STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335233	A. Building B. Wing	04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Park Rehabilitation and Nursing Center	950 Floyd Avenue Rome, NY 13440

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observations, record review, and interviews the facility failed to ensure a process was in place for residents to have their grievances addressed appropriately for 79 of 79 residents residing in the facility. Specifically, information on how to file a grievance and grievance forms were not available to the residents and the facility did not have a process for residents to file an anonymous grievance. Additionally, six (6) of six (6) anonymous residents present at the resident group meeting stated they did not know if there were grievance forms or where they would be located, of their right to file anonymously, did not know who the grievance officer was, and resident council concerns were not addressed. Findings include:The facility policy Grievances/Complaints, Filing, revised 01/2026, documented residents and their representatives had the right to file grievances concerning care, treatment, behavior of other residents, staff members, theft of property, or any other concerns regarding their stay at the facility. Grievances may also be voiced or filed regarding care that was not furnished. Residents, family, and resident representatives had the right to voice or file grievances without discrimination or reprisal in any form, and without fear of discrimination or reprisal. Actions on such issues were responded to in writing and included a rationale for the response. On admission, residents were provided with written information on how to file a grievance. Grievances may be submitted orally or in writing and may be filed anonymously. The Administrator delegated the responsibility to the Grievance Officer who was the Director of Social Work. The resident, or person filing the grievance was informed verbally and in writing of the findings of the investigation and the actions taken to correct any identified problems within seven (7) working days of filing the grievance with the facility. A written summary was also provided to the resident. The 2025 grievance log documented eight (8) grievances for the year. The 2026 grievance log documented one (1) grievance in January, two (2) grievances in February, one (1) grievance in March and zero (0) grievances in April. During an observation on 04/14/2026 at 10:58 AM, there was a metal box on the wall across from the receptionist at the main entrance for grievance submissions. There was a sign on the box that said to put the grievance in the box or submit to social work or department manager/supervisor. There were no forms with the box. There were no postings in prominent locations throughout the facility of the right to file grievances orally or in writing; the right to file grievances anonymously; and the contact information of the grievance official with whom a grievance could be filed. During a resident group meeting on 04/14/2026 at 2:00 PM, six (6) anonymous residents stated they did not know if there were grievance forms or how to obtain them and thought they wrote a grievance on their own piece of paper and placed it in the box by the receptionist. There was no way to file a grievance anonymously as the box was in a prominent location and others would see them put the piece of paper in the box. There was no follow up. One resident stated they filed a grievance six (6) to seven (7) months ago and had yet to hear anything about it. They were not sure who the grievance official was. When concerns were voiced in resident council, they went to the Administrator but that was as far as they went. There was no follow up on their concerns and the same concerns went from meeting to meeting unaddressed. Some residents had stopped attending the resident council meetings because they felt it was pointless. During an observation on 04/15/2026 at 10:22 AM, there was a metal box (continued on next page)

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on the wall across from the receptionist at the main entrance for grievance submission. There were four (4) staff members and four (4) residents in view of the box. There was a sign on the box that said to put the grievance in the box or submit to social work or department manager/ supervisor. There were no forms with the box. There were no postings in prominent locations throughout the facility of the right to file grievances orally or in writing; the right to file grievances anonymously; and the contact information of the grievance official with whom a grievance could be filed. During an interview on 04/17/2026 at 9:53 AM, Certified Nurse Aide #14 stated if a resident wanted to file a grievance, there was a pamphlet they could give them to contact the ombudsman. During an interview on 04/17/2026 at 10:08 AM, Licensed Practical Nurse #16 stated if a resident wanted to file a grievance they could verbally come to them, the Director of Social Work, or the Assistant Director of Nursing. They would document a nursing note about it. There was also a poster for the ombudsman, and they were at the facility regularly. During an interview on 04/17/2026 at 10:16 AM, the Assistant Director of Nursing stated any staff member could take a resident grievance. It would go directly to the supervisor or the Director of Social Work. There was a form to file a grievance, and the forms were kept in the social work office or the nursing office. The residents could not file anonymously because they would have to ask for the form. During an interview on 04/17/2026 at 1:43 PM, the Director of Social Work stated there were blank grievance forms behind the nurse's station. They were considered the grievance officer, so they were the gatekeeper. Staff or residents gave them the completed grievance forms. They read them and based on the area of concern it was given to the appropriate department. The investigation was done within five (5) days. After there was a conclusion/resolution, they verbally reviewed it with the resident, and the resident signed the form. Residents had to ask for the grievance form. They thought residents could submit anonymously because there was a box on the wall. They confirmed the box was in a high traffic area. During a follow up interview at 2:34 PM, they did not have a key to the grievance box and did not know who checked it. 10 New York Codes, Rules, and Regulations 415.3(C)(1)(ii)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. Based on observations, record review, and interviews (iQIES Intakes 2807999 and 473681) the facility failed to ensure residents maintained acceptable parameters of nutritional status for two (2) of six (6) residents (Residents #7 and #64) reviewed. Specifically, Resident #7 had significant weight loss, weights were not obtained as ordered, and there was no documented evidence a medical provider addressed the resident's weight loss; Resident #64 did not receive their nutritional supplements as ordered, had a decline in their eating abilities, and was not assisted at meals. Findings include:The undated facility policy Comprehensive Nutrition Assessment, documented the Clinical Nutrition team would clarify nutrition issues, needs, and goals in the context of the individual's overall condition. Health care practitioners would help define the nature of the problem, identify causes of nutrition problems (i.e. anorexia and weight loss), tailor interventions to the individual's specific causes and situation, monitor the continued relevance of those interventions.The undated facility policy Weights and Weight Changes, documented each resident's weight was recorded in the medical record. Each resident was weighed monthly or more frequently per physician's order, nursing or dietary recommendations. Monthly weights were obtained by the 10th of the month and a reweight would be obtained within 72 hours if there was a weight change of 5 pounds noted from the previous weight. If after the reweight, the resident had a significant weight change of greater than 5% in 30 days or 10% percent in 180 days, the registered dietitian would reassess within 7 days. Residents with significant weight changes were reviewed by the interdisciplinary team at the weekly weight meeting. 1) Resident #7 had diagnoses including adult failure to thrive (progressive decline in health) and cerebral palsy (neurological disorders affecting movement, muscle tone, and posture). The 02/22/2026 Minimum Data Set (a resident assessment tool) documented the resident had severely impaired cognition, did not reject care, required partial/moderate assistance with eating, weighed 113 pounds, had no significant weight changes at one month or six months, and was on a mechanically altered diet. The 08/19/2024 comprehensive care plan, revised 02/12/2026, documented the resident was at risk for malnutrition related to history of low body weight and history of significant weight changes. Interventions included assistance with feeding, encourage meals in the dining room, encourage intakes, identify/honor food preferences, monitor/document intakes, provide diet as ordered, provide fortified foods and oral nutrition supplements, and report any significant weight changes to registered dietitian and medical provider. The July 2025-February 2026 Treatment Administration Record documented to obtain weekly weights every day shift on Tuesday for weight monitoring.The 08/25/2025 physician orders documented puree texture diet and nectar thick liquids.The comprehensive care plan revised 02/20/2026 documented the resident required partial/moderate assistance at meals and received a puree diet with nectar thick liquids. Alternate between small bites and sips of liquids and remain in an upright position during intakes. The physician orders documented:-on 03/26/2026, 8 fluid ounces of nutritional shake three (3) times a day for weight loss, offer at lunch, dinner and at hour of sleep. -on 03/27/2026, 7.5 milligrams of mirtazapine (antidepressant used as appetite stimulant) once daily at hour of sleep for appetite stimulant and continue weekly weights.The resident's weight record documented:-10/08/2025: 114.2 pounds-11/03/2025: 103.4 pounds (10.8 pound loss/ 9.4% loss at one month)-11/06/2025: 101.7 pounds-11/13/2025: 105 pounds-11/18/2025: 103.4 pounds-11/25/2025: 107.2 pounds-12/02/2025: Licensed Practical Nurse #21 documented the resident refused -12/09/2025: 103.9 pounds-12/13/2025: no documented weight -12/16/2025: Licensed Practical Nurse #21 documented the resident refused-12/23/2025: Licensed Practical Nurse #22 did not document the resident's weight -12/30/2025: 107.4 pounds-01/06/2026: 109.4 pounds-01/09/2026: no documented weight-1/20/2026: no documented weight, Licensed Practical Nurse #20 documented see nursing progress note and documented passing on to next shift. There was no documented evidence the weight obtained-01/27/2026: no documented weight -02/03/2026: 112.6 pounds-02/09/2026: weekly (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	weights discontinued -03/06/2026: 96.2 pounds (16.4 pounds loss/ 14.5% loss at one month) and no documented reweight obtained. -03/20/2026: 96.8 pounds-03/25/2026: 92.2 pounds-04/01/2026: 92.3 pounds-04/10/2026: 98 pounds-04/14/2026: 98.4 pounds The 11/10/2025 Registered Dietitian #3 progress note documented the resident had a significant weight loss over the past month of 10.9%, their body mass index (BMI) was 15.5 (underweight). Their current weight was 101.7 pounds, their estimated nutritional needs were 1562 calories per day, 55-60 grams of protein daily, and 1617 milliliters of fluid daily. The resident's meal preferences were updated, and they would continue with current interventions, including fortified foods at meals and nutrition supplements. Their intakes at meals were good, consuming greater than 75% at meals. The resident was a high nutrition risk. The 11/28/2025 Nurse Practitioner #41 progress note documented they were notified via facility clinical alert to review the chart. No acute issues at this time per nursing notes, the resident was at their baseline functional status. The plan was to order labs for review. There was no documented evidence the medical provider was notified of the sever weight loss from 10/08/2025-11/06/2025The 11/28/2025 Registered Dietitian #3 progress note documented the resident was followed for high nutrition risk and met the criteria for malnutrition. The 12/29/2025 Registered Dietitian #3 progress note documented the resident was continued to be followed for high nutrition risk due to significant weight fluctuations/ loss. The resident's weight continued to fluctuate over the past month, and weights were to be monitored weekly. Their body mass index was considered underweight, and the goal was to promote weight gain until body mass index was greater/equal to 23. The resident's intakes were fair to good, and they would continue with the current nutritional interventions. They would continue to follow as they were high nutrition risk. The 01/21/2026 Registered Dietitian #3 progress note documented updates were made to the resident's meal pattern and to continue to promote intakes. The resident was moderate nutrition risk at this time. The 