

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335188	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/13/2025
NAME OF PROVIDER OR SUPPLIER New Paltz Center for Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Jansen Road New Paltz, NY 12561	

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335188	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/13/2025
NAME OF PROVIDER OR SUPPLIER New Paltz Center for Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Jansen Road New Paltz, NY 12561	
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)		
<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews during the recertification and abbreviated surveys (Intake #2569939), the facility did not ensure sufficient nursing staff to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial wellbeing of each resident. Specifically, the Daily Nurse Staffing Rosters reviewed from 08/10/2025 through 09/12/2025 documented on four (4) of 34 days, there was one (1) certified nurse aide documented for the A unit night shift (1:35 or 1:36 ratio) and on one (1) of 34 nights, there was one (1) certified nurse aide assigned to B unit (1:36 ratio). On 29 of 34 days reviewed, assigned staff did not complete their assigned shift (came in late or left early). A nurse supervisor was not assigned on 4 of 34 dates reviewed for day shift, 15 of 34 dates for evening shift and 26 of 34 dates for the night shift. Additionally, during the 11:00PM to 7:00 AM shift on 09/11/2025, Resident #32 sustained a fall and there was only one staff member, a licensed practical nurse, working on the A unit. Resident #56 dislodged their urinary catheter and nursing staff did not address in a timely manner. Residents, family members, and staff expressed concerns about low staffing, long wait times in response to call bells, and delays in receiving care. The findings included: The Facility assessment dated [DATE] documented the maximum capacity as 77 residents and an average daily census range of 70-77 residents. The Staffing Plan documented one registered nurse/licensed practical nurse per unit, per shift; two certified nurse aides per unit, day and evening shift (1:19 ratio); and one certified nurse aide per unit, night shift (1:38 ratio). Unit Acuity levels provided by the Director of Nursing documented six (6) residents were scheduled to get up prior to 7:00 AM on the A unit and one (1) resident on the B Unit. Seven (7) residents were on wander guard list on the A unit and two (2) on the B unit. Two (2) residents on A unit required supervision checks. Twenty residents on the A unit required incontinence cares and 11 required assistance with toileting. Thirteen residents on the B unit required incontinence cares and 11 required assistance with toileting. Eleven residents on the A unit and 11 residents on the B unit required a mechanical lift for transfers requiring two staff members. Five (5) residents on the A unit and one (1) resident on the B unit required total care assistance. On 4 of 34 days reviewed from 08/10/25 through 09/12/2025, a nurse supervisor was not assigned on the day shift. On 15 on 34 days reviewed from 08/10/2025 through 09/12/2025, a nurse supervisor was not assigned on the evening shift. On 26 of 34 days reviewed from 08/10/2025 through 9/12/2025, a nurse supervisor was not assigned for the night shift. On 08/23/2025, 08/30/2025, and 09/10/2025 there was one certified nurse aide documented for A unit night shift on the Daily Staffing Report. There were staffing inconsistencies noted between review of the Daily Certified Nurse Aide Assignment Sheets and the Daily Staffing Reports reviewed. For example, the Daily Certified Nurse Aide Assignment Sheets documented one certified nurse aide on the A unit on 08/17/25 for the 11:00 PM to 7:00 AM shift which was inconsistent with the Daily Staffing Report staffing of two (2) certified nurse aides assigned to A unit. On the 09/11/2025 11:00 PM to 7:00 AM shift, the Daily Staffing Report documented one (1) certified nurse aide was assigned to the A unit. The Certified Nurse Aide Schedule Form documented the name of an aide who called out. During interviews with staff, there was no aide assigned to Unit A unit until after Resident #32 sustained a fall at 2:00 AM. During a Resident Council meeting on 09/10/2025 at 11:06 AM, Resident #15's representative stated staff were not responsive to call bells. They stated Resident #15 was not taken out of bed at times due to low staffing and frequently had to return to bed early because there would not be enough staff to get them back into bed. Resident #67 stated turning and repositioning was not completed according to facility policy because of low staffing. All residents in attendance stated that the overnight shift was the worst for low staffing. During an observation on 09/10/2025 at 11:34 AM, a strong smell of urine was present in Resident #12's room. During interviews on 09/11/2025 at 4:20 PM and 09/12/2025 at 11:36 AM, the Director of Human Resources/Staffing Coordinator stated the night shift frequently did not have a supervisor in the building. They stated they had been instructed by Administrator to staff up to four (4) certified nurse aides on Unit A and Unit B for the day and evening shift and a minimum of two (2) certified nurse aides on Unit A and Unit B for the night shift and this was accomplished most of the time. They stated they had not been instructed to add more certified nurse aides during any shift based on acuity needs/changes and had been instructed to reduce staffing of certified nurse aides if the facility census dropped. They stated recruitment of nursing staff was on-going and licensed practical nurse recruitment was particularly difficult with main deterrent being salary. During interviews on 09/09/2025 at 9:03 AM and</p>		