STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335228	A. Building B. Wing	06/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgewater Center for Rehab & Nursing L L C	159 163 Front Street Binghamton, NY 13902

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations, record review, and interviews (IQIES intake 2647397), the facility failed to ensure residents had the right to a dignified existence in a manner and an environment that promoted the maintenance or enhancement of quality of life for three of three residents (Residents #19, #41, and #72) reviewed and for 10 of 12 anonymous residents present at a resident group meeting. Specifically, Resident #19's wheelchair was unclean and in disrepair; Resident #41's ceiling dripped liquid over their bed; Resident #72's clothing was improperly labeled and was worn by another resident; and 10 anonymous residents reported their clothing was not labeled properly, was not returned to them after laundering and was distributed to other residents. Findings include: The facility policy Wheelchair Cleaning, revised 12/2025, documented all resident wheelchairs were cleaned and disinfected at least weekly and as needed to maintain a clean and sanitary condition to reduce the risk of infection transmission, promote resident comfort, and maintain a safe environment. The facility policy Homelike Environment, revised 12/2025 documented residents were provided with a safe, clean, comfortable, and homelike environment. The facility policy Laundry Services, revised 11/2025, documented resident clothing shall be labeled with the resident's identifying information upon admission and as needed. Resident laundry shall be washed, dried, folded and prepared for return in accordance with established laundering procedures and infection control practices. Personal laundry shall be processed and returned to the resident within 48 hours whenever possible. Unclean Wheelchair: Resident #19 had diagnoses including Alzheimer's disease. The 5/19/2026 Minimum Data Set assessment documented the resident had severely impaired cognition and required supervision or touching assistance with chair transfers. Resident #19 was observed in a geriatric chair (specialty wheelchair) with a broken arm rest and dried white debris drips on the chair base air on 06/08/2026 at 12:20 PM and 06/09/2026 at 8:57 AM. Dripping Ceiling: Resident #41 had diagnosis including sepsis (extreme response to an infection) and lower leg cellulitis (bacterial skin infection). The 03/10/2026 Minimum Data Set assessment documented the resident had intact cognition and required supervision for bed mobility. During an observation and interview on 06/08/2026 at 10:42 AM, Resident #41 was in bed covered (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with a clear trash bag. The resident stated they were protecting themselves as the ceiling leaked at times and they did not want to get wet. The ceiling had a piece of white tape that went from the window to the wall. The tape was puckered in several places and had large brown stains along the line of the tape. The 04/20/2025 work order documented Resident #41 stated there was water leaking from the ceiling. [NAME] spots were observed, however there was no leaking. No repairs were completed. The work order was completed on 04/21/2025 by Maintenance Technician #8 During an observation and interview on 06/09/2026 at 10:10 AM, Resident #41 stated several months ago the ceiling leaked. They told staff but could not remember who they notified. The staff brought them trash bags so they could cover their body and stay dry. They stated 06/08/2026 was the third time the ceiling leaked on them, staff was notified, and the leaking stopped. When there was leaking in their room, they noticed it also dripped outside their window. They stated they just want the problem fixed. The ceiling was observed with a piece of white tape that went from the window to the wall. The tape was puckered in several places and had large brown stains along the line of the tape. During an observation and interview on 06/11/2026 at 11:40 AM, Resident #41 showed Certified Nurse Aide #7 trash bags stored in their shoe on the windowsill. The resident stated they used trash bags as a tarp to protect themselves from getting wet when the ceiling leaked. They told Certified Nurse Aide #7 their ceiling leaked on 06/08/2026 and was told a toilet overflowed which meant the leaking was toilet water. The resident stated they were glad they covered themselves with a tarp because they did not want toilet water dripping on them. During an interview on 06/11/2026 at 11:33 AM, Certified Nurse Aide #7 stated the certified nurse aides were responsible for making sure wheelchairs were clean and free from food and debris. Wheelchair cleaning was assigned to the evening shift and was not documented anywhere. They did not notice Resident #19's dirty, broken chair, and if they had, they would clean the chair and call maintenance to repair the arm. When something was broken, they notified maintenance either electronically or by phone and maintenance usually came within the hour. On 06/08/2026 Resident #19 notified them their