02/11/2026 Nutrition Assessment completed by Registered Dietitian #3 documented the resident received a puree consistency diet with nectar thick liquids. They received a 4 ounce mighty shake (nutrition supplement), enhanced peanut butter pudding, and yogurt three (3) times daily at meals along with a Magic Cup (nutrition supplement) twice daily. Their current weight was 112.6 pounds, their body mass index was 17.1, and intakes at meals were good. They had no significant weight changes in the past one (1) or six (6) months. The goal was to continue with weight gain until body mass index reached appropriate range. The resident met the criteria for mild malnutrition and per discussion with the resident their meal pattern was updated, and magic cups were removed. The 03/09/2026 Registered Dietitian #3 progress note documented a re-weight was requested to confirm weight as weight had been stable. They continued on a puree diet with nectar liquids and received nutritional supplements and fortified foods at meals. Intakes were good, would trial increasing Might Shakes to 8 ounces at lunch and dinner. They would monitor weight weekly and monitor for re-weight. The 03/26/2026 Registered Dietitian #3 progress note documented the resident was followed for high nutrition risk. Their current weight was 92.2 pounds; their body mass index was 14 and met the criteria for malnutrition. Intakes were variable, ranging poor to excellent, and received puree consistency with nectar liquids. They would try adding an 8 ounces Health Shake at hour of sleep and may consider adding an appetite stimulant if medically beneficial and able. The resident remained high risk for nutrition and they would continue to follow weekly weights for four (4) weeks. There was no documented evidence that a re-weight was obtained timely. The physician order for weekly weights was not entered until 03/27/2026.There was no documented evidence that a medical provider was notified of or addressed the resident's significant weight loss. The resident was observed:- on 04/16/2026 at 8:20 AM, seated in the main dining room. The resident was assisted by Certified Nurse Aide #26, the resident had pureed pancakes, pureed eggs, hot cereal, pureed ham salad, peanut butter pudding, applesauce, nectar thick water and nectar thick coffee. At 8:34 AM, the resident stated they were done with their meal and had consumed 100% of their pancakes and peanut butter pudding, 0-25% hot cereal, and 50% of their nectar thick water and coffee. They did not want any of the pureed ham (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	salad or any more of their hot cereal. - on 04/16/2026 at 12:43 PM, seated in the main dining room being assisted by Licensed Practical Nurse #26. The resident had pureed turkey and gravy, pureed stuffing, pureed creamed spinach, two (2) 4 ounce dishes of pureed turkey salad and pureed chicken salad, four (4) chocolate milk shakes, two (2) yogurt containers, nectar thick coffee, and enhanced peanut butter pudding. At 1:03 PM, the resident consumed 100% of their meal tray. During an interview on 04/17/2026 at 11:46 AM, Registered Nurse Unit Manager #4 stated the registered dietitian provided the unit with the weight list. Nursing staff obtained the weights and the registered dietitian provided a list of residents who needed to reweighed. They did not notify medical if a resident had a significant weight change. The interdisciplinary team did discuss significant weight changes in the weekly weight meeting. The medical providers attended the meeting if they were in the building. Weights were expected to be obtained as ordered and if the resident refused, nursing should document the refusal. During an interview on 04/17/2026 at 12:09 PM Nurse Practitioner #7 stated the registered dietitian notified medical of significant weight changes and if a medical provider was in the building during the weekly weight meeting, they attended. The facility looked at significant weight changes with an interdisciplinary approach. Resident #7 had a significant weight change and their weight was now trending upwards. Nursing should obtain weights as ordered and document any refusals. The facility recently had a change with medical providers. They stated an appetite stimulant was ordered for the resident in March of 2026. If a resident had significant weight changes and the medical team was notified, they should assess the resident and document the findings. During an interview on 04/17/2026 at 12:30 PM Certified Nurse Aide #25 stated a resident's weights were obtained as ordered. Some residents were weighed monthly, and others were weighed weekly. The registered dietitian provided a list of residents who needed to be weighed, and the recertified nurse aides obtained the weights. If a resident refused, they would reapproach the resident and tell the nurse if the refusal. If a resident needed to be reweighed, the registered dietitian provided the unit with a list, and it was the same process. They worked with Resident #7 and the resident never refused to be weighed. The resident was eating well at this time.During an interview on 04/17/2026 at 2:01 PM Registered Dietitian #3 stated the facility recently started a new weight process. The Director of Nursing or the Assistant Director of Nursing generated the weight lists and brought them to the units. Previously they had provided the units with the lists and there were issues, so the facility revised the process. Weights were obtained per the medical order, monthly weights were obtained during the 1st and 10th of the month, and weekly weights were completed as ordered. Any resident who had a significant weight change of 5% at one (1) month, 7.5% percent at three (3) months, or 10% percent at six (6) months a reweight would be obtained within 72 hours to confirm the weight change. If the weight loss was confirmed they reassessed the resident's nutritional needs and the resident was discussed during the weekly weight meeting. The Director of Nursing, Assistant Director of Nursing, and the unit managers attended the weekly weight meeting. The medical providers did not always attend the weekly weight meeting, and they would typically verbally notify the medical providers of significant weight changes. Resident #7 was at risk for weight loss and had weight fluctuations. The resident was supposed to be weighed weekly, and they were not, and reweights were not obtained as requested. They updated the resident's preferences and attempted different supplements, and the resident was started on an appetite stimulant in March to aid with weight gain when they triggered for a weight decline.2) Resident #64 had diagnoses including dementia, adult failure to thrive (progressive decline in overall health), and diabetes. The 03/23/2026 Minimum Data Set (a resident assessment tool) documented the resident had severely impaired cognition, did not reject care, required supervision or touching assistance with eating, weighed 165 pounds, had no significant weight changes at one or six months, and was on a mechanically altered diet. The 04/06/2020 comprehensive care plan, revised 11/23/2025, documented the resident was at risk for malnutrition related to dementia, diabetes, and adult failure to thrive. Interventions include assistance with feeding, encourage intakes, monitor meal consumption, provide diet and supplements as ordered. The (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	07/27/2022 physician order documented a chopped, thin liquid diet with the expectation of chips and peanut butter and jelly sandwiches. The resident's weight record documented:-02/05/20026: 177.4 pounds-03/19/2026: 172 pounds-03/20/2026 165.4 pounds-03/26/2026: 163 pounds.The 03/23/2026 Registered Dietitian #3 progress note documented the resident met the criteria for malnutrition and had a significant weight loss of 12 pounds/ 6.8% at month. Weekly weights were to be monitored for four (4) weeks until stable and the resident was at high nutrition risk. The 03/26/2026 physician order documented 8 ounces of Ensure Plus (nutrition supplement) with meals three (3) times daily. The resident's weight record documented:-04/02/2026: 156 pounds (16 pounds/9.3% loss at one (1) month)-04/03/2026: 158.2 pounds (13.8 pounds/ 8% loss at one (1) month).The 04/07/2026 Registered Dietitian #3 progress note documented the resident was followed for high nutritional risk. The resident had a significant weight loss of 13.8 pounds/8% within less than one (1) month. The resident continued on a chopped diet with thin liquids and received 8 ounces of Ensure Plus three (3) times daily. They would try a Magic Cup (frozen nutrition supplement) at lunch and supper for additional calories and protein. Weekly weights were to be monitored for four weeks. The resident remained at high nutrition risk. The 04/07/2026 physician order documented Magic Cup at lunch and dinner. The care instructions documented the resident required supervision (in-line of sight) or touching assistance with meals. They received a chopped diet with thin liquids. Alternate small single bites and sips of liquids and observe for pocketing of food and provide supplements as ordered. The following observations of Resident #64 were made:-on 04/14/2026 at 12:28 PM, seated at a table in the dining room with their eyes closed and their lunch meal in front of them. Their meal included sauerkraut, sweet potatoes, a peanut butter and jelly sandwich cut into squares, a Magic Cup, cottage cheese, diced fruit, chocolate milk shake, and ginger ale. At 12:29 PM, Registered Nurse Unit Manager #4 woke the resident up and provided them with their chocolate milk shake and the resident consumed 100% of it. They provided the resident a with a spoonful of sweet potatoes, and the resident declined anymore sweet potatoes. They cut the peanut butter sandwich smaller and assisted the resident with the sandwich. The meal tray did not include Ensure Plus as ordered. -on 04/15/2026 at 12:24 Licensed Practical Nurse #5 provided the resident their meal in the dining room. They poured their milk and soda into cups and asked the resident if they wanted straws. At 12:25 PM, the resident had not started eating or drinking and was looking at their meal tray. At 12:27 PM, Licensed Practical Nurse #5 put the straws in the resident's drink. At 12:31 PM, the resident struggled to bring the cup to their mouth and sip their drink. At 12:32 PM, they picked up their cup of milk and drank it. At 12:34 PM, Certified Nurse Aide #28 unwrapped the resident's peanut butter and jelly sandwich and placed a fork on the plate. The resident had rice, broccoli, cottage cheese, diced pears, a Magic Cup, soda, and a chocolate milk shake. At 12:39 PM, the resident consumed 100% of their chocolate milk, 50% soda, and 50% of the magic cup. At 12:42 PM, the resident put the Magic Cup on the table and looked at the food on their plate. At 12:47 PM, Certified Nurse Aide #28 asked the resident if they were going to eat. Registered Nurse Unit Manager #4 sat next to the resident and assisted them to take bites of their peanut butter and jelly sandwich and Magic Cup. They provided the resident with a fork to feed themselves the cottage cheese. The resident's hands were shaking and Registered Nurse Unit Manager #4 turned away from the resident to attend to another resident at another table. Resident #64 continued to take small bites of cottage cheese. At 1:03 PM, Registered Nurse Unit Manager #4 returned to Resident #64 and removed their meal tray. The resident consumed 25-25% of the cottage cheese, 50% of the peanut butter and jelly sandwich, 100% Magic Cup, 100% chocolate milk shake, and 100% soda. They consumed 0-25% of the broccoli, rice, and diced pears. The meal tray did not include Ensure Plus as ordered.