STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335188	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Paltz Center for Rehabilitation and Nursing	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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review during an abbreviated survey #2616039, the facility did not ensure that pain management was provided to residents who require such services, consistent with professional standards of practice, and the comprehensive person-centered care plan for two (2) of three (3) residents (Resident #1 and Resident #3) reviewed for pain medication. Specifically, for Resident #1 and Resident #3 there was lack of consistent documentation of pain assessments each shift prior to and after administration of physician ordered as needed oxycodone 5 mg tablets.The findings include:The policy and procedure titled Pain Management revised 4/28/2025 documented prior to administering as-needed pain medication the nurse will evaluate and document in the clinical record the location of pain, pain level prior to medication administration, and the pain scale used. 1. Resident #1 had diagnoses including but not limited to bipolar disorder (psychiatric disorder), fracture of the right femur (long bone in the upper leg), and facture of the left tibia fibula (two long bones located in the lower leg). The comprehensive care plan titled Alteration in Comfort dated 12/13/2024 documented evaluate effectiveness of pain interventions in alleviating symptoms, dosing schedules, identify and record previous pain history and its management. The Minimum Data Set (a resident assessment tool) dated 01/08/2025 documented Resident #1 had intact cognition, no pain, and received pain medication.The physician's order, dated 12/12/2024, documented oxycodone HCl 5 milligrams, one (1) tablet every four (4) hours as needed for a pain scale of 4-6, and oxycodone HCl 5 milligrams, two (2) tablets every four (4) hours as needed for a pain scale of 7-10.The December 2024 narcotic control sheets revealed oxycodone HCL 5 mg tablets were signed out 26 times.There was no documented evidence in the December 2024 Medication Administration Record that oxycodone HCl 5 mg was administered, and that pain was assessed prior to and after administration of oxycodone 13 out of 26 times.The January 2025 narcotic control sheets revealed oxycodone HCL 5 mg tablets were signed out 83 times.There was no documented evidence in the January 2025 Medication Administration Record that oxycodone HCl 5 mg was administered, and that pain was assessed prior to and after administration of oxycodone 47 out of 83 times. The February 2025 narcotic control sheets revealed oxycodone HCL 5 mg tablets were signed out 82 times. There was no documented evidence in the February 2025 Medication Administration Record that oxycodone HCl 5 mg was administered, and that pain was assessed prior to and after administration of oxycodone 50 out of 82 times.During a telephone interview on 10/28/2025 at 10:59 AM, Resident #1 stated they were not getting their pain medication as ordered and as needed, especially on the overnight shift. They stated they did report, but their concerns were discounted. 2. Resident #3 was admitted with diagnoses that included, but not limited to right femur fracture, pain, and right hip wound. The admission Minimum Data Set, dated [DATE] documented Resident #3 had intact cognition pain of 7/10 and received pain medications. The care plan titled Alteration in Comfort dated 10/17/2025 documented medication as ordered and evaluation of the effectiveness of pain interventions. The physician's order dated 10/17/2025 documented oxycodone 5 MG 1 (one) tablet every six (6) hours as needed for pain of 6-10.The narcotic control sheets revealed oxycodone 5 mg tablets were signed out 22 times from 10/19/2025 to 10/28/2025. There was no documented evidence in the medication administration record that oxycodone 5 mg was administered from 10/19/2025 to 10/28/2025 and that pain was assessed prior to and after the administration of oxycodone11 out of 22 times During an interview on 10/28/2025 at 12:00 PM Licensed Practical Nurse #2 stated documentation on Resident #1's medication administration record was not complete therefore pain assessment was not always done prior to and after the administration of the oxycodone. During an interview on 10/29/2025 at 1:11 PM Licensed Practical Nurse #3 stated Resident #1 was alert, oriented, and demanded as-needed medications. They stated the narcotic book was usually reviewed to determine the last administration time instead of checking the medication administration record. They stated pain medication that was administered to Resident #1 as requested was not always documented as given on the medication administration record therefore, pain evaluation was not done prior to and after the administration of the oxycodone. During a telephone interview on 10/30/2025 at 11:16 AM Licensed Practical Nurse #5 stated when they signed in the Medication Administration Record that they administered as needed pain medication, the pain evaluation tool automatically populated on the medication administration record for evaluation prior to and after administration. During an interview on October 29, 2025, at 2:00 PM the Director of Nursing stated pain assessment would be documented in the Medication Administration Record when the medication was signed