ceiling was leaking. They notified maintenance, and the issue was fixed. They were unaware the resident was covering themselves with a trash bag. During an interview on 06/12/2026 at 9:42 AM, Licensed Practical Nurse #5 stated wheelchairs, and geriatric chairs were power washed by the certified nurse aides on the night shift. Maintenance was responsible for repairs. If they observed a leaking ceiling, they would place a trash can to collect the liquid, put a towel down to ensure the floor was dry, and notify maintenance. They stated they were not aware the ceiling was leaking on Resident #41. During an interview on 06/12/2026 at 10:34 AM, Registered Nurse Unit Manager #4 stated certified nurse aides were responsible for cleaning wheelchairs. Maintenance was responsible for repairs. They previously reported the leak in Resident #41's ceiling as the leak comes and goes. When the liquid leaked directly on the resident, they recommended moving the resident during a morning meeting that both Administration and the department directors attended. They did not know the resident was covering themselves with a trash bag as a tarp and stated it was not reasonable to sleep in a bed that was wet from liquid dripping onto the bed. It was a safety concern because the floor was wet, and a wet floor sign was a tripping hazard for residents. It was not homelike to have a leaking ceiling and not dignified to live in an area of disrepair. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/12/2026 at 12:51 PM, the Maintenance Director stated they reviewed the work orders every day, prioritized them, and distributed the work orders to their staff. Most of the time staff repaired items in disrepair and at other times they contracted the work to a corporate approved contractor. They were notified on 06/08/2026 liquid was leaking on Resident #41 and determined the housekeeper was using too much water when they were stripping the floor in the room above. They stated they had no previous work orders for a leaking ceiling in Resident #41's room. They were notified liquid was coming through the ceiling on 06/11/2026 and again on 06/12/2026. The leak was related to an air conditioning unit in the room above. Missing Clothing: During an interview on 06/08/2026 at 12:32 PM, Resident #72 stated they lost clothing when they gave it to a certified nurse aide to be labeled. They stated their church gave them a zippered top they loved, they sent it to be labeled, it never came back to them, and they saw the top on another resident. They stated the other resident told them a certified nurse aide gave them the top. During an anonymous resident meeting on 06/08/2026 at 1:58 PM, 10 of 12 anonymous residents stated the facility took their clothes and gave them to other people. The facility labeled their clothes with another resident's name. Five of 12 residents stated they received items back from laundry that were not theirs. It was an ongoing issue. They thought some of their items were in the donation section of laundry. The 2025 Missing Items Log documented 12 reports of clothing going to laundry to be labeled and not returning. The 2026 Missing Items Log documented three reports of clothing or blankets going to laundry to be labeled and not returning. During an interview on 06/12/2026 at 12:02 PM, Certified Nurse Aide #46 stated when a resident had new clothing items that needed to be labeled, the certified nurse aide had to go downstairs, get an inventory list, fill out the sheet with the separate items and give it to the receptionist. The receptionist would then take it to laundry who would label the clothes. They liked to put the resident's room number and name inside the bag as well. If a resident reported missing clothing, they called laundry to see if they had it. During an interview on 06/12/2026 at 12:24 PM, the Assistant Director of Environmental Services stated they had a backlog of items that needed to be labeled due to the labeler breaking. All the laundry needing to be labeled came down in a bag and had a sheet attached to the bag that listed what was in the bag. After laundry was done labeling the items, they signed off on the sheet and the clothes were hung on a rack and brought back to the resident. The sheets were scanned into the computer. If something was unlabeled, the laundry staff would attempt to find out who it belonged to. If they could not determine the owner, it went into the donation area which only laundry staff had access to. During an interview on 06/12/2026 at 1:11 PM, Receptionist #48 stated they only assisted with completing the itemized clothing form for residents who received new clothing. A resident's family member or a staff member brought them the resident's clothing, and they filled out the sheet with the resident's name, room number, and list of items. They made three copies: one for the book at the front desk, one for the bag, and one was placed in an envelope that went back to the resident's room. If the (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	items were soiled, they did not go in the bag, they just put the resident's name and room number and a note to wash the items prior to