-on 04/16/2026 at 12:48 PM, the resident was seated in the dining room. They had a peanut butter and jelly sandwich cut up into squares, a Magic Cup, 8 ounces of Ensure Plus, peaches, creamed spinach, stuffing, cottage cheese, and ginger ale. No staff assisted the resident with their meal. At 12:54 PM, the resident sat at the table with their eyes closed and had not consumed any food or fluids. At 1:02 PM, the resident continued to sit at the table and had not (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	received any assistance or encouragement to consume their meal. At 1:07 PM, the resident's head was down, and they had not consumed any food or fluids. At 1:08 PM, Certified Nurse Aide #28 asked the resident if they were going to eat, did not offer assistance and walked away. At 1:14 PM, Certified Nurse Aide #29 sat down next to the resident poured their ginger ale into a cup, asked the resident if they wanted any of their ginger ale, and what did they want to eat. At 1:16 PM, Certified Nurse Aide #29 walked away to assist another resident. At 1:21 PM, Certified Nurse Aide #28 asked the resident if they were going to eat and the resident declined. The resident consumed 0-25% of their food and fluids. During an interview on 04/17/2026 at 10:01 AM, Certified Nurse Aide #29 stated the level of assistance a resident required at meals was listed on their care instructions, they also had a yellow meal ticket, and staff could also ask the nurse if they were unsure. If a resident required touching assistance or supervision staff were to encourage them to eat and offer alternatives if they were not eating. If a resident was requiring more assistance at meals than they were care planned for they should tell the nurse. Resident #64 required assistance at meals and did not eat well. Staff should set up the meal for the resident, pour drinks and cut items if needed. If the resident was not eating, staff should assist them with their meal or provide encouragement. The resident received Ensure Plus at meals and typically drank that. This week the kitchen ran out of Ensure Plus and substituted Mighty Shakes (nutritional supplement). During an interview on 04/17/2026 at 10:09 AM Certified Nurse Aide #25 stated Resident #64 sometimes needed assistance with meals and ate better if they were assisted. The resident spilled their drinks, and they thought they would benefit from having lids on their drinks. The resident recently required more assistance at meals. They received supplements at meals and did not receive their Ensure Plus at meal this week, but received a Mighty Shake instead. During an interview on 04/17/2026 at 10:36 AM Licensed Practical Nurse #26 stated if a resident required supervision/ touching assistance at meals staff should assist them with their meal if they were not eating. If a resident was consistently requiring more assistance than what was on their care plan the Unit Manager should be notified and it should be documented. They stated Resident #64 required more assistance with meals than in the past, but they did not consistently work on the unit. Staff should be observing to see if the resident required assistance, as they had a yellow meal ticket. The resident received Ensure Plus and if that was not available the kitchen would substitute Mighty Shakes. They did not document if the Ensure Plus was substituted but verbally told the Unit Manager. During an interview on 04/17/2026 at 12:11 PM Registered Nurse Unit Manger #4 stated if a resident was consistently requiring more assistance the registered dietitian should be notified and discussed with the interdisciplinary team in morning report, so everyone was aware. Resident #64 was able to feed themselves but sometimes did not eat on their own and required more encouragement at times. The resident had been losing weight and did not appear to feed themselves this week. If the resident was not eating staff should provide encouragement and assistance. The resident was supposed to receive Ensure Plus at meals and this week received Mighty Shakes. They thought the registered dietitian should be notified by the kitchen if there was a substitution with nutritional supplements. During an interview on 04/17/2026 at 1:21 PM, the Food Service Director stated sometimes the facility has issues with getting Ensure products, but they typically came within a day. If they did not have any Ensure products they spoke to the registered dietitian and asked what should be substituted. They had a handwritten sheet and stated if it was not available, they would substitute Boost (nutrition supplement) or fortified milk. During an interview on 04/17/2026 at 2:01 PM, Registered Dietitian #3 stated the facility was having issues not receiving all the supplements they ordered from their food vendor. They did not always receive the Ensure products. If the product was not received the kitchen should notify them so a substitution could be made. They were not consistently notified when the products were not available, and they were unaware Ensure Plus was being substituted with Mighty Shakes. Ensure Plus was more calorically dense and had more protein than Mighty Shakes. They were not notified the kitchen was substituting Mighty Shakes for Ensure Plus. Resident #64 was planned to receive Ensure Plus and had weight loss.During an interview on (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Park Rehabilitation and Nursing Center	950 Floyd Avenue Rome, NY 13440

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	04/17/2026 at 2:50 PM, the Director of Nursing stated weights should be obtained as ordered. The registered dietitian would provide a list to the units of who needed to be weighed and any needed reweights. The facility had a weekly weight meeting and discussed significant weight changes. Any resident who required more assistance with meals should be re-evaluated.During an interview on 04/17/2026 at 3:02 PM, Physician #30 stated if a resident's ability to eat changed from what they were care planned for they should be re-evaluated. They saw Resident #64 yesterday for weight loss and spoke to the Director of Nursing about re-evaluating the resident's eating abilities. The registered dietitian should be notified if the resident did not receive their supplements as ordered. 10 New York Codes, Rules and Regulations 415.12(i)1

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. Based on observations and interviews (iQIES intake 2963932), the facility failed to provide each resident with a nourishing, palatable, well-balanced diet that met their daily nutritional needs for six (6) anonymous residents and two (2) of two (2) meals (the 04/15/2026 and 04/16/2026 lunch meals) reviewed. Specifically, the 04/15/2026 lunch meal had hot and cold food served outside of the appropriate temperature range; the 04/16/2026 lunch meal tray had missing food items, missing adaptive meal equipment, and food items were not serviced at palatable temperatures and the 04/16/2026 replacement lunch meal was missing items, the appropriate adaptive equipment was not provided, and the meal ticket directions were not followed; and six (6) anonymous residents present at the resident group meeting stated the food was often cold and the meal tray did not match the meal tickets. Findings include:The undated facility policy Accuracy and Quality of Tray Line Service, documented all meals were checked by food service personnel for accuracy, and by the employees serving the meals prior to the individual being served. Hot foods were kept above 140 degrees Fahrenheit and cold foods were kept below 41 degrees Fahrenheit. Prior to leaving the kitchen, each meal was checked for accuracy that items on the meal tray matched the meal ticket. During an anonymous resident group meeting on 04/14/2026 at 2:00 PM, six residents stated the food was often cold and the meal tickets did not match the food items placed in front of them. During a B unit lunch meal observation on 04/15/2026 at 12:12 PM, Resident #1's lunch meal was the last meal served. The lunch tray was tested and verified with the Regional Director of Food Operations. The ziti measured at 133 degrees Fahrenheit, the broccoli measured at 110 degrees Fahrenheit and was cool to taste, the garlic bread measured at 100 degrees Fahrenheit, the coffee measured at 133 degrees Fahrenheit, and the pineapple measured at 68 degrees Fahrenheit. During an A unit lunch meal observation on 04/16/2026 at 12:39 PM, Resident #4's lunch meal was tested and verified with Certified Nurse Aide #15. Certified Nurse Aide #15 stated the resident was out on an appointment and they were going to have to order a new tray because the tray was wrong. The tray was missing turkey, gravy, creamed spinach, cottage cheese, chilled peaches, diet house shake, Mrs. Dash seasoning, margarine and a scoop plate. The stuffing was measured at 125.1 degrees Fahrenheit and did not taste warm; the carrots were measured at 110.2 degrees Fahrenheit, and the water was measured at 62.8 degrees Fahrenheit. At 1:18 PM, the resident received a replacement tray. The replacement tray was missing gravy, the turkey was not cut up per the meal ticket directions, the resident received a divided plate instead of a scoop plate, and the resident received regular milk instead of the diet house shake. During an interview on 04/17/2026 at 1:21 PM, the Food Service Director stated everyone had a part in ensuring meal ticket accuracy. The meal ticket was referenced by each dietary worker who placed items on the tray. If they were out of something or missing something, it was crossed off the ticket and the resident was made aware. They attended resident food council meetings and was aware of how the residents felt as if items were just not being sent. Residents complained about missing items for the past couple of months. Hot food should be served above 140 degrees Fahrenheit and cold food below 41 degrees Fahrenheit. Any food item outside of those ranges was unacceptable because bacteria could grow and residents deserved to have hot food. 10 New York Codes, Rules, and Regulations 415.14

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on observations, record review, and interviews during the recertification survey, the facility failed to consult with the physician when there was a significant change in the resident's physical status for one (1) of one (1) resident (Resident #3) reviewed. Specifically, Resident #3 had significant weight gain, weights were not obtained as ordered, there was no documented evidence that the physician was notified of a significant weight gain, and the resident was hospitalized .Findings include:The facility policy Change of Resident Condition, revised 01/2025, documented the nurse would notify the physician when there was a significant change in the resident's physical/ emotional/mental condition. A significant change of condition was a major decline or improvement in the resident status that would not normally resolve itself without intervention by staff. Resident #3 had diagnoses including heart failure, chronic kidney disease stage 4 and hypertension. The 04/01/2026 Minimum Data Set (a resident assessment tool) documented the resident had intact cognition, weighed 159 pounds, had weight loss of five (5) percent at one (1) month or ten (10) percent at six (6) months, and received a mechanically altered and therapeutic diet. The resident's weight record documented:-on 01/07/2026 167.5 pounds-on 01/08/2026 167.5 pounds The 01/25/2026 at 7:30 AM, Nurse Practitioner #37 progress note documented nursing staff reported the resident's face was swollen at baseline. The resident had a history of end stage renal disease and refused dialysis (medical procedure that filters blood when kidneys fail). Nursing staff was advised to administer furosemide as ordered and monitor urine output, vital signs, oxygen saturation, and respiratory status closely. Notify the provider immediately if there were any changes in respiratory status, urine output, or worsening edema. The 01/25/2026 at 9:20 AM, Nurse Practitioner #37 progress note documented nursing staff called and reported the resident complained of itching and mild pain eye pain. Given new symptoms of eye pain in the presence of facial edema and renal failure the resident would be sent to the hospital for further evaluation. The 01/29/2026 Physician #34 progress note documented the resident was readmitted to the facility. They recently were started on losartan (high blood pressure medication) and presented with angioedema (deep facial swelling) due to losartan. The medication was discontinued, and allergy list was updated. The resident's hospital course was complicated by acute congestive heart failure (a life-threatening medical emergency characterized by rapid onset of severe symptoms due to fluid buildup in the lungs and body), acute kidney injury, and chronic kidney disease. Management included furosemide (diuretic) 40 milligrams twice daily, and renal dietary restrictions including 1500 milliliter fluid restriction. Physician orders documented:-on 01/29/2026 - 02/03/2026: weekly weights every day shift on Tuesday for weight monitoring-on 01/30/2026 - 02/25/2026: 40 milligrams of Furosemide twice daily for edema -on 02/03/2026: Renal (a diet limiting sodium, potassium, phosphorus, to reduce kidney workload), no concentrated sweet, and 1500 milliliter fluid restriction. –on 02/03/2026 - 03/10/2026: weights upon admission, the next day, and weekly for four weeks thereafter. If no noted weight concerns weights would be monitored monthly. -on 02/04/2026: remove compression stockings before bed for bilateral lower extremity for 3+ pitting edema (swelling that leaves indentation after pressure is applied).