10/21/2025 at 4:10 AM, documented Resident #5 was lying on the floor next to their bed. face down, nude, with a small amount of feces observed. An Accident/Incident Report staff statement dated 10/21/2025, written by Certified Nurse Aide #3, documented they had changed Resident #5 a half an hour beforehand at 3:30 AM. A question on the statement asked did the resident have appropriate footwear on and it was checked no. An Accident/Incident Report staff statement dated 10/21/2025, written by Licensed Practical Nurse #4, documented Resident #4's roommate put their call light on and was screaming that their roommate was on the floor. It was documented that Licensed Practical Nurse #4 had flushed Resident #5's Gastronomy -tube at 2:00 AM. A question on the statement asked did the resident have appropriate footwear on and it was checked no. An (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	investigative summary dated 10/21/2025, documented a Registered Nurse assessment as completed when Resident #5 was observed lying on the floor next to their bed on 10/21/2025 at 4:10 AM and no apparent injury was found. Resident #5 had received incontinence care approximately 30 to 40 minutes prior to the incident. Another Registered Nurse assessment was completed later in the morning during a post fall follow up and Resident #5 complained of pain in their right hip and had facial grimacing with range of motion. The medical provider was notified, an x-ray was ordered, and the x-ray indicated the resident had a right femoral fracture. There was no documented evidence that Resident #5 was wearing non-skid socks as per their care plan at the time they were observed on the floor on 10/21/2025. Further, there was no documented evidence Resident #5 had refused to wear non-skid socksDuring an observation on 11/14/2025 at 12:31 PM, Resident #5 was observed up in their wheelchair, dressed, groomed, with a sneaker on their right foot and a non-skid sock on their left foot. On 12/08/2025 at 1:05 PM attempted contact was made to Certified Nurse Aide #3, who worked at the time of the fall. Certified Nurse Aide #3 was unable to be reached. During an interview on 12/08/2025 at 1:12 PM, Licensed Practical Nurse #4 stated Resident #5's fall occurred on the night shift. They stated the resident's room light started going off, so they and Certified Nurse Aide #3 walked down the hallway and heard Resident #5's roommate screaming that Resident #5 had fallen out of bed. Licensed Practical Nurse #4 stated they observed Resident #5 on their left side, face down, on the gray floor mat near their bed and the bed was in the lowest position. They further stated they did not remember if the resident was wearing non-skid socks. During an interview on 12/08/2025 at 1:25 PM, Registered Nurse #2 stated they were per diem and worked the night shift. They completed an assessment of Resident #5 after they were found on the floor. Registered Nurse #2 stated they observed Resident #5 on a floor mat near their bed, wearing non-skid socks. They stated the resident did not have any injuries at the time. During an interview on 12/09/2025 at 1:46 PM, Director of Nursing #1 stated they did not specifically remember all the circumstances of Resident #5's fall. When asked what interventions were in place to prevent falls in Resident #5's care plan prior to the fall on 10/21/2025, Director of Nursing #1 stated bilateral floor mats, encourage use of non-skid socks, bed in lowest position, and call bell within reach. ^42 New York Codes, Rules, and Regulations 415.4(b)(l)(i)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews during the Abbreviated Survey (complaint #2656654), the facility did not ensure that all alleged violations of resident abuse, neglect, exploitation, or mistreatment were reported to the New York State Department of Health as required. This was evident for 1 of 3 residents reviewed for abuse (Resident #1). Specifically, a resident was transported to dialysis and returned to the facility and was pronounced deceased shortly after. The facility did not report the events leading to the death of Resident #1 to the New York State Department of Health as required.This is evidenced by:A facility policy titled Reporting and Investigating Resident Accident/Incidents, dated [DATE], documented that all occurrences which were not consistent with the routine operations of the facility and care of the residents that had or may have caused physical injury or harm would be reported, reviewed and thoroughly investigated. If an incident occurred that was related to an allegation of possible abuse; all additional abuse investigation materials were also completed. A completed Accident/Incident Report should have included a copy of the updated care plan and Certified Nurse Aide profile so as to confirm interventions were taken as the result of the incident.For any and all injuries of unknown origin a completed and through Accident and Incident report must be completed. Proper notifications to