labeling. If a resident was missing items, they looked up the clothing items in the book and gave them to the activities or social work department to try and find the missing item. If the items were not found, a missing items sheet was filled out and the resident was reimbursed. They stated sometimes when they came to work there were already clothing bags at the front desk. The laundry staff worked until 4:30 PM. 10 New York Codes Regulations Rules 415.5(d)(1)(i)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, (IQIES intake 2991234), the facility did not ensure a safe, clean, comfortable, and homelike environment for four of seven resident units (Units 2A, 3A, 4A and 5A) reviewed. Specifically, Units 2A, 3A, 4A and 5A were unclean and in disrepair. Findings include: The facility policy Homelike Environment, revised 12/2025, documented residents were provided with a safe, clean, comfortable, and homelike environment and encouraged to use their personal belongings to the extent possible. Unit 2A During an observation on 06/10/2026 at 10:57 AM, the floors were very sticky throughout the unit and staff shoes were heard squeaking. Unit 3B During an observations on 06/08/2026 at 4:54 PM and 06/09/2026 at 1:37 PM, room [ROOM NUMBER]'s wallpaper was peeling off the wall and the toilet paper holder was broken. The visitor in the room stated it was like that for a long time and they reported it to the facility months ago. Nothing was done to repair the wall or the toilet paper holder, and they requested a transfer to another facility because the environment was awful. Work orders documented the following issues in room [ROOM NUMBER]: -on 08/19/2025 the wallpaper was coming down over the bed, waiting on when to do it. -on 06/09/2026 the wallpaper was peeling, work was completed 06/09/2026. Unit 4A The following observations were made: -on 6/08/2026 at 11:22 AM, room [ROOM NUMBER] had spoiled and stale air odors. -on 06/08/2026 at 11:53 AM, room [ROOM NUMBER] had a strong urine odor. -on 06/08/2026 at 12:37 PM, the dining room wall outlet under the television had a live prong broken into the lower outlet. -on 06/08/2026 at 1:08 PM and 1:47 PM, 06/09/2026 at 8:16 AM, and 06/10/2026 at 8:26 AM room [ROOM NUMBER] had a sticky floor. -on 06/08/2026 at 1:53 PM, room [ROOM NUMBER] had a sticky floor. -on 06/08/2026 at 2:24 PM, room [ROOM NUMBER] had a sticky floor. -on 06/09/2026 at 8:12 AM, room [ROOM NUMBER] had a large amount of liquid on the floor in front (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of the bathroom. -on 06/09/2026 at 9:20 AM, room [ROOM NUMBER] had a white powdery substance and a straw on the floor under the resident's urinary catheter bag. -on 06/10/2026 at 10:43 AM, room [ROOM NUMBER] had a sticky floor. -on 06/12/2026 at 8:16 AM, room [ROOM NUMBER] had water on the floor at the base of the bed. There were wet towels on the floor and a wet floor sign near the wet towels. There was visible leaking from the ceiling. The Administrator entered the room and moved the trash can to catch the leak. During an interview on 06/11/2026 at 8:55 AM, Dietary Aide #50 stated there was no soap or paper towels in the 4A kitchenette for them to wash their hands before or after meal preparation, therefore they were unable to wash their hands. It was important to wash hands before and after meal preparation to prevent the spread of infection. They did not tell anyone about the lack of soap and paper towels in the kitchenette and should have told maintenance. Work orders documented on 12/15/2025 both sinks in the 4A pantry were clogged and about to overflow. There was no documentation about the missing soap dispenser or paper towel holder. Unit 5A The following observations were made: -on 06/08/2026 at 10:39 AM, the floor in front of the nursing station was sticky.-on 06/08/2026 at 12:32 PM, room [ROOM NUMBER] had a sticky floor.-on 06/08/2026 at 11:18 AM, room [ROOM NUMBER] had heavily scuffed floors, a dried brown liquid spill on the floor, a tan dried smear to the left when entering the room, and the entrance floor was sticky-on 06/10/2026 at 9:21 AM, the floor in front of the nursing station was sticky, the floor in front of the elevator had crumbs and several dime sized spots of black/dark brown debris-on 06/10/2026 at 9:31 AM, housekeeping used a long-handled scraper on the floor at the beginning of the upper hall across from nursing station to remove some of the stuck-on debris and did not sweep it up, mopped the area and the debris spread across the floor.-on 06/10/2026 at 9:37 AM, there were dried liquid drops in an arc in front of room [ROOM NUMBER] after the area was mopped. -on 06/10/2026 at 10:34 AM, drawers along bottom of the counter in the pantry were sticky to the touch, all six of them were visibly dirty with built up grime.-on 06/11/2026 at 1:11 PM, there was half dollar sized hole in the flooring in the middle of the hallway across from the soiled utility room.-on 06/11/2026 at 4:09 PM, room [ROOM NUMBER] had crumbs and debris under and around the bed. -on 06/11/2026 at 4:10 PM, room [ROOM NUMBER] had several grey track marks to and from the bed.