-on 02/05/2026: apply compression stockings in the morning for (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bilateral lower extremity 3+ pitting edema. The resident's weight record documented: -on 02/01/2026 166.8 pounds-on 02/10/2026 178.6 pounds (11.8 pound/ 7% gain) in nine (9) days. There was no documentation that a reweigh was obtained. There was no documented evidence that a reweight was obtained and the medical provider was notified of the severe weight gain from 02/02/2026 to 02/10/2026. The 02/11/2026 Registered Dietitian #3 progress note documented the resident's weight on 02/10/2026 was 178.6 pounds, this was greater than five (5) pound change from previous weight and a reweight was requested. There was no documented evidence that a reweight was obtained and the medical provider was notified of the severe weight gain from 02/02/2026 to 02/10/2026. On 02/16/2026 Registered Nurse #35 documented the resident had 2+ edema, their face edema had increased, and labs were drawn. There was no documented evidence of a weekly weight on 02/17/2026. The 02/19/2026 Registered Nurse #35 progress note documented the resident had 2+ edema, their face edema had increased, and labs were drawn. The 02/20/2026 Licensed Practical Nurse #36 progress note documented the resident's lower extremities were swollen, the supervisor was made aware, and compression stockings would not be worn due to swelling. There was no documented evidence the medical provider was notified of the resident's worsening edema. The 02/24/2026 Assistant Director of Nursing/ Licensed Practical Nurse #8 progress note documented the resident had increased angioedema, was unable to open eyes, and complained of difficulty breathing. Their bilateral lower extremities were observed with 4+ pitting edema (indicates significant fluid retention). Medical was notified and the resident would be sent to the hospital. The 02/24/2026 Physician #34 progress note documented the resident reported difficulty breathing and facial swelling. They were unable to open their eyes due to increased angioedema. They had bilateral lower extremity 4+ edema. Their assessment documented acute angioedema with airway compromise, fluid overload secondary to chronic kidney disease with pulmonary (lung) congestion, and significant peripheral edema. The resident was to be sent to the emergency room for acute management. The 01/24/2026 hospital emergency department summary documented the resident presented with facial and leg swelling. The resident was ill-appearing, had diffuse facial swelling, decreased breath sounds, and right and left lower leg edema. During an interview on 04/17/2026 at 1:17 PM, Certified Nurse Aide #14 stated the registered dietitian provided the unit with a weight list for monthly weights. The Director of Nursing provided a list of (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	weekly weights and the certified nurse aides obtained weights. Resident #3 had weight fluctuations related to their fluid status and was on weekly weights. During an interview on 04/17/2026 at 1:46 PM, Licensed Practical Nurse #16 stated residents were weighed as ordered. Weights were obtained as soon as possible and if a resident refused to be weighed nursing would document the refusal. They did not know if Resident #3 had any weight changes. During an interview on 04/17/2026 at 1:47 PM, Assistant Director of Nursing #8 stated weights were obtained as ordered and the registered dietitian requested reweights as needed. Significant weight changes were discussed during the weekly weight meeting, and the registered dietitian notified the medical provider of any significant weight changes. They were unsure if Resident #3 had any significant weight changes, but they went to the hospital for fluid overload. The facility was monitoring their edema and if staff were unable to obtain the resident's weight, they should notify the nursing supervisor and document the weight was unable to be obtained. During an interview on 04/17/2026 at 1:59 PM, Registered Dietitian #3 stated the weight process recently changed at the facility as they were having issues getting weights as ordered. The Director of Nursing or the Assistant Director of Nursing provided the units with a weight list. Any resident who had a weight change of five (5) pounds should have a reweight. Residents who had a significant weight change were discussed in the weekly weight meeting. The medical team did not always attend the weight meetings, and they notified the medical provider verbally of any significant weight changes. Resident #3's weights were not obtained as ordered and they had fluctuations. It was important to obtain weights as ordered to monitor the resident's fluid status. During an interview on 04/17/2026 at 2:44 PM, Nurse Practitioner #7 stated they expected weights to be obtained as ordered, and if the resident refused it should be documented. Medical attended the weight meeting if they were in the building and if they were not at the meeting they would expect to be notified. They expected the medical providers to assess the resident and document on significant weight changes if they were notified. During an interview with the Director of Nursing on 04/17/2026 at 2:50 PM, they stated weights were to be obtained as ordered, the registered dietitian provided a list to the units of who needed to be weighed and any needed reweights. The facility had a weekly weight meeting and discussed significant weight changes. 10 New York Codes, Rules, and Regulations 415.3(2)(ii)(a)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observations, record review, and interviews, the facility failed to ensure services provided met professional standards of clinical practice for one (1) of four (4) residents (Resident #7) reviewed. Specifically, Resident #7 regularly refused their ordered inhaler and nebulizer treatments (respiratory treatments) and there was no documented evidence the physician was notified of the refusals or reviewed the resident's medication administration records during their monthly visits; there was no documented evidence the irregularity of the refused medications were noted by the pharmacist during their monthly medication reviews; and there was no documented evidence of a care plan related to the resident's refusals of their medications. Findings include: The facility policy Medication Orders, last reviewed 01/2025, documented each resident must be under the care of a licensed physician authorized to practice medicine in this state and must be seen by the physician at least every sixty days. A current list of orders must be maintained in the clinical record of each resident. Physician orders and progress notes must be signed and dated every thirty days unless the frequency was increased to 60 days by the attending physician and the Utilization Review Committee. The facility policy Medication Regime Review, revised 08/2025, documented the consultant pharmacist performed a comprehensive medication regimen review at least monthly. The review included evaluating the resident's response to medication therapy to determine that the resident maintains the highest practicable level of functioning and prevents or minimizes adverse consequences related to medication therapy. In performing medication regimen reviews, the consultant pharmacist incorporates federally mandated standards of care, in addition to other applicable professional standards. The consultant pharmacist identifies irregularities through a variety of sources including medication administration records. Resident-specific irregularities and/or clinically significant risks resulting from or associated with medications are documented on a Medication Regimen Review form and reported to the Director of Nursing, physician and the Medical Director. Resident #7 had diagnoses including chronic obstructive pulmonary disease (lung disease) and cerebral palsy. The 02/22/2026 Minimum Data Set documented the resident had severely impaired cognition, had no behavioral symptoms, and required moderate assistance for all activities of daily living. The 08/19/2024 Comprehensive Care Plan, revised 09/05/2025, documented the resident had an alteration in their respiratory system related to chronic obstructive pulmonary disease, being a smoker, shortness of breath while lying flat and a lung nodule. Interventions included administer treatments (nebulizer) and medication per the medical orders, provide psychiatric services for anxiety or fear, and observe vital signs as ordered and report to the medical provider any abnormalities. Physician orders documented:-on 06/12/2025 inhale 3 milliliters of ipratropium-albuterol Solution 0.5-2.5 milligrams/3 milliliters orally three times a day for chronic obstructive pulmonary disease and lung nodule.-on 11/17/2025 inhale 2 milliliters of budesonide inhalation suspension 0.5 milligrams/2 milliliters orally two times a day for chronic obstructive pulmonary disease and asthma wheeze and rinse mouth after. The March 2026 Medication Administration Record documented the resident refused their two budesonide inhalation suspension 0.5 milligram/2 milliliter except for the:- 8:00 AM dose on 03/03/2026, 03/10/2026, and 03/24/2026;- 7:00 PM dose on 03/02/2026, 03/06/2026, 03/07/2026, 03/10/2026, 03/11/2026, 03/13/2026, 03/14/2026, 03/20/2026, 03/21/2026, 03/24/2026, 03/25/2026, and 03/28/2026. The March 2026 Medication Administration Record documented the resident refused their ipratropium-albuterol Solution 0.5-2.5 milligram/3 milliliter except for the:- 8:00 AM dose on 03/03/2026, 03/10/2026 and 3/24/2026;- 2:00 PM dose on 03/06/2026, 03/10/2026, 3/13/2026, and 3/24/2026;- 7:00 PM dose on 03/02/2026, 03/06/2026, 03/10/2026, 03/11/2026, 03/13/2026, 03/14/2026, 03/20/2026, 03/21/2026, 03/24/2026, 03/25/2026, and 03/28/2026. The April 2026 Medication Administration Record documented the resident refused their budesonide inhalation suspension 0.5 milligram/2 milliliter except for the:- 8:00 AM dose on 04/04/2026 and 04/07/2026;- 7:00 PM dose on 04/02/2026 through 04/04/2026, 04/07/2026, 04/08/2026, (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	04/11/2026, 04/13/2026, 04/15/2026, and 04/16/2026. The April 2026 Medication Administration Record documented the resident refused their ipratropium-albuterol Solution 0.5-2.5 milligram/3 milliliter except for the:- 8:00 AM dose on 04/04/2026- 2:00 PM dose on 04/08/2026- 7:00 PM dose on 04/03/2026, 04/04/2026, 04/07/2026, 04/08/2026, 04/11/2026, 04/13/2026, 04/15/2026, and 04/16/2026 There was no documented care plan related to the resident's refusals of medications. The 03/28/2026 Physician #30 progress note documented the resident was seen for a routine monthly follow up and medication review. The staff reported no shortness of breath or any new or worsening concerns. The plan of care for the resident's chronic obstructive pulmonary disease was the resident was stable on albuterol nebulization 2.5/3 milliliter inhale and budesonide inhalation 0.5mg/2 milliliters inhaler twice daily. There was no documented evidence the provider was notified regarding the resident refusals of budesonide inhalation suspension or ipratropium-albuterol solution breathing treatment, or a review of the resident's medication administration record was completed. The February and March 2026 pharmacy reviews completed by Pharmacist #40 had no recommendations or irregularities noted. During an interview on 04/07/2026 at 10:36 AM, Licensed Practical Nurse #26 stated if a resident refused medications or treatments, they tried to educate the resident on the medication and encourage them to take it. If a resident still refused their medication or treatment, they notified Registered Nurse Unit Manager #4 and wrote a progress note. Resident #7 had not taken their inhaler or nebulizer treatment for a long time. They inquired about getting the medications discontinued or made as needed since the resident did not take them. During an interview on 04/17/2026 at 12:11 PM, Registered Nurse Unit Manager #4 stated if a resident refused a medication or treatment the nurse should tell them as the unit manager, and they should probably tell someone else. They were aware Resident #7 refused both their inhaler and their nebulizer treatment on a consistent basis. The resident did not even allow the nebulizer machine in their room. They had a conversation with the provider, who was no longer at the facility, about getting rid of the orders. They believed they had a conversation with the current providers but was unsure. They tried to discontinue the orders themself but was unable to. If the orders were not going to be discontinued, the resident should have a refusal care plan. During an interview on 04/17/2026 at 1:48 PM, Medical Director #38 stated ideally the medical provider should review the medication and treatment administration records for medication compliance. The medical team should be notified if a resident was consistently refusing an inhaler or a nebulizer. They met with Resident #7 on 04/16/2026 regarding their pulmonary history and lung nodule/pulmonary mass. They stated they were unaware the resident did not consistently take their inhaler or nebulizer. That is something they should have been made aware of as the resident may not need to be on the medications if they were stable without them. During an interview on 04/17/2026 at 2:04 PM, Pharmacist #40 stated they reviewed the resident's medication and treatment administration records for medication compliance when they did a pharmacy review. If they noticed a resident had a lot of refusals, they read the nursing progress notes to see if there was a pattern and they would write it up. During a follow up interview at 2:33 PM, Pharmacist #40 stated they met with the Director of Nursing and the nurses every month to go over medications and discontinue unnecessary medications. They were aware Resident #7 was refusing their inhaler and their nebulizer treatment and had put in their own notes that the resident had a lung nodule and chronic obstructive pulmonary disease. When a resident had diagnoses such as these attached to the medications, they did not recommend discontinuing medications as it was out of their scope. 