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review during an abbreviated survey #2616039 the facility did not provide pharmaceutical services including procedures that assure the accurate dispensing, and administering of all drugs and biologicals to meet the needs of each resident for two (2) out of three (3) residents reviewed for pain medication administration. Specifically, for Resident #1 and Resident #3 oxycodone 5mg tablets (narcotic) were signed out on the narcotic control sheets but were not accounted for and documented in the resident's Medication Administration Record as administered to the residents. Additionally, there was no evidence that a pharmacist conducted periodic audits or oversight to ensure accurate record keeping and accounting of the controlled substances.The findings include: The policy and procedure titled Medication Administration, revised 2/2019, documented the individual administering the medication must initial the resident's Medication Administration Record on the appropriate line after giving each medication and before administering the next dose.1. Resident #1 had diagnoses including but not limited to bipolar disorder (psychiatric disorder), fracture of the right femur (long bone in the upper leg), and facture of the left tibia fibula (two long bones located in the lower leg). The Minimum Data Set (a resident assessment tool) dated 01/08/2025 documented Resident #1 had intact cognition, no pain, and received pain medication.The physician's order, dated 12/12/2024, documented oxycodone HCl 5 milligrams, one (1) tablet every four hours as needed for a pain scale of 4-6, and oxycodone HCl 5 milligrams, two (2) tablets every four hours as needed for a pain scale of 7-10.The narcotic control sheets revealed oxycodone HCL 5 mg tablets were signed out 26 times in December 2024, 83 times in January 2025, and 82 times in February 2025.There was no documented evidence in the Medication Administration Record that oxycodone HCl 5 mg was administered 13 out of 26 times in December 2024, 47 out of 83 times in January 2025, and 50 out of 82 times in February 2025. During a telephone interview on 10/28/2025 at 10:59 AM, Resident #1 stated they thought there was a drug diversion problem while they were at the facility. They stated they were not getting their pain medication as ordered and as needed, especially on the overnight shift. They stated they did report their suspicions, but their concerns were discounted. During an interview on 10/29/2025 at 2:51 PM, Licensed Practical Nurse Unit Manager #4 stated Resident #1 never reported concerns to them regarding administration of their pain medication. They stated if they received complaints or concerns from Resident #1, they would have investigated and reported it to the Director of Nursing. 2. Resident #3 was admitted with diagnoses that included, but not limited to, right femur fracture, pain, and wound right hip. The admission Minimum Data Set, dated [DATE] documented Resident #3 had intact cognition, pain of 7/10, and received pain medications. The care plan titled Alteration in Comfort dated 10/17/2025, documented medication as ordered and evaluation of the effectiveness of pain interventions. The physician's order dated 10/17/2025 documented oxycodone 5 MG, 1 (one) tablet every six (6) hours as needed for pain of 6-10.The narcotic control sheets revealed oxycodone 5 mg tablets were signed out 22 times from 10/19/2025 to 10/28/2025. There was no documented evidence in the Medication Administration Record that oxycodone 5 mg was administered 11 of the 22 times from 10/19/2025 to 10/28/2025.During an interview on 10/28/2025 at 3:11PM, Resident #3 stated that they received their pain medication consistently every six hours and denied any problems related to the administration of the medication.During an observation on 10/28/2025 at 3:00 PM, Licensed Practical Nurse Manager #5 and Licensed Practical Nurse #1 conducted a narcotic count. All narcotics were accounted for, and both individuals signed the sign-off sheet. No discrepancies were noted. The narcotic box was double locked, the medication room was locked, and the nurse kept the keys securely on their person.During an interview on 10/28/2025 at 12:00 PM, Licensed Practical Nurse #2 stated documentation on Resident #1's Medication Administration Record was not complete. They stated they knew they should sign the Medication Administration Record when giving an as needed pain medication but did not always do that as they were busy. During an interview on 10/29/2025 at 1:11 PM, Licensed Practical Nurse #3 stated Resident #1 was alert, oriented, and demanded as-needed medications. They stated pain medication that was administered to Resident #1 as requested was not always documented as given on the Medication Administration Record. They stated the narcotic control sheets were usually reviewed to determine the last administration time instead of checking the Medication Administration Record.During a telephone interview on 10/30/2025 at 11:16 AM Licensed Practical Nurse #5 stated when they administered a controlled medication, they usually signed it out in the narcotic book and then the Medication