-on 06/11/2026 at 4:11 PM, the area around the entrance to nursing station had visible black spots, stuck on debris, and the floor was sticky. The front of the nursing station had black stuck on debris spots and food crumbs. -on 06/11/2026 at 4:51 PM, there was a bucket in the ceiling under the sprinkler system. The ceiling was dripping, and the Director of Nursing and Maintenance were observing the area. -on 06/12/2026 at 8:07 AM, room [ROOM NUMBER]'s ceiling along the wall tiles were bubbled up in several spots-on 06/12/2026 at 8:08 AM, there was a large water stain on the ceiling tile at the entrance to the North Hall. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/11/2026 at 11:33 AM, Certified Nurse Aide #7 stated housekeeping was responsible for cleaning resident rooms, mopping, sweeping, and emptying trash. When they noted an odor in a resident room or sticky floors, they notified housekeeping. The floors were very sticky, and residents did not like it because their feet stuck to the floor and at times, they lost their balance. Sticky floors were a safety concern; it was not homelike or dignified. Maintenance was responsible for fixing things that needed repair like air conditioning, toilets, and beds. When maintenance was required, they put a work order in the electronic system and maintenance usually addressed the issue within the hour. The dining room was very hot on 06/10/2026 and maintenance was on the unit addressing the air conditioning unit. They stated the air conditioner was in the wrong mode, however it was still hot in the dining room hours after they left. During an interview on 06/12/2026 at 9:42 AM, Licensed Practical Nurse #5 stated housekeeping was responsible for cleaning resident rooms including sweeping and mopping. The floors were always sticky and tacky because of the chemical they used to clean the floors. It was important to keep the rooms clean and floors not sticky because it was the residents' home. Maintenance was responsible for building upkeep and general repairs. If they noticed something that required a repair, they completed a work order and maintenance responded within 30 to 40 minutes. Maintenance fixed things such as leaks, spots on walls and ceilings, and beds. It was important for the building to be in good working order, so the rooms were homelike. During an interview on 06/12/2026 at 10:34 AM, Registered Nurse Unit Manager #4 stated they were responsible for oversite of the unit. They noticed sticky floors and reported the issue to the Director of Environmental Services who stated it was related to humidity. When they noticed the rooms had odors, they called housekeeping so the room could be refreshed. When they arrived on the unit on 06/12/2026 the Director of Nursing told them about a leak in room [ROOM NUMBER]. There was a wet floor sign in the room, and the room was a safety concern because of the wet floor, and the wet floor sign could cause a resident to slip or trip. During an interview on 06/12/2026 at 11:32 AM, Housekeeper #60 stated they were responsible for cleaning mirrors, sinks, toilets, sweeping, mopping, and wiping down walls. They had a list with every room number on it and documented when they needed things like a soap dispenser and turned the sheet into their supervisor. The floors were sticky, and they believed it was the floor cleaner the facility used. When they noted bad odors in resident rooms they used the airlift air freshener. Maintenance was responsible for installing soap dispensers and paper towel holders. During an interview on 06/12/2026 at 12:51 PM, Maintenance Director #3 stated they were responsible for property maintenance, general upkeep of resident rooms, grounds, trash pick-up, driveway maintenance, and building maintenance. Most work orders were entered into the work order system and others were called in directly. Every day they reviewed the work orders, prioritized them, and distributed the work orders to their staff. Most of the time facility staff repaired items in disrepair and other times they contracted the work to a corporate approved contractor. They were notified that liquid was coming through the ceiling in room [ROOM NUMBER] on 06/11/2026 and again on 06/12/2026. The leak was related to an air conditioning unit in the room above. They cleaned the condensation and cleared out the line and believed the problem was corrected. When it continued to leak on 06/12/2026, they replaced the unit. They completed environmental rounds every day and looked at ceilings, walls, floors, and air temperatures. In addition to the environmental rounds, they had a daily safety meeting. All staff should report areas of concern as maintenance could miss things on their daily environmental rounds. 