10 New York Codes, Rules, and Regulations 415.11(c)(3)(i)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for one (1) of one (1) resident (Resident #85) reviewed. Specifically, Resident #85 was admitted to the facility, was not assessed by a registered nurse until three (3) days later on the day they were discharged against medical advice; physician orders were not completed; treatments were not provided as ordered; diagnostic testing was not completed as ordered; and care was not provided for two (2) of nine (9) shifts during the residents admission. Additionally, when the resident was discharged against medical advice there was no documented evidence of who the resident left with, if education was provided to the resident, and if a medical provider was notified. Findings include: There was no documented evidence of a policy addressing admission assessments by a registered nurse. The undated facility admission Agreement documented residents received basic services including 24-hour a day professional nursing care. The facility policy Against Medical Advice, revised 08/2025, documented residents and family members understood their rights to request an immediate discharge without physician's approval. Nursing staff informed medical staff and social work if a resident or representative requested an immediate discharge. The Director of Social Work notified the Director of Admissions, Director of Nursing, and the Administrator of the resident leaving against medical advice. Medical staff/ social work documented and discussed with the resident and family member the current medical condition and consequences of discharge. Prescriptions were provided at the physician's discretion. Social work asked where they were going and how they were going to get there. Social Work called Adult Protective Services regarding the discharge. Social work documented in the Medical Record the names of the individuals they spoke with from various agencies. Resident #85's 03/18/2026 at 10:00 AM Hospital Discharge Summary/Instructions documented the resident was hospitalized from [DATE] through 03/18/2026. The resident was in the intensive care unit until 03/11/2026 when they were transferred to a medical floor. They were critically ill and required mechanical ventilation three (3) times, emergency surgery, medications to maintain their blood pressure, intravenous antibiotics, artificial feeding (tube delivered nutrition directly to the stomach), and had a post-surgical wound vacuum (device used to close wounds). Follow up care with surgery, neurology, neurosurgeon, cardiovascular, and primary care provider was recommended. Their discharge diagnoses included atrial fibrillation and flutter (irregular heartbeat), acute respiratory failure (breathing problems), stomach perforation (hole through the stomach wall), upper gastrointestinal hemorrhage (internal bleeding), acute kidney failure, ischemic stroke (blood flow and oxygen are cut off to part of the brain) with dysphagia (difficulty swallowing), and expressive language disorder (difficulty with verbal communication). Activity recommendations included activity as tolerated, three (3) liters of oxygen via nasal cannula continuously, bilevel positive airway pressure mask (device that aids breathing) at night. Dietary recommendations included mechanical soft texture with nectar thickened liquids and one (1) can of Ensure High Protein (nutritional supplement) twice a day. Additional instructions documented wound care with wound cleanser, pack with moistened kerlix, cover with dry gauze and change daily. The resident was discharged to the facility for short term rehabilitation. There was no documented evidence of a nursing progress notes addressing the resident's admission to the facility. There was no documented evidence a nursing admission assessment was completed. The 03/18/2026 facility staffing documented there was not a registered nurse working on the evening or night shifts. The 03/17/2026 physician orders with a start date of 03/18/2026 documented:-By Physician #38 pre-assessment: administer incentive spirometer (a device used to expand lungs) therapy to resident at least daily for 14 days to assist with lung function.-By Physician #34 post assessment: administer incentive spirometer therapy to resident at least daily for 14 days to assist with lung function. There was no documented evidence the resident was provided with incentive (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	spirometry therapy or pre and post assessments were completed. The 03/18/2026 physician orders documented:-By Nurse Practitioner #39, cleanse abdominal incision/wound with wound cleanser, pack with moistened gauze, and cover with dry gauze daily. There were no orders for wound monitoring. -By Physician #34, laboratory tests including complete blood count with differential (lab test that measures blood cells), iron, folate, ferritin, total iron binding capacity, complete metabolic panel, prealbumin level, lipid profile, liver function tests, vitamin D, glycated hemoglobin (HgbA1C), thyroid-stimulating hormone, and free thyroxin, Vitamin B12 (diagnostic blood tests) one time only for monitoring. There was no documented evidence the abdominal wound was assessed/ monitored, or the diagnostic blood tests were collected. The 03/19/2026 physician orders documented:-By Physician #34, drain the Jackson Pratt drain (removes extra fluids from a surgical site) to the abdomen every shift status post full exploratory laparotomy (abdominal surgery); oxygen via nasal cannula at three (3) liters per minute continuously for acute respiratory failure with hypoxia (lungs do not oxygenate the blood sufficiently). There were no orders for site monitoring or dressing changes around the drain site.-By Nurse Practitioner #39, complete blood count, complete metabolic panel, phosphorus, and magnesium (diagnostic blood tests) one time related to acute kidney failure. There was no documented evidence the drain site was assessed, a dressing around the drain was changed, or the diagnostic blood tests were collected. There was no documented evidence of a physician order for the use of bilevel positive airway pressure mask at night. The 03/20/2026 at 9:25 AM, Director of Social Work admission assessment documented the resident's family was supportive and motivated to have the resident return to their home to care for them. The family ordered a mechanical lift for the home. The 03/20/2026 at 12:33 PM, Registered Nurse #35 progress note documented the resident's family wished to take them home and would purchase a mechanical lift if needed. The 03/21/2026 at 7:57 AM Registered Nurse #23 admission progress note documented the resident was admitted on [DATE] at 1:16 PM from an acute hospital for short term rehabilitation (four days after admission). The 03/21/2026 at 2:21 PM Registered Nurse #23 progress note documented the resident was not satisfied with the care provided at the facility. Their abdominal dressing was changed this morning, and their oxygen was on. There was no documented evidence the resident received activity of daily living care on 03/20/2026 on the evening shift, or on 03/21/2026 on the day shift. The 03/21/2026 Discharge Minimum Data Set assessment (a health status assessment tool) documented return was not anticipated. The discharge was unplanned, and the resident was discharged home. The resident had severely impaired cognitive decision-making skills. The resident required substantial/ maximum assistance or was dependent with most activities of daily living. The 03/21/2026 facility transfer/discharge report documented the resident was discharged at 3:00 PM to a private home with no home health services. The 03/21/2026 at 3:09 PM Post admission Note by Registered Nurse #23 documented the resident was admitted on [DATE]. They had skilled needs for rehabilitation, nutritional, respiratory, cardiac, and wounds. They received physical, occupational, and speech therapies. They required assistance of two for activities of daily living. Required nursing interventions included medication and treatment administration as per physician orders, intakes and outputs were monitored, assistance with activities of daily living, Jackson Pratt drain care and abdominal wound dressing changes. They needed a ground texture diet with nectar thickened liquids and aspiration precautions. They received oxygen via nasal cannula at three (3) liters per minute continuously. There was no documented evidence the resident left against medical advice; who they left with; or if they/ their representative were educated on their medication conditions, altered diet, medications, wound care, care of the Jackson Pratt drain, oxygen therapy, follow up care with their medical providers, and risks of leaving against medical advice; and the medical provider was notified. The 03/23/2026 at 9:30 AM Director of Social Work progress note documented they were updated the resident left against medical advice on 03/21/2026. They called the resident's family that morning, left a voicemail message, and was waiting for a call back. They contacted Adult Protective Services to relay contact information. The note did not document who they spoke with at Adult Protective Services or if the (continued on next page)

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	335233	A. Building B. Wing	04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Park Rehabilitation and Nursing Center	950 Floyd Avenue Rome, NY 13440

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medical provider was notified. The 03/23/2026 at 1:15 PM, Physician #38 progress note (late entry) documented it was confirmed the resident left against medical advice from a social work note that posted on 03/23/2026. There was no documentation about medical team involvement. During an interview on 04/17/2026 at 9:53 AM, Certified Nurse Aide #14 stated when there was a new admission, they introduced themselves, got their weight, and oriented them to their room. The nursing supervisor or any registered nurse could go in and do their assessment. In the event a resident wished to discharge against medical advice, they would get any staff member that was above them. They did not recall Resident #85. During an interview on 04/17/2026 at 10:08 AM, Licensed Practical Nurse #16 stated when a new admission came in, the resident received an entrance packet, was weighed, and initial vital signs were obtained. They then informed the Director of Nursing there was a new admission or the Unit Manager to do an assessment. They did not currently have a unit manager, so the Assistance Director of Nursing was filling in that role. The admission assessment was completed by a registered nurse as soon as they arrived within 24 hours. If a resident wanted to leave against medical advice, they talked to them to determine what the issue or driving force was. They informed the Director of Social Work to intervene. If the resident did leave against medical advice, they charted a nursing note and notified the supervisor. They did not recall Resident #85. During an interview on 04/17/2026 at 10:16 AM, the Assistant Director of Nursing stated they were covering as the A wing unit manager. In the event of an admission, they greeted the resident, obtained a weight, and escorted them to their room. They notified all department heads, told the staff on the floor, and obtained a diet order. They could not assess them as a licensed practical nurse so either B wing Registered Nurse Unit Manager #4, the Director of Nursing, or the registered nurse supervisor on the evening shift was responsible the resident was assessed within 24 hours. If a resident wished to leave against medical advice, they educated them on the risks associated and tried to convince them otherwise because it was not in their best interest. They could not assist residents that were discharged against medical advice, and they were on their own. There was a paper they signed if they discharged against medical advice. There was a progress note, and the orders were discontinued. Adult Protective services and the resident's primary care provider were notified. They did not recall Resident #85 but looked up their electronic medical chart. They were not assessed by a registered nurse within 24 hours. The admission assessment was important to ensure orders and care were correctly coordinated. There was not a nursing note indicating the resident left against medical advice. The medical team should have been notified if a resident left against medical advice in case there was something they needed to tell them. During an interview on 04/17/2026 at 1:43 PM, the Director of Social Work stated if a resident wanted to leave against medical advice, they notified a medical provider if they were present and if not a nurse or a nurse supervisor. If the resident was adamant about leaving, they signed an against medical advice form. They documented in a note the form was signed, who the resident left with, and that adult protective services was notified. If this happened during off hours, the supervisor or a nurse should enter a progress note. Resident #85 left on a Saturday (03/21/2026) and they found out about it on Monday (03/23/2026). They did not recall how they found out. There was no nursing documentation. Physician #38's note documented they found out from their progress note the following Monday. Things needed to be explained to