family, Director of Investigations and Administrator must take place for investigative purposes.A. Federal regulation: 42 CFR 483.13 An injury should be classified as an injury of unknown source when both of the following conditions were met: a. The source of the injury was not observed by any person, or the source of the injury could not be explained by the resident.b. The injury is suspicious because the extent or location of the injury, or the location of the injury(e.g., the injury was located in an area not generally vulnerable to trauma), or the number of injuries observed at one particular point in time, or incidences of injuries over timeB. The following two elements must be present for an incident to be reportable to the New York State Department of Health and Director of Investigations and Administrator must be made aware As Soon Aa Possible: a. Injury without known incident. b. Facility unable to rule out abuse or care plan violationThe completed Accident/Incident Report would be submitted to the Director of Nursing, Administrator and Medical Director to sign and then filed accordingly within the Director of Investigations office.The facility policy titled Renal Dialysis dated [DATE], last reviewed at 5/2025, documented that all residents were to be sent to the dialysis center with a communication book that had the Interfacility Report completed prior to transporting. The dialysis unit would complete its section and a Dialysis Information Sheet. The notebook was to be returned from dialysis with the Resident.Resident #1 was admitted to the facility with diagnoses including chronic kidney disease on dialysis (kidneys no longer function to filter the blood of toxins, requiring manual filtration of the blood by a machine), cellulitis of right lower leg (an infection causing redness and irritation), malignant neoplasm of endometrium (cancerous cells formed on the lining of the uterus that has spread to other body areas). The Minimum Data Set assessment (an assessment tool) dated [DATE] documented the resident was able to be understood, understand others, and was minimally cognitively impaired.On [DATE], Resident #1 left the facility around 11:00 AM to go to hemodialysis, returning at approximately at 6:41 PM. When assessed upon their return, Resident #1 was found to be absent of respirations, had no pulse and was pronounced deceased at 6:50 PM. There was no documented evidence that the facility reported what happened to Resident #1 to the New York State Department of Health. In a facility provided video dated [DATE] at 12:00 PM, Resident #1 appeared to be exiting the facility in a wheelchair with an oxygen tank on the back of the seat, sitting upright, and communicating with both the facility staff member helping them onto the transport bus and the person driving the transport bus while being placed on the bus. In a facility provided video dated [DATE] at 6:00 PM, Resident #1 appeared to be returning to the facility. Resident #1's friend was visible in the (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	frame, appearing to be waiting for Resident #1 to be unloaded from the transport bus. As Resident #1 was rolled out of the bus and handed off to their friend, it was notable that Resident #1 was slumped over to the left, wrapped in a blanket, wearing a mask. Oxygen tubing could be viewed underneath the mask on Resident #1's face. Resident #1 was not seen interacting with the transport driver, or their friend as they were rolled into the facility. A facility provided statement from Resident #1's friend dated [DATE] at 7:15 PM, documented that 1:20 PM, Resident #1 arrived at the dialysis center at 1:20 PM and was very uncomfortable and crying. Friend #1 wrote that Resident #1 was disoriented but knew their name, knew their address and recognized Friend #1. At 5:30 PM, Friend #1 documented in their note that they arrived at the dialysis center to meet Resident #1 and accompany them back to the facility (Friend #1 drove in their personal vehicle, Resident #1 rode in the facility provided transport bus). Friend #1 documented that Resident #1 appeared to be unconscious, was not moving and did not respond to their friend. The dialysis staff that brought Resident #1 to Friend #1 in the waiting area reportedly said to Friend #1 that Resident #1 was crying and yelling then fell asleep finally while receiving their treatment. Friend #1 further documented that upon arriving to the facility, Friend #1 was alarmed Resident #1 was noted to be limp and drooling. Friend #1 documented that they brought Resident #1 to the nursing station, and they were quickly attended to. A facility provided form titled Dialysis Communication Sheet, dated [DATE], documented that Resident #1 had vital signs taken prior to leaving the facility for dialysis at 11:00 AM. The section of the sheet that was supposed to be filled out by the dialysis center, before the resident returned to the facility, was noted to be blank. This was noted to be true for the previous Dialysis