10 New York Codes Regulations and Rules 415.29(j)(1)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations and interviews (IQIES intakes 2991229 and 3008641) the facility failed to ensure residents were provided food and drink that was palatable, flavorful, and at an appetizing temperature for two of two test trays (06/08/2026 lunch tray and 06/09/2026 breakfast tray) sampled, and for 10 of 12 anonymous residents present at the Resident Council meeting. Specifically, the 06/08/2026 breakfast tray and the 06/09/2026 lunch tray had hot foods served below 130 degrees Fahrenheit, cold foods served above 49 degrees Fahrenheit and were not palatable; and 10 anonymous residents stated the hot food was cold and flavorless, milk was often served spoiled, lettuce was often brown, and the facility often ran out of food and cups.Findings include: The facility policy Food Temperature at Point of Service, revised 01/2026, documented hot food would be held and served at 135 degrees Fahrenheit or higher and cold food would be held and served at 41 degrees Fahrenheit or lower to prevent foodborne illness. During an observation on 6/8/2026 at 10:31 AM, the 2-door mobile refrigerator was plugged in outside the dining room of floor 2B in the hallway. The thermometer on the outside of the unit read 56 degrees Fahrenheit. The door gaskets were torn, and some were partially outside the door and did not create a seal. The door was clipped closed with two S-hooks and did not securely close the unit. The lunch trays were sitting inside the cart with milk beverages on the trays. The milk cartons felt warm. During an observation and interview on 06/08/2026 at 12:04 PM, Dietary Aide #15 stated they were assigned to serve lunch on 2B. The 2-door mobile refrigerator temperature was 46 degrees Fahrenheit. They stated they brought the mobile refrigerator with trays to the floor around 10:00 AM. The refrigerator temperature should have been between 34-36 degrees Fahrenheit. They could not locate an internal thermometer. During an observation on 06/08/2026 at 12:34 PM, Resident #379's lunch meal was tested as the first tray served, and a replacement meal was ordered. Food temperatures were measured and verified by Certified Nurse Aide #20 as follows: creamy Maryland chicken w/ mushroom was 128.7 degrees Fahrenheit, mandarin oranges were 58.1 degrees Fahrenheit, milk was 55.8 degrees Fahrenheit, and water was 72 degrees Fahrenheit. The beverages all tasted warm. During a resident council meeting on 06/08/2026 at 1:58 PM ten anonymous residents stated the food was often cold, meals were not on time, milk was sour, iceberg lettuce was brown, and the facility frequently ran out of food. The weekends seemed to be worse. Over this past weekend they ran out of cups for drinks. During an observation and interview on 06/08/2026 at 4:00 PM the 2-door mobile refrigerator from lunch was observed plugged in on 2B outside the dining room. The log sheet on the side of the cart documented 37 degrees Fahrenheit by Food Service Supervisor #16. At 4:10 PM, Food Service Supervisor #16 stated the cooler came up from the kitchen around 4:00 PM and the temperature should be 32-38 degrees Fahrenheit. It was plugged in downstairs and only unplugged to bring it upstairs, then immediately plugged in again. The temperature was recorded before bringing the unit upstairs. They found the internal thermometer on the back wall of the refrigerator, and it read 52 degrees Fahrenheit. They did not know the unit temperature was out of safe range. They were trying to obtain new equipment but made do with what they had until new refrigerators could be obtained. During an observation on 06/09/2026 at 8:20 AM, Resident #9's breakfast meal was tested, and a (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	replacement meal was ordered. Food temperatures were measured and verified by Certified Nurse Aide #19 and were as follows: scrambled eggs were 120.9 degrees Fahrenheit, milk was 50 degrees Fahrenheit, yogurt was 49.5 degrees Fahrenheit and oatmeal was 172.4 degrees Fahrenheit and burned surveyor mouth. During an interview on 6/12/26 at 9:00 AM, Certified Nurse Aide #17 stated the residents often complained that the hot food was cold, they were missing items on their tray, and the food did not look or taste appealing. During an interview on 6/12/2026 at 9:17 AM, Charge Nurse #18 stated the residents complained the flavor of the food was bad, they did not get many options, and the presentation was bad. When they really liked something, it was pulled off the menu because it was too expensive. During an interview on 06/12/2026 at 12:00 PM, Food Service Director #25 stated the dietary aide assigned to the unit was responsible for taking and recording temperatures for the refrigerators and rolling carts on the units. When a refrigerator was out of temperature (above 39 degrees Fahrenheit) the dietary aide should notify their supervisor and place a work order with maintenance. When a refrigerator or freezer was not working properly there was potential for residents to be exposed to food borne illness. They completed test trays and expected temperatures of cold items including milk to be 140 degrees Fahrenheit and hot entrees to be served at 140 degrees Fahrenheit or higher. Residents complained about cold food which was attributed to the time it took certified nurse aides to pass the trays. Milk arrived at the facility on Mondays and Thursdays and was stored in a cooler. When it arrived, it should be put in the cooler immediately and rotate first in first out. Recently residents complained about spoiled milk and out of date milk. They determined there was a condenser coil in the milk cooler that was not working properly, and it was repaired. 10 New York Codes, Rules, and Regulations 415.14(d)(1)(2)