the resident medically, so they understood the severity of the risks. During a telephone interview on 04/17/2026 at 1:48 PM, Physician #38 stated a member of the medical team optimally was notified if a resident wished to leave against medical advice. That way the medical team had the opportunity to interact with the resident and answer any questions to ensure their safety, reviewed risks versus benefits and alternatives to ensure continuity of care and safe transitions, and provided a bridge of therapy while in the transition from skilled nursing to the outpatient world. They looked up Resident #85 in the electronic medical record and recalled they were not at the facility for long. They were not notified of the discharge against medical advice in real time. The resident was discharged on a Saturday but there was an on-call service and a satellite team that could have facilitated the opportunity to interact with the resident for the (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	previously stated reasons. During an interview on 04/17/2026 at 2:36 PM, the Director of Nursing stated Resident #85 was admitted on [DATE]. admission assessments were expected to be completed within 24 hours by the registered nurse on duty. The order notes went in around 3:30 PM by the Assistant Director of Nursing and they should have contacted the registered nurse supervisor. There should have been a registered nurse for the evening shift. The resident did not have a registered nurse assessment until 03/21/2026 on the day they discharged against medical advice. The admission assessment was to determine what the resident needed to be properly cared for. There was a social work note the resident left against medical advice. The registered nurse supervisor was responsible to ensure medical was notified and it was documented. The resident signed an against medical advice form, but Resident #85 did not have one in their electronic record. Also, education on the risks of leaving against medical advice should have been provided but they did not see documentation of that either. The resident's electronic record did not reveal where they went, who they went with, why, and if any education was provided, so there was really no way of knowing what happened. 10 New York Codes, Rules, and Regulations 415.12

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observations, record review, and interviews (IQIES Intake 2577870), the facility failed to ensure residents with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote wound healing, prevent infection, and prevent new ulcers from developing for one (1) of three (3) residents (Resident #64) reviewed. Specifically, Resident #64's wound treatments were not completed as ordered.Findings include:The facility policy Wound Care, reviewed 01/2025, documented during wound care preparation, staff should verify there was a physician's order for the procedure, review the resident's care plan to assess any special needs of the resident, and assemble the equipment and supplies as ordered to perform the procedure. Following the procedure, information should be documented in the resident's medical record. If the resident refused the treatment, document the reason why and notify the supervisor.Resident #64 had diagnoses including dementia, adult failure to thrive (overall physical decline), and a Stage 4 pressure ulcer (full thickness tissue loss with exposed tendon or muscle) of the left heel. The 03/23/2026 Minimum Data Set (a resident assessment tool) documented the resident had moderately impaired cognition; required substantial/maximal assistance with personal hygiene; was dependent for bed mobility; had one (1) Stage 4 pressure ulcer; had one (1) unstageable (full thickness tissue loss in which the base of the ulcer is covered by dead tissue) pressure ulcer presenting as a deep tissue injury (purple/maroon localized area of discolored intact skin due to underlying tissue damage); had moisture associated skin damage; had pressure reducing devices for the bed and chair; and had pressure ulcer/injury care.The 06/25/2025 comprehensive care plan, revised 11/23/2025, documented the resident had alteration in skin integrity with a Stage 4 pressure ulcer to the left heel related to impaired mobility and poor nutrition. Interventions included monitor dressing daily to ensure it was clean, dry and intact, ensure heel protector was in place, and assess the wound weekly.The 02/25/2026 Comprehensive Care Plan documented the resident had alteration in skin integrity with an unstageable pressure ulcer to the right heel related to impaired mobility and poor nutrition. Interventions included monitor dressing daily to ensure it was clean, dry and intact, ensure heel protector was in place, and assess wound weekly.Physician orders documented the following wound care orders:-on 01/30/2024 apply skin prep (protective barrier) to top of toes on bilateral feet every day shift for skin integrity.-on12/17/2025 apply skin prep to the left second toe every day shift for wound care.-on 01/05/2026 wash buttocks, pat dry, apply thick layer of zinc cream (skin protectant) every shift for moisture associated skin damage.-on 03/12/2026 cleanse left heel with wound cleanser, pat dry, apply skin prep to periwound (skin around the wound edge), apply Medihoney (medical-grade honey) to the wound bed, cover with dry gauze, wrap with Kling (rolled gauze), and secure with tape every evening shift and a needed for wound care.-on 03/12/2026 cleanse right heel with wound cleanser, pat dry, apply skin prep to periwound, apply Xeroform (petroleum dressing) to the wound bed, cover with abdominal pad, wrap with Kling, and secure with tape every evening shift and as needed for wound care.-03/12/2026 cleanse scabbed area on the left dorsal (top) foot with wound cleanser, pat dry, and apply skin prep every evening shift for wound care.The April 2026 Treatment Administration Record documented:-apply skin prep to top of toes on bilateral feet every day shift for skin integrity was not completed on 04/02/2026 by Licensed Practical Nurse #26, 04/04/2026 by Licensed Practical Nurse #31, 04/06/2026 by Licensed Practical Nurse #26, and 04/07/2026 by Licensed Practical Nurse #31.-apply skin prep to the left second toe every day shift for wound care was not completed on 04/02/2026 by Licensed Practical Nurse #26, 04/04/2026 by Licensed Practical Nurse #31, 04/06/2026 by Licensed Practical Nurse #26, and 04/07/2026 by Licensed Practical Nurse #31.-cleanse left heel with wound cleanser, pat dry, apply skin prep to periwound, apply Medihoney to the wound bed, cover with dry gauze, wrap with Kling, and secure with tape every evening shift for wound care was not completed on 04/05/2026 by Licensed Practical Nurse #32.-cleanse right heel with wound cleanser, pat dry, apply skin prep to periwound, apply (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Xeroform to the wound bed, cover with abdominal pad, wrap with Kling, and secure with tape every evening shift for wound care was not completed on 04/05/2026 by Licensed Practical Nurse #32.-cleanse scabbed area on the left dorsal foot with wound cleanser, pat dry, and apply skin prep every evening shift for wound care was not completed on 04/05/2026 by Licensed Practical Nurse #32.-wash buttocks, pat dry, apply thick layer of zinc cream every shift for moisture associated skin damage was not completed on 04/02/2026 day shift by Licensed Practical Nurse #26, 04/04/2026 day shift by Licensed Practical Nurse #31, 04/05/2026 evening shift by Licensed Practical Nurse #32, 04/06/2026 day shift by Licensed Practical Nurse #26, and 04/07/2026 day shift by Licensed Practical Nurse #31.During an interview on 04/17/2026 at 10:36 AM, Licensed Practical Nurse #26 stated they looked at physician orders to determine what kind of wound care a resident needed and after they completed the wound care, they signed it off in the treatment administration record. If it was not signed off it may not have been done. Resident #64 had wounds and orders to complete wound care but when they worked by themself, they were busy and had to focus on passing medications, so sometimes they could not complete the wound care even though they should have completed it before they left for the day.During an interview on 04/17/2026 at 12:11 PM, Registered Nurse Unit Manager #4 stated all wound care should be completed as ordered. If there was no documentation or it was not signed off in the treatment administration record, that meant it was not completed. The nurses sometimes asked for their assistance if they were unable to complete wound care, but they usually had a ton of things to get done themself, so they did not often assist. They were not notified that Resident #64 had various wound care orders not completed. During an interview on 04/17/2026 at 2:13 PM, Wound Nurse Practitioner #33 stated they recently started doing the wound rounds at the facility and they did not have access to the facilities documentation, so they went off the nursing report that was given to them. Resident #64's wounds stayed the same based off report but looked better than last week. They were not aware of any open areas on Resident #64's buttocks but the nurses should have been completing the wound care as ordered. 10 New York Codes, Rules, and Regulations 415.12(c)(1)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observations, record review, and interviews, the facility failed to ensure residents who were fed by enteral means (tube feeding, delivery of nutrition directly to the stomach or small intestine) received the appropriate treatment and services to prevent complications of enteral feeding for one (1) of one (1) resident (Resident #52) reviewed. Specifically, Resident #52's tube feeding was not infusing at the ordered rate; they did not receive their water flushes as ordered; their tube feeding was not dated: and their tube feeding pump was unclean with brownish streaks on the monitor. Findings include: The facility policy Enteral Feeding Via Continuous Pump, revised 03/2022, documented to verify the physician order and connect the infusion pump set rate, and press start. The facility policy did not document dating and timing of tube feeding when administered. Resident #52 had diagnoses including cerebral palsy (neurological disorders affecting movement), dysphagia (difficulty swallowing), and Alzheimer's Disease. The 04/16/2026, Minimum Data Set (a resident assessment tool) documented the resident had severely impaired cognition, did not reject care, weighed 158 pounds, and received nutrition through a feeding tube.The comprehensive care plan initiated 02/15/2024, and revised 12/11/2025, documented the resident required a tube feeding related to poor nutrition and dysphagia. Interventions included to administer water flushes and tube feeding as ordered.Physician orders documented:-12/08/2025 nothing by mouth and 100 milliliters free water flushes before and after each feeding twice daily, at 2:00 PM and 10:00 AM.-01/04/2026 150 milliliters free water flushes three (3) times daily via percutaneous endoscopic gastrostomy (a type of feeding tube) tube every shift. -03/17/2026 30 milliliters of liquid protein supplement once daily, for nutrition, via percutaneous endoscopic gastrostomy tube.-03/17/2026 Jevity 1.5 (tube feeding formula) at 55 milliliters an hour for 20 hours/ day via percutaneous endoscopic gastrostomy tube, start time 2:00 PM and end time 10:00 AM.The 03/17/2026 at 3:12 PM Registered Dietitian #3 Nutrition Assessment documented based on estimated nutritional needs, they recommended to increase the resident's tube feeding rate from 50 milliliters an hour to 55 milliliters an hour for 20 hours a day. This would provide 1750 calories, 85 grams protein, and 1846 milliliters of free water, meeting 99% of their estimated calorie needs, 100% protein needs, and greater than 100% of their fluid needs. They discussed their plan with the nurse practitioner and the Assistant Director of Nursing. The resident remained at high nutritional risk. The April 2026 Medication Administration Record documented Jevity 1.5 (tube feeding formula) at 55 milliliters an hour for 20 hours/ day via percutaneous endoscopic gastrostomy tube, start time 2:00 PM and end time 10:00 AM. Licensed Practical Nurse #5 documented they started the tube feeding and it was infusing at the ordered rate of 55 milliliters on 4/15/2026 at 2:00 PM.The following observations were made:-on 04/14/2026 at 11:16 AM, the resident was in bed. A plastic bottle of Jevity 1.5 was hanging from the tube feeding pump and was not dated or timed. The tube feeding pump monitor was unclean with brownish streaks on it. -on 04/15/2026 at 3:15 PM, the resident was in bed. The pump indicated the tube feeding was infusing at 50 milliliters per hour and 201 milliliters of formula had infused. -on 04/15/2026 at 3:52 PM, the resident in bed. The pump indicated the tube feeding was infusing at 50 milliliters per hour and 234 milliliters of formula had infused.-on 04/16/2026 at 7:24 AM, the resident was in bed. The pump indicated the tube feeding was infusing at 50 milliliters per hour and 23 milliliters had infused. At 8:37 AM, The pump indicated the tube feeding was infusing at 50 milliliters per hour and 87 milliliters had infused. The tube feeding pump monitor was unclean with brownish streaks on it.