Communication Sheet, dated [DATE] as well. During an interview on [DATE] at 12:37 PM, Certified Nurse Aide #1 stated that when a resident goes to dialysis, they get the residents up, washed and dressed. They might get the oxygen tanks or dialysis book if needed. When asked if they ever write anything in the dialysis book, Certified Nurse Aide #1 stated no. During an interview on [DATE] at 12:38 PM, Licensed Practical Nurse #1 stated that they did not remember Resident #1. Licensed Practical Nurse #1 was observed to have the dialysis sheet for Resident #2 in their hand when approached. Licensed Practical Nurse #1 was asked to review the procedure of getting a resident ready for dialysis and receiving a resident back from dialysis. Licensed Practical Nurse #1 stated that they fill out the top of the sheet (observed to be filled out for [DATE]), and dialysis fills out the bottom of the sheet (sheet noted to be filled out for [DATE]). When asked what Licensed Practical Nurse #1 would do if dialysis did not fill out their portion of the sheet, Licensed Practical Nurse #1 stated that they would call the dialysis center to get the information. When asked what they would do if they were unable to reach anyone at the dialysis center, Licensed Practical Nurse #1 stated they would let the supervisor know so they could continue to try and get the information. During an interview on [DATE] at 1:02 PM, Director of Nursing #1 stated that Resident #1 had only been at the facility for a week. Director of Nursing stated that Resident #1's friend accompanied them to dialysis. When Resident #1 returned, they were unconscious. If the resident had been a full code, the facility would have coded Resident #1 when they arrived at the nurse's station and were seen by facility staff. During an interview on [DATE] at 1:15 PM, Assistant Director of Nursing #1 stated that they saw Resident #1 rolling down the corridor and stated to Friend #1 that they looked sleepy. Friend #1 stated very. About 15 minutes later, a nurse called Assistant Director of Nursing #1 to say they needed to contact the funeral home because Resident #1 had passed. Assistant Director of Nursing #1 called the dialysis center around 6:40 PM and no one answered the phone. Resident #1 had gone to two dialysis treatments since arriving at the facility. The dialysis facility did not fill out their section of the paperwork either time and would not answer the phone when staff called. Assistant Director of Nursing #1 stated they did not know what happened during dialysis. No other residents were currently using the same dialysis facility, so there was no other resident to compare the care to. During an interview on [DATE] at 2:31 PM, Registered Nurse #1 stated that they were on another unit when Licensed Practical Nurse #2 called them to come assess Resident #1. Registered Nurse #1 stated that when they arrived to the unit, Resident #1 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was still in the chair, in the common area, and the staff were attempting to get vitals and assessing their condition. Registered Nurse #1 stated that they observed the resident to be mottling in their hands and fingers. Registered Nurse #1 took a statement from Friend #1, checked the dialysis communication book, and noted that the dialysis section was blank. Registered Nurse #1 stated both they and the Assistant Director of Nursing #1 both tried to call the dialysis center and never got an answer. During an interview on [DATE] at 3:24 PM, Licensed Practical Nurse #2 stated that Resident #1 was brought back to the floor by Friend #1. Licensed Practical Nurse #2 stated that they normally did vital signs, and a finger stick upon a resident's return from dialysis. Licensed Practical Nurse #2 stated that they believed Resident #1's fingerstick was within normal limits. Resident #1 was not really responding to Licensed Practical Nurse #2 at the time. Friend #1 stated that Resident #1 had been unresponsive since dialysis. Licensed Practical Nurse #2 stated that the vital sign machine wasn't reading Resident #1's blood pressure and stated they could not recall if they were able to get an oxygen reading. During an interview on [DATE] at 2:16 PM, Director of Transportation #1 stated that they usually just have to make sure that transportation arrangements were made correctly. The transportation bus was part of the local CDTA bus system. The drivers were not medically trained and would not necessarily know what to look for if a resident had a change of condition that wasn't obvious. Typically, dialysis residents have a bag on the back of their chair that has a bagged lunch or breakfast, a blanket and their dialysis book. If they are on oxygen, the facility sends two tanks with the resident to account for any extra wait time, so they don't run out. During an interview on [DATE] at 9:58 AM, Registered Nurse #3 stated that for residents going to dialysis, they typically pack lunch, the dialysis communication book and a blanket in