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	335228	A. Building B. Wing	06/12/2026

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Bridgewater Center for Rehab & Nursing L L C	159 163 Front Street Binghamton, NY 13902

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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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observations, record review, and interviews (IQIES intake 482787), the facility failed to ensure accommodation of resident food preferences for one of one resident (Resident #9) reviewed. Specifically, Resident #9's meal trays were missing preferred food items and included foods they requested not to receive.Findings include: The facility policy Food Service Tray Accuracy, revised 9/2025, documented the Dietary Department will ensure that each resident receives the correct meal, diet, portion size, and nourishments as ordered by the physician and care team to promote safety, satisfaction, and compliance with physician ordered diets while ensuring quality meal service. Special diets, allergies, food preferences, and texture modifications shall be prepared and served as ordered. Meal trays would be checked for accuracy prior to leaving the kitchen and when errors were identified it should be corrected immediately.Resident #9 had diagnoses including anxiety and diabetes. The 3/24/2026 Minimum Data Set assessment documented the resident had intact cognition, required set up assistance with eating, and was on a therapeutic diet.The comprehensive care plan initiated 3/17/2025, documented Resident #9 had a nutritional deficit related to cellulitis, anemia, diabetes mellitus, anxiety, and chronic kidney disease. Interventions included maintaining weight, following prescribed diet, providing food preferences and a sandwich with lunch and dinner.The 01/16/2026 physician order documented no added salt, no concentrated sweets, regular consistency diet. During an observation and interview on 06/08/2026 at 1:08 PM, a certified nurse aide brought the lunch tray to Resident #9 room. The lunch meal ticket documented no gravy. The meal tray was missing margarine, tossed salad, and a grilled cheese sandwich. The pork chop had gravy on it. The resident stated they specifically asked for no gravy, yet they get it all the time. They stated they were missing margarine for their noodles, therefore they were unable to eat the noodles. They wanted their salad for the fiber as it made them feel full and without the sandwich, they felt hungry all afternoon. The 06/09/2026 Registered Dietitian #43 progress note documented the resident had a significant weight loss of 45 pounds, but the last available weight was in February 2026 as the resident refused weight measurements. Average meal intakes were 70 % and the resident frequently refused meals when preferences were not met. The resident regularly contacted the nutrition office regarding food related concerns and preferences, requiring ongoing attention to promote meal acceptance and satisfaction. The resident received many extras items in their meal plan to support skin integrity and wound healing; supplements included two eggs, yogurt at breakfast, sandwich at lunch and dinner in addition to entree and sandwich at night for their snack. During an observation and interview on 06/09/2026 at 8:16 AM, Resident #9 stated they did not get their grilled cheese sandwich for dinner on 06/08/2026 and got upset. They told staff the sandwich was missing. They sent their tray back without eating anything, was not brought a new tray with the ordered items or offered their grilled cheese sandwich. They stated they were hungry all night. During an observation and interview on 06/09/2026 at 8:20 AM, Certified Nurse Aide #19 brought Resident #9's breakfast tray to their room. The tray was missing toast and was used as a test tray. Certified Nurse Aide #19 ordered a replacement tray, and the replacement tray was also missing toast. The resident stated they were upset the toast was missing because they wanted the toast. During an observation and interview on 06/09/2026 at 12:45 PM, a lunch tray was brought to Resident #9. The resident stated they never received their toast for breakfast even after asking for it. Their lunch ticket documented no gravy and the mashed potatoes had gravy on them. The tossed salad was missing, and the sandwich was missing the mustard and mayonnaise. The resident stated they could not eat the sandwich without the mustard and mayonnaise. During an observation and interview on 06/10/2026 at 8:19 AM, Certified Nurse Aide # 44 brought Resident #9's breakfast tray to their room. The meal ticket documented wheat toast, and the resident received white toast and the diet jelly one each (no grape) was missing along with coffee x 2. Certified Nurse Aide #44 was not sure why the coffee or jelly was missing and stated they would (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	get them. They returned to the room with 2 coffees and left