-on 04/16/2026 at 9:45 AM, the resident's tube feeding pump was alarming and was heard in the hallway. At 9:53 AM, Licensed Practical Nurse #6 donned personal protective equipment and entered the resident's room. They observed the tube feeding pump was alarming and checked the bottle of tube feeding formula. They stated the formula needed to be replaced, as it was empty. They turned off the tube feeding pump, doffed personal protective equipment, and exited the resident's room to gather (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	supplies. At 10:00 AM, Licensed Practical Nurse #6 donned personal protective equipment and entered the resident's room. They shook a 1000 milliliter plastic bottle of Jevity 1.5 and dated the bottle and a plastic piston syringe. They stated they thought the tube feeding infused at 50 milliliters an hour, as that is what they saw on the pump prior to turning it off. They attached the new bottle of formula to the resident's percutaneous endoscopic gastrostomy tube. They checked for gastric residuals (amount of formula, water, and digestive fluids remaining in the stomach) and gastric Ph (acid-alkaline ratio) of the gastric contents. They flushed the percutaneous endoscopic gastrostomy tube with 60 milliliters of water, turned on the pump, which was set at 50 milliliters and hour and exited the room. The tube feeding pump monitor remained unclean with brownish streaks on it.During an interview on 04/16/2026 at 10:48 AM, Licensed Practical Nurse #6 stated prior to administering tube feedings and water flushes staff should check the physician orders to ensure the proper amount of fluids, correct tube feeding formula, and correct rate. They did not review or verify the resident's tube formula or water flush orders prior to administering the tube feeding and water flushes. They stated they reviewed the order after exiting the room and shut off the feeding pump, as the resident's feeding ended at 10:00 AM. Staff should always check the orders as the resident relied on the tube feeding and water flushes to meet their nutritional and hydration needs. During an interview on 04/16/2026 at 11:42 AM Registered Nurse Unit Manager #4 stated all physician orders including tube feeding and water flushes should be followed. Staff should review the orders prior to administering the tube feeding and water flushes to ensure accuracy. If the order was not followed it could have an impact on their nutritional, hydration, and weight status. They were unaware the resident did not receive their tube feeding or water flushes as ordered.During an interview on 04/17/2026 at 11:43 AM Licensed Practical Nurse #5 stated they were supposed to verify the physician orders prior to administering the tube feeding. They did not check the physician orders prior to administering the resident's tube feeding on 4/15/2026. If the resident did not receive their tube feeding as ordered, they would not receive all the nutrients they required. Staff should wipe down the tube feeding pump anytime it was unclean as it was not homelike.During an interview on 04/17/2026 at 12:09 PM Nurse Practitioner #7 stated they expected staff to follow the physician orders for tube feeding and water flushes. They expected to be notified if a resident did not receive their tube feeding or water flushes as ordered, and they were not notified about Resident #52. The resident was dependent on their tube feeding and water flushes to maintain their nutritional and hydration status. During an interview on 04/17/2026 at 2:01 PM Registered Dietitian #3 stated nursing staff should administer the tube feeding and water flushes as ordered. They recommended to increase the resident's tube feeding rate in March 2026 to maintain their usual body weight of 150 pounds. If a resident did not receive their tube feeding or water flushes as ordered it could impact their nutritional, hydration, and weight status. They were not aware the resident did not receive their tube feeding as ordered and would expect to be notified. 10 New York Codes, Rules and Regulations 415.12(g)(2)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observations, record review, and interviews the facility failed to ensure that residents who required dialysis (used to filter waste products from the blood when the kidneys do not work properly) received such services consistent with professional standards of practice for one (1) of one (1) resident (Resident #4) reviewed. Specifically, Resident #4 received hemodialysis treatments at a community-based dialysis center and did not have on-going assessments and oversight before and after dialysis treatments including assessment of the dialysis access site.Findings include: The facility policy Dialysis, last reviewed 01/2025, documented a communication log was be used for each resident that leaves the building for the dialysis center to communicate the resident's needs and response to dialysis treatment. The facility was to track and follow up. The policy did not include assessing the dialysis access sites or vital signs.Resident #4 had diagnoses including end-stage renal (kidney) disease. The 02/12/2026 Minimum Data Set assessment (a health status assessment tool) documented the resident was cognitively intact and required hemodialysis treatments.The comprehensive care plan initiated 08/05/2025 documented the resident needed hemodialysis treatments related to kidney failure. Interventions included dialysis three times a week on Monday, Wednesday, and Friday; monitor the hemodialysis port on the right upper chest for signs and symptoms of bleeding or infection and notify the supervisor immediately. The plan did not include pre and post dialysis assessments.The 12/09/2025 updated physician order documented dialysis three times a week, pre and post dialysis assessments, and monitoring of right upper chest dialysis site for signs and symptoms of bleeding and infection every shift.There was no documented evidence that post-dialysis information was reviewed by the facility for all dialysis treatments between 03/16/2026 and 04/13/2026.There was no documented evidence of access site assessments for 03/16/2026, 03/18/2026, 03/20/2026, 03/23/2026, and 04/03/2026 through 04/13/2026.There was no documented evidence of post-dialysis access site assessments for 03/16/2026, 03/25/2026, 03/27/2026, 03/30/2026, and 04/03/2026 through 04/13/2026.There was no documented evidence of completed dialysis communication reports for 03/25/2026, 03/29/2026, 03/30/3026, and 04/01/2026 in the medical record.During an observation on 04/14/2026 at 11:20 AM, Resident #4 had a hemodialysis access site to the right upper chest. The dressing was clean and intact. During an interview on 04/17/22026 at 10:45 AM, Licensed Practical Nurse #16 stated the general procedure for all dialysis residents was before dialysis, they got vital signs, filled out the dialysis communication sheet, and documented the pre-dialysis information in the electronic health record. When the resident returned, they reviewed the comments and recommendations from the dialysis center and transcribed the information from the dialysis communication form into the electronic health record. They were supposed to monitor dialysis access sites every shift because it could be the source of severe medical complications. They reported any concerns to the nursing supervisor. During an interview on 04/17/22026 at 12:15 PM, Assistant Director of Nursing stated the general procedure for all dialysis residents was the licensed practical nurse performed a pre-dialysis evaluation including monitoring the access site and performing vital signs. They recorded this on the dialysis communication form and in the electronic health record. This assessment was repeated upon return to the facility. The licensed practical nurse also looked at return information from the dialysis center and would report significant findings to the nursing supervisor. Staff placed the dialysis communication form in the resident's personal binder kept at the nurse's station where medical records picked them up and scanned them into the electronic health record.10 New York Codes, Rules and Regulations 483.25(l)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. Based on observations, record review, and interviews, the facility failed to ensure each resident received and the facility provided the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for one (1) of one (1) resident (Resident #49) reviewed. Specifically, Resident #49 exhibited behavioral disturbances, did not have a personalized care plan to address triggers or personalized interventions, and the facility did not coordinate with outside behavioral health services for continuity of care. Findings include: There was no documented evidence of a comprehensive care plan policy and an initial care plan policy. Resident #49 had diagnoses including bipolar disorder (fluctuating mood shifts), severe psychotic features (loss of contact with reality), cerebral palsy (movement disorder caused by abnormal brain development or damage), and anxiety. The 03/26/2026 Minimum Data Set documented the resident had intact cognition, had moderate depression, had no behaviors, required moderate assistance or was dependent for all activities of daily living, and received antipsychotic and antianxiety medications. The 06/26/2024 comprehensive care plan, revised 03/23/2026, documented the resident had behavior symptoms including being an inaccurate reporter, accusing others of being verbally aggressive and abusive which were related to their change in environment, mood disorder, and attention seeking. The resident also had inappropriate conversations on the phone on loudspeaker, threw things, punched staff, and talked about staff members to other staff. On 03/19/2025 the resident struck the wall with their left hand and on 03/20/2026 the resident punched a wall. Interventions included the resident was seen by the medical provider on 03/19/2025 and by psychiatry on 03/20/2026 for medication changes, was educated on 03/20/2026 using breathing exercises, had an appointment with their mental health provider on 03/26/2026, administer psychotropic medications as ordered, contract with the resident as needed, determine the cause of behavior and remove resident, distract the resident with activities of interest, to document all behaviors and attempt to identify a patter to target interventions, initiate a psychiatric and psychological evaluation as needed, and modify the environment to reduce episodes of negative behavior. The 06/27/2024 Comprehensive Care Plan, revised 08/04/2025, documented the resident was at risk for alterations in mood due to a diagnosis of anxiety, bipolar and depression. The resident often sought out staff to vent and followed with psychiatric services in the community. Interventions included administering psychotropic medications as ordered, assessing suicidal ideations as needed, encouraging family involvement, encouraging participation in activities offered, encouraging resident to remain social with peers and staff, monitoring for changes in mood, providing opportunities for resident to express themselves, providing support and reassurance, and referring for psychological and psychiatric evaluation as needed. Resident #49's Pre-admission Screening and Resident Review Level II (an in-depth person-centered evaluation required by federal law for nursing facility applicants with suspected or confirmed serious mental illness) documented:- the resident had a history of bipolar with psychotic features and depression. Their symptoms included irritability, feeling hopeless, trouble sleeping, worrying, sadness, and becoming upset when they did not get their way. The resident had a history of paranoia- the staff should provide empathic listening and statements to encourage sense of support, encourage participation in pleasant activities, provide positive reinforcement and redirection. It was helpful to inform the resident what they were doing and why, along with one-to-one attention.- triggers included boredom, feeling people were not listening to them, and not getting their way- it was important to have a good day when everything went right, and their family was supportive. They got mad when people did not treat them well.- coping mechanism included prayer and bible study to manage their symptoms. They also loved the local football team, playing video games, listening to country music, gospel music, cars, and dogs. Staff were to engage the resident in topics of interest and provide opportunities to participate in activities the resident found meaningful.- the resident was (continued on next page)

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	335233	A. Building B. Wing	04/17/2026

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Colonial Park Rehabilitation and Nursing Center	950 Floyd Avenue Rome, NY 13440