a bag that goes on the back of the chair. When asked about the incident and if a report was filed, Registered Nurse #3 stated that they couldn't say if there was an investigation report done, the Supervisor was there and handled it. Receptionist #1 joined the conversation and stated that an unnamed Social Worker from the dialysis center called to request a copy of Resident #1's Advanced Directives. During an interview on [DATE] at 11:13 AM, Director of Nursing #1 stated that there was no documentation of what gets packed up with the resident, no checklist of items. There was no facility investigation done regarding what happened to Resident #1. If there had been a change of condition on the property, they would have done report, initiated Cardiopulmonary Resuscitation, called the doctor, etc. If there was a change in condition at dialysis, they should have sent Resident #1 to the emergency room and not back to the facility. Resident #1 arrived with no pulse or respirations and was a Do Not Resuscitate, therefore there was nothing to investigate. It did not occur to the Director of Nursing #1 that the incident should have been reported to the New York State Department of Health. During an interview on [DATE] at 11:34 AM, Registered Nurse #4 stated that they were doing an admission on the unit when Resident #1 arrived. Licensed Practical Nurse #2 was taking vital signs in the common area, as was common practice for residents returning from dialysis. Licensed Practical Nurse #2 asked Registered Nurse #4 to check Resident #1 for a pulse because they were struggling to find one. Registered Nurse #4 stated that they told Licensed Practical Nurse #1 that Resident #1 was pulseless, and that their lips were blue. Friend #1 told Registered Nurse #2 that Resident #1 had been like that since dialysis brought Resident #1 out. During an interview on [DATE] at 12:21 PM, Administrator #1 stated that the Assistant Director of Nursing #1 had attempted to reach out to the dialysis center but was unable to speak to anyone. Administrator #1 stated that based on what happened, no investigation was done because it was believed that Resident #1 did not pass here, they passed at dialysis and the facility had tried to follow up with dialysis, even though they didn't answer them. When asked what rose to a reportable level, Administrator #1 stated injuries of unknown origin, falls with fracture, abuse concerns, but in hindsight, Administrator #1 stated they should have looked into it harder as they were overall responsible for the residents. 10 New York Code Rules and Regulations 415.4 b (2)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews during the survey (complaint #2656654), the facility did not ensure that all alleged violations of resident abuse, neglect, exploitation, or mistreatment were investigated as required. This was evident for 1 of 3 residents reviewed for abuse (Resident #1). Specifically, a resident was transported to dialysis and returned to the facility and was pronounced deceased shortly after. The facility did not thoroughly investigate the events leading to the death of Resident #1. This is evidenced by: A facility policy titled Reporting and Investigating Resident Accident/Incidents, dated [DATE], documented that all occurrences which were not consistent with the routine operations of the facility and care of the residents that had or may have caused physical injury or harm would be reported, reviewed and thoroughly investigated. If an incident occurred that was related to an allegation of possible abuse; all additional abuse investigation materials were also completed. A completed Accident/Incident Report should have included a copy of the updated care plan and Certified Nurse Aide profile so as to confirm interventions were taken as the result of the incident.For any and all injuries of unknown origin a completed and through Accident and Incident report must be completed. Proper notifications to family, Director of Investigations and Administrator must take place for investigative purposes.A. Federal regulation: 42 CFR 483.13 An injury should be classified as an injury of unknown source when both of the following conditions were met: a. The source of the injury was not observed by any person, or the source of the injury could not be explained by the resident.b. The injury is suspicious because the extent or location of the injury, or the location of the injury(e.g., the injury was located in an area not generally vulnerable to trauma), or the number of injuries observed at one particular point in time, or incidences of injuries over timeB. The following two elements must be present for an incident to be reportable to the New York State Department of Health and Director of Investigations and Administrator must be made aware As Soon Aa Possible: a. Injury without known incident. b. Facility unable to rule out abuse or care plan violation The completed Accident/Incident Report would be submitted to the Director of Nursing, Administrator