the room for the diet jelly. During an observation and interview on 06/10/2026 at 12:40 PM, Certified Nurse Aide #45 brought Resident #9's lunch tray to their room. The meal ticket documented Italian dressing, and the meal tray had ranch dressing and no Italian dressing. The resident stated they did not like ranch dressing. During an interview on 06/11/2026 at 8:34 AM, Food Service Worker #49 stated the tray line in the main kitchen put condiments, sandwiches, and cold items on the tray and the trays were sent to the units in carts. The server on the unit placed the hot items on the tray and an assigned certified nurse aide completed the final check for meal accuracy before the tray was served to the resident. When items were missing from a resident tray, staff should call the kitchen for the items. During an interview on 06/11/2026 at 11:33 AM, Certified Nurse Aide #7 stated residents complained items documented on their meal ticket were often missing. Kitchen staff were responsible for making sure the tray contained all items listed on the meal ticket. The certified nurse aides completed the second check for accuracy before they delivered the tray to the resident. There were many times when the kitchen ran out of food, they called the main kitchen, and food eventually arrived. There were also times when certain items were not on trays and staff called the main kitchen and they were out of the item and other times they would send the item up when available. During an interview on 06/12/2026 at 8:32 AM, Dietary Aide #50 stated they were responsible for matching the food items to the meal tickets. Sometimes items were not available and were not put on the resident tray. Sometimes they ran out of food and called the main kitchen. When it was available, the main kitchen sent it up but other times it was not available. They were not sure why Resident #9 was missing their salad, coffee, diet jelly, mayonnaise, mustard, or sandwich but should get all items listed on their meal tickets. They were not sure why the resident had gravy on their food when the meal ticket documented NO GRAVY, but they must have missed it when they were reading the meal ticket even though it was documented in all capital letters. During an interview on 06/12/2026 at 9:42 AM, Licensed Practical Nurse #5 stated the puller (assigned certified nurse aide) gives the tray to the kitchen staff from the cooler cart with condiments and other items already on the tray. The kitchen staff completes the preparation of the meal tray, and the puller verified tray accuracy before they brought the tray to the resident. Residents complained about missing items and the kitchen was notified to give additional items to the resident. Resident #9 reported missing items frequently and staff called the kitchen to get the items. During an interview on 06/12/2026 at 10:34 AM, Registered Nurse Unit Manager #4 stated residents often complained about food items missing from their trays. Resident #9 has a sandwich on their meal ticket for lunch and dinner and when it is missing staff will call the kitchen for one. They were not sure why the sandwich was not on the tray. Sometimes items listed on the meal ticket were not available and residents were offered substitutions. 10 New York Codes Rules Regulations 415.14(d)(3)(4)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, record review, and interviews (iQIES intake #2997455 and 3008641), the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for two of eight residents (Resident #13 and Resident #376) reviewed and two of two staff (Housekeeper #64 and Certified Nurse Aide #61) observed. Specifically, Resident #13 was on contact precautions for clostridioides difficile (a highly infectious bacteria that causes diarrhea) and Certified Nurse Aide #61 walked into the resident's room to retrieve a meal tray without wearing a gown or gloves or washing their hands with soap and water; Resident #376 did not have a contact precaution sign on their door with clostridioides difficile results pending; and Housekeeper #64 cleaned the floors of all rooms, including contact precaution for clostridioides difficile, with a quaternary sanitizer (broad spectrum sanitizer ineffective against clostridioides difficile) instead of chlorine-based bleach.Findings include: The facility procedure Cleaning Patient Rooms identified with Clostridium Difficile documented the housekeeper would use sodium hypochlorite (chlorine-based sanitizer) disinfectant to clean the room, including the floors.The purple Contact Precautions sign documented all staff must wear a gown and gloves before entering the room and must wash their hands with soap and water when exiting the room. Hand sanitizer was not allowed.1)Resident #13 had diagnoses including recurring clostridioides difficile. The 05/13/2026 Minimum Data Set (assessment tool) documented frequent bowel incontinence and staff supervision was provided with toileting. Resident #13's care card documented contact precautions for clostridioides difficile. During an observation and interview on 06/10/2026 at 8:56 AM, Certified Nurse Aide #61 walked into Resident #13's room without donning a gown or