and Medical Director to sign and then filed accordingly within the Director of Investigations office. The facility policy titled Renal Dialysis dated [DATE], last reviewed at 5/2025, documented that all residents were to be sent to the dialysis center with a communication book that had the Interfacility Report completed prior to transporting. The dialysis unit would complete its section and a Dialysis Information Sheet. The notebook was to be returned from dialysis with the Resident. Resident #1 was admitted to the facility with diagnoses including chronic kidney disease on dialysis (kidneys no longer function to filter the blood of toxins, requiring manual filtration of the blood by a machine), cellulitis of right lower leg (an infection causing redness and irritation), malignant neoplasm of endometrium (cancerous cells formed on the lining of the uterus that has spread to other body areas). The Minimum Data Set assessment (an assessment tool) dated [DATE] documented the resident was able to be understood, understand others, and was minimally cognitively impaired. On [DATE], Resident #1 left the facility around 11:00 AM to go to hemodialysis, returning at approximately at 6:41 PM. When assessed upon their return, Resident #1 was found to be absent of respirations, had no pulse and was pronounced deceased at 6:50 PM. There was no documented evidence that the facility investigated what happened to Resident #1. In a facility provided video dated [DATE] at 12:00 PM, Resident #1 appeared to be exiting the facility in a wheelchair with an oxygen tank on the back of the seat, sitting upright, and communicating with both the facility staff member helping them onto the transport bus and the person driving the transport bus while being placed on the bus. In a facility provided video dated [DATE] at 6:00 PM, Resident #1 appeared to be returning to the facility. Resident #1's friend was visible in the frame, appearing to be waiting for Resident #1 to be unloaded from the transport bus. As Resident #1 was rolled out of the bus and handed off to their friend, it was notable that Resident #1 was slumped over to the left, wrapped in a (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	blanket, wearing a mask. Oxygen tubing could be viewed underneath the mask on Resident #1's face. Resident #1 was not seen interacting with the transport driver, or their friend as they were rolled into the facility. A facility provided statement from Resident #1's friend dated [DATE] at 7:15 PM, documented that 1:20 PM, Resident #1 arrived at the dialysis center at 1:20 PM and was very uncomfortable and crying. Friend #1 wrote that Resident #1 was disoriented but knew their name, knew their address and recognized Friend #1. At 5:30 PM, Friend #1 documented in their note that they arrived at the dialysis center to meet Resident #1 and accompany them back to the facility (Friend #1 drove in their personal vehicle, Resident #1 rode in the facility provided transport bus). Friend #1 documented that Resident #1 appeared to be unconscious, was not moving and did not respond to their friend. The dialysis staff that brought Resident #1 to Friend #1 in the waiting area reportedly said to Friend #1 that Resident #1 was crying and yelling then fell asleep finally while receiving their treatment. Friend #1 further documented that upon arriving to the facility, Friend #1 was alarmed Resident #1 was noted to be limp and drooling. Friend #1 documented that they brought Resident #1 to the nursing station, and they were quickly attended to. A facility provided form titled Dialysis Communication Sheet, dated [DATE], documented that Resident #1 had vital signs taken prior to leaving the facility for dialysis at 11:00 AM. The section of the sheet that was supposed to be filled out by the dialysis center, before the resident returned to the facility, was noted to be blank. This was noted to be true for the previous Dialysis Communication Sheet, dated [DATE] as well. During an interview on [DATE] at 12:37 PM, Certified Nurse Aide #1 stated that when a resident goes to dialysis, they get the residents up, washed and dressed. They might get the oxygen tanks or dialysis book if needed. When asked if they ever write anything in the dialysis book, Certified Nurse Aide #1 stated no. During an interview on [DATE] at 12:38 PM, Licensed Practical Nurse #1 stated that they did not remember Resident #1. Licensed Practical Nurse #1 was observed to have the dialysis sheet for Resident #2 in their hand when approached. Licensed Practical Nurse #1 was asked to review the procedure of getting a resident ready for dialysis and receiving a resident back from dialysis. Licensed Practical Nurse #1 stated that they fill out the top of the sheet (observed to be filled out for [DATE]), and dialysis fills out the bottom of the sheet (sheet noted to be filled out for [DATE]). When asked what Licensed Practical Nurse #1 would do if dialysis did not fill out their portion of the sheet, Licensed Practical Nurse #1 stated that they would call the dialysis center to get the information. When asked what they would do if they were unable to reach anyone at the dialysis center, Licensed Practical Nurse #1 stated they would let the supervisor know so they could continue to try and get the information. During an interview on [DATE] at 1:02 PM, Director of Nursing #1 stated that Resident #1 had only been at the facility for a week. Director of Nursing stated that Resident #1's friend accompanied them to dialysis. When Resident #1 returned, they were unconscious. If the resident had been a full code, the facility would have coded Resident #1 when they arrived at the nurse's station and were seen by facility staff. During an interview on [DATE] at 1:15 PM, Assistant Director of Nursing #1 stated that they saw Resident #1 rolling down the corridor and stated to Friend #1 that they looked sleepy. Friend #1 stated very. About 15 minutes later, a nurse called Assistant Director of Nursing #1 to say they needed to contact the funeral home because Resident #1 had passed. Assistant Director of Nursing #1 called the dialysis center around 6:40 PM and no one answered the phone. Resident #1 had gone to two dialysis treatments since arriving at the facility. The dialysis facility did not fill out their section of the paperwork either time and would not answer the phone when staff called. Assistant Director of Nursing #1 stated they did not know what happened during dialysis. No other residents were currently using the same dialysis facility, so there was no other resident to compare the care to. During an interview on [DATE] at 2:31 PM, Registered Nurse #1 stated that they were on another unit when Licensed Practical Nurse #2 called them to come assess Resident #1. Registered Nurse #1 stated that when they arrived to the unit, Resident #1 was still in the chair, in the common area, and the staff were attempting to get vitals and assessing their condition. Registered Nurse #1 stated that they observed the resident to be mottling in their (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335110	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evergreen Commons Rehabilitation and Nursing Ctr	1070 Luther Road East Greenbush, NY 12061

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hands and fingers. Registered Nurse #1 took a statement from Friend #1, checked the dialysis communication book, and noted that the dialysis section was blank. Registered Nurse #1 stated both they and the Assistant Director of Nursing #1 both tried to call the dialysis center and never got an answer. During an interview on [DATE] at 3:24 PM, Licensed Practical Nurse #2 stated that Resident #1 was brought back to the floor by Friend #1. Licensed Practical Nurse #2 stated that they normally did vital signs, and a finger stick upon a resident's return from dialysis. Licensed Practical Nurse #2 stated that they believed Resident #1's fingerstick was within normal limits. Resident #1 was not really responding to Licensed Practical Nurse #2 at the time. Friend #1 stated that Resident #1 had been unresponsive since dialysis. Licensed Practical Nurse #2 stated that the vital sign machine wasn't reading Resident #1's blood pressure and stated they could not recall if they were able to get an oxygen reading. During an interview on [DATE] at 2:16 PM, Director of Transportation #1 stated that they usually just have to make sure that transportation arrangements were made correctly. The transportation bus was part of the local CDTA bus system. The drivers were not medically trained and would not necessarily know what to look for if a resident had a change of condition that wasn't obvious. Typically, dialysis residents have a bag on the back of their chair that has a bagged lunch or breakfast, a blanket and their dialysis book. If they are on oxygen, the facility sends two tanks with the resident to account for any extra wait time, so they don't run out. During an interview on [DATE] at 9:58 AM, Registered Nurse #3 stated that for residents going to dialysis, they typically pack lunch, the dialysis communication book and a blanket in a bag that goes on the back of the chair. When asked about the incident and if a report was filed, Registered Nurse #3 stated that they couldn't say if there was an investigation report done, the Supervisor was there and handled it. Receptionist #1 joined the conversation and stated that an unnamed Social Worker from the dialysis center called to request a copy of Resident #1's Advanced Directives. During an interview on [DATE] at 11:13 AM, Director of Nursing #1 stated that there was no documentation of what gets packed up with the resident, no checklist of items. There was no facility investigation done regarding what happened to Resident #1. If there had been a change of condition on the property, they would have done report, initiated Cardiopulmonary Resuscitation, called the doctor, etc. If there was a change in condition at dialysis, they should have sent Resident #1 