gloves. They exited the room carrying the resident's breakfast tray then, used hand sanitizer, and proceeded to enter the next resident's room. Certified Nurse Aide #61 stated they knew what precautions were required by looking at the sign on the door. They reviewed the purple contact precaution sign hanging on the resident's door and stated they only had to wear a gown and gloves when doing direct care, and they were not required to be worn when taking the meal tray out of the room. They stated hand sanitizer was effective after leaving the room. During an interview on 06/10/2026 at 9:01 AM, Registered Nurse #62 stated contact precautions required staff to wear a gown and gloves any time they entered the room and handwashing with soap and water was required when leaving the room. During an interview on 06/10/2026 at 9:06 AM, Registered Nurse #18 stated contact precautions required staff to wear a gown and gloves any time they entered the room and required handwashing with soap and water when leaving the room. Resident #13 also required their room to be cleaned with bleach. The in-service coordinator recently provided annual infection control training on the topic to all staff. During an interview on 06/12/2026 at 9:07 AM, Housekeeper #64 stated they used a quaternary sanitizer on the sinks in all resident rooms, even rooms with contact precaution for clostridioides difficile. When they mopped the floors in all resident rooms, regardless of precautions, they used individual mop pads and a quaternary sanitizer. During an interview on 06/12/26 at 9:41AM the Director of Housekeeping stated staff should clean contact precaution rooms with bleach and mop the floors with a quaternary sanitizer. During an interview on 06/12/2026 at 10:39 AM, Infection Preventionist #39 stated if a resident was on contact precautions for clostridioides difficile the room needed to be cleaned with bleach, including the floors. A quaternary sanitizer would not kill clostridioides difficile. There was a checklist environmental services referenced when cleaning a resident's room who had clostridioides difficile. 2)Resident #376 had diagnoses including osteomyelitis (bone infection), urinary tract infection, and diarrhea. The 06/04/2026 Minimum Data Set assessment documented the resident was cognitively intact, was frequently incontinent of bowel, was taking an antibiotic, and received intravenous medications.The comprehensive care plan initiated 05/29/2026 documented the resident was a risk for alteration in bowel related to antibiotic use. Interventions included monitoring for loose (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stools, and any changes were reported to the physician. The 6/11/2026 at 1:15 PM Physician #40 order documented the resident had a laboratory order for stool specimen for clostridioides difficile for diarrhea.The 06/11/2026 at 1:15 PM, Registered Nurse Unit Manager #30 progress note documented there was a new order for stool culture and sensitivity for clostridioides difficile.Resident #376's room was observed without contact precaution signage outside their room door on 06/11/2026 at 2:13 PM and 4:53 PM, and on 06/12/2026 at 8:39 PM. During an interview on 06/12/2026 at 8:58 AM, Certified Nurse Aide #35 stated they knew what personal protective equipment to wear based on the sign outside the door. During an interview on 06/12/2025 at 9:05 AM, Licensed Practical Nurse #41 stated the proper personal protective equipment worn was determined by the sign outside the resident's room. The signs were placed by the Infection Preventionist. They verified the order for the clostridioides difficile specimen for Resident #376, but they did not enter it. Precautions for clostridioides difficile should probably be started as soon as there was an order to rule it out because the precautions were beyond just the enhanced barrier precautions.During an interview on 06/12/2026 at 9:30 AM, Registered Nurse Unit Manager #30 stated staff knew what personal protective equipment to wear in a resident room based on the sign outside their room. Clostridioides difficile required contact precautions with the purple sign and the sign was different than the enhanced barrier precaution sign. Contact precautions should be initiated as soon as the laboratory order was obtained. Typically, the Infection Preventionist put up the signs. They did not call the Infection Preventionist when they got the order for stool for clostridioides difficile, however, they could have put up the sign themselves and did not. During an interview on 06/12/2026 at 11:55 AM, the Infection Preventionist stated they were responsible for initiating and maintaining isolation precautions. The sign informed all staff and visitors what personal protective equipment was required prior to entering the room. Clostridioides difficile had its own sign because it required different cleaning and was highly contagious. To prevent it's spread, a gown and gloves and hand washing were required every time the room was entered. Those precautions should be initiated as soon as a specimen was ordered for clostridioides difficile. 10 New York Codes, Rules and Regulations 415.19(a)(b)