to the emergency room and not back to the facility. Resident #1 arrived with no pulse or respirations and was a Do Not Resuscitate, therefore there was nothing to investigate. During an interview on [DATE] at 11:34 AM, Registered Nurse #4 stated that they were doing an admission on the unit when Resident #1 arrived. Licensed Practical Nurse #2 was taking vital signs in the common area, as was common practice for residents returning from dialysis. Licensed Practical Nurse #2 asked Registered Nurse #4 to check Resident #1 for a pulse because they were struggling to find one. Registered Nurse #4 stated that they told Licensed Practical Nurse #1 that Resident #1 was pulseless, and that their lips were blue. Friend #1 told Registered Nurse #2 that Resident #1 had been like that since dialysis brought Resident #1 out. During an interview on [DATE] at 12:21 PM, Administrator #1 stated that the Assistant Director of Nursing #1 had attempted to reach out to the dialysis center but was unable to speak to anyone. Administrator #1 stated that based on what happened, no investigation was done because it was believed that Resident #1 did not pass here, they passed at dialysis and the facility had tried to follow up with dialysis, even though they didn't answer them. When asked what rose to the investigation level, Administrator #1 stated injuries of unknown origin, falls with fracture, abuse concerns, but in hindsight, Administrator #1 stated they should have looked into it harder as they were overall responsible for the residents. 10 New York Code Rules and Regulations 415.4 b (3)

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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 abbreviated survey, the facility did not ensure that each resident received the necessary respiratory care and services that were in accordance with professional standards of practice for 1 (Resident #1) of 3 residents reviewed for oxygen administration. Specifically, Resident #1 did not have a physician's order for oxygen, despite being on oxygen on and off during their admission to the facility. This is evidenced by: A review of the facility's policy and procedure titled Oxygen Therapy - Mask and Nasal Cannula, dated 3/2012, documented that 1. Oxygen administration required a medical order (Medical Doctor, Nurse Practitioner, Physician Assistant), specific to include liter flow, route of administration, as well as frequency. All residents with an order of Oxygen Therapy needs a At Risk for Compromised Respiratory Care Plan initiated and interventions as deemed appropriate; 2. Oxygen was initiated by licensed staff. Only a nurse, Medical Doctor, Nurse Practitioner, or Physician's Assistant may adjust the oxygen liter flow; 3. In an emergency, a nurse may administer oxygen and obtain an order within 24 hours. Resident #1 was admitted to the facility with diagnoses including chronic kidney disease on dialysis (kidneys no longer function to filter the blood of toxins, requiring manual filtration of the blood by a machine), cellulitis of right lower leg (an infection causing redness and irritation), malignant neoplasm of endometrium (cancerous cells formed on the lining of the uterus that has spread to other body areas). The Minimum Data Set assessment (an assessment tool) dated [DATE] documented the resident was able to be understood, understand others, and was minimally cognitively impaired. There was no documented evidence that there was an order for oxygen administration for Resident #1. There was no documented evidence that there was an interventions or associated goals regarding the use of oxygen. A Medication Administration Record dated [DATE] documented pre-dialysis vitals at 11:00 AM, Resident #1 was using 2 liters of oxygen. A Medication Administration Record dated [DATE] documented pre-dialysis at 11:00 AM, Resident #1 was using 2 liters of oxygen. Vital sign records documented Resident #1 was using 2 liters of oxygen on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. During an interview on [DATE] at 1:15 PM, Assistant Director of Nursing #1 stated that they saw Resident #1 coming back from dialysis with Friend #1. Assistant Director of Nursing #1 stated they believed the resident was wearing oxygen from a portable tank. During an interview on [DATE] at 2:31 PM, Registered Nurse #1 stated that they removed oxygen from Resident #1's face when they pronounced Resident #1 deceased . During an interview on [DATE] at 3:24 PM, Licensed Practical Nurse #2 stated that Resident #1 was wearing oxygen when they arrived to the unit from dialysis. During an interview on [DATE] at 11:20 AM, Registered Nurse #2 stated that they typically send two oxygen tanks out with residents when they go out to dialysis trips or longer trips so that resident don't run out of oxygen while waiting for transportation. During an interview on [DATE] at 12:21 PM, Administrator #1 stated that there should have been an order for oxygen. 10 New York Code of Rules and Regulations 415.12(k)(3)(6)