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to be provided with the development of a written, person-centered psychiatric plan of care that included how the resident experienced their mental health such as past symptoms, mental health services, what can make the symptoms worse, early signs they were not doing well, and how best to support the resident if symptoms increase. There should also be a list of personalized coping skills, ongoing psychiatric consultations and medication management. The 09/26/2025 Psychiatric-Mental Health Nurse Practitioner #24 progress note documented the resident had recent irritability and behaviors and had frequent disagreements with staff and other residents. Symptom triggers included interpersonal issues and loss of independence. Bible study and prayers seemed to be helpful along with medication and counseling which helped in the past. The 9/29/2022025 Psychiatric-Mental Health Nurse Practitioner #24 progress note documented the resident continued with agitation and paranoia regarding their items being stolen. They had frequent disagreements with staff and other residents and discussed the ways they could have staff moved and reported the staff triggered them. The facility reported they continued to have angry outbursts toward staff and other residents, and the resident reported significant frustration today. The 10/13/2025 hospital social work progress note documented the resident was seen due to anxiousness and restlessness. The resident was anxious related to their frustrations with their current nursing home placement. The resident relied on their faith to get them through their mental health concerns and identified great support through their parents and their faith. The 03/20/2026 Assistant Director of Nursing #8 progress note documented the resident reported punching the wall with their right hand because they were mad. The resident requested an x-ray. They educated the resident on breathing techniques to help calm down without using physical force and the resident demonstrated deep breathing technique. The right upper part of the back of the resident's hand was red. Ice was applied, pain medication was administered, and the on-call physician was notified with no new orders. There was no documented evidence of follow up by the social worker following the resident's episode of punching the wall. The 04/14/2026 Nurse Practitioner #7 progress note documented the resident approached the provider in the office without an appointment and demanded to be seen. The provider counseled the resident that unscheduled, non-emergent concerns must follow the standard workflow and would need to wait their turn. The resident refused to leave the office after multiple requests and was persistent in demanding an evaluation. The resident became increasingly agitated, raised their voice, and expressed dissatisfaction with the provider's recommendation. The resident had a history of attention seeking and psychiatric behavior disorder. The resident also had a history of inappropriate healthcare utilization and insistence on unnecessary interventions, behavioral dysregulation with possible underlying psychiatric components such as manipulative and attention-seeking behaviors. The resident was counseled extensively on appropriate process for medical requests and needed to adhere to facility workflow and advised against independently contacting outside providers to demand care. The facility staff should continue with behavior monitoring and reinforce boundaries consistently across care teams. The resident should also follow psychiatric services. There was no documentation of consultations, follow ups, or collaboration from the resident's outside behavioral health appointments from 12/01/2025 to 04/01/2026. During an interview on 04/14/2026 at 2:04 PM, Resident #49 stated they were agitated earlier in the day because they felt the staff were touching their things when they were not in the room. They stated they calmed down and did their anger management by doing bible studies. They had a psychiatrist and a counselor outside the facility who they thought communicated with the facility. During an interview on 04/16/2026 at 9:58 AM, Resident #49 stated they saw their behavioral health every month starting in December 2025 through February 2026 over the phone and in person in March 2026. They did not know if the facility received the consultation from their appointment in December 2025 but was told by the mental health practice, they did not send the consultations for January 2026 and February 2026 and they did not know why. They stated in March 2026 the mental health practice gave the resident a copy. During an observation on 04/16/2026 at 11:24 AM, Resident #49 angrily approached the nurses' station and threw their hat. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	They were demanding to know where a certified nurse aide was they were angry at because the aide had gotten into an argument with their father in a care conference over lies. The Director of Nursing stood next to the resident while the resident vented and yelled. The Director of Nursing waited for the resident to stop and turned their power wheelchair toward their room and followed the resident into their room. Upset, high pitched yells from the resident could be heard from the resident's room. During an interview on 04/17/2026 at 10:09 AM Certified Nurse Aide #25 stated Resident #49 had behaviors of angry outbursts and punching themself. They tried to be as far away from the resident as possible when they had behaviors. Sometimes the resident came to find them to ask them to talk. At those times, they just tried to comfort the resident, talk to them and calm them down but they mainly gave the resident their space. During an interview on 04/17/2026 at 10:14 AM, Certified Nurse Aide #27 stated the resident had behaviors and their newest behavior was throwing things at the staff. They stated the resident had a short fuse and when they were mad, they would go down the hallway screaming. They stated when they performed the resident's care, they just tried to remain quiet and calm. During an interview on 04/17/2026 at 10:36 AM Licensed Practical Nurse #26 stated interventions for behaviors were on a resident's care plan. Resident #49 had behaviors every day. The behaviors depended on what the resident's mood was. They offered the resident their medications a couple weeks ago and the resident started screaming, throwing things and stated if they wanted their medications they would ask for them. It did not take much to set the resident off. When the resident had behaviors, they tried to get the resident to their room to relax, try not to engage them, speak calmly and leave the resident alone if they were in a safe area. During an interview on 04/17/2026 at 12:11 PM Registered Nurse Unit Manager #4 stated Resident #49 had behaviors. The resident liked to be in control of things. There were several staff the resident did not want to work with and if they even saw the staff in the building, it triggered the resident and they became paranoid the staff were talking about them. Staff tried to redirect Resident #49 when they had behaviors. Calling their parents really helped the resident, along with playing their gaming system, bible study, music, and they went to a specialty behavioral health service. During an interview on 04/17/2026 at 1:06 PM, the Director of Social Services stated the behavior care plans were completed by nursing and should be person-centered. Distracting the resident with activities of interest was only person-centered if the staff knew what the activities of interest were. Resident #49 had behaviors which included a lot of paranoia and mental health concerns. The resident needed a lot of one-to-one attention. After the resident screamed it out, they were okay. Effective interventions included reading scripture, listening to music, and support from their parents. If the resident was not getting along with their parents, that would be a trigger for them. These things should be included in the resident's care plan, but they were not. They were unsure what Nurse Practitioner #7 meant by reinforcing boundaries across staff except the resident could twist words when speaking to multiple staff. The Pre-admission Screening and Resident Review Level II recommendations should be incorporated into the resident's care plan. They had not followed up on not receiving any consultations from the outside behavioral health facility because the resident did a lot of self-directing on their own. There should be some sort of communication between the facility and the outpatient therapist to make sure no recommendations were missed. During an interview on 04/17/2026 at 2:50 PM, the Director of Nursing stated the behavior care plans were jointly done by the unit managers and social worker but mostly by nursing. The care plans should be person-centered and the interventions for behaviors individualized. Encouraging participation in activities of interest, encouraging the resident to remain social with peers/staff, and distracting the resident with activities of interest were not person-centered interventions. Resident #49's behaviors included yelling, going from person to person to tell their story, picking and choosing who took care of them, and refusing medications and care. Going to their room, doing their bible studies, talking to a staff member, talking to their counselor, and talking to their parents helped the resident when they had behaviors. When a resident saw an outside mental health provider, a consult sheet was sent with them and if the resident did not come back with the (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	consult sheet, staff should follow up with the provider. This included telehealth appointments. Sometimes Resident #49's mental health provider called the facility with recommendations or interventions. The calls should be documented in the medical record if they occurred. 10 New York Codes, Rules and Regulations 415.12

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observations and interviews the facility failed to ensure the results of the most recent Federal and State surveys were posted in a place readily accessible where individuals who wished to examine the survey results did not have to ask for them. Specifically, the facility did not provide records for the standard health survey results or any complaint survey results and subsequently, there was no posted notification of the availability of the previous three (3) years of survey reports. Findings include:The New York State Department of Health Your Rights as a Nursing Home Resident in New York State documented residents had the right to read the results of the most recent State and Federal inspection survey and the facility's plan to correct any violations. During an anonymous resident group meeting on 04/14/2026 at 2:00 PM, six residents stated they had never seen any previous survey results and did not know where they were located. During a walk-through of the entire facility on 04/14/2026 at 11:22 AM and on 04/15/2026 at 10:22 AM, there was no posted notification of the availability of survey reports and there were no surveys readily available for individuals who wished to examine the survey results without asking. During an interview on 04/17/2026 at 9:53 AM, Certified Nurse Aide #14 stated they did not know how the residents were able to review the previous survey results. During an interview on 04/17/2026 at 10:08 AM, Licensed Practical Nurse #16 stated they thought the previous survey results were in the Director of Nursing's office. During an interview on 04/17/2026 at 10:16 AM, the Assistant Director of Nursing stated they would have to ask the Director of Nursing where the previous survey results were located. During an interview on 04/17/2026 at 2:36 PM, the Director of nursing stated they thought there was a binder of previous survey results on the bulletin board near the front entrance. It was a resident right to review the previous survey results, so they knew what was going on and happening in their home. 10 New York Codes, Rules and Regulations 415.3(1)(c)(1)(v)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observations and interviews, the facility failed to ensure nurse staffing information was posted daily at the beginning of each shift and included the daily current resident census and the total number, and actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift in a prominent location readily accessible to residents and visitors for four (4) of four (4) days (04/14/2026, 04/15/2026, 04/16/2026, and 04/17/2026) reviewed. Specifically, the facility did not post the daily nurse staffing on 04/14/2026 and the posted daily nurse staffing on 04/15/2026, 04/16/2026, and 04/17/2026 did not include the resident census and actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care as required.Findings include:The undated facility policy Posting Direct Care Daily Staffing Numbers, documented the facility would post the number of nursing personnel responsible for providing direct care to residents on a daily basis for each shift. The information recorded on the form should include: the name of the facility, the date for which the information was posted, the resident census at the beginning of the shift for which the information was posted, the actual time worked during the shift for each category and type of nursing staff, and the total number of licensed and non-licensed nursing staff working for the posted shift.During observations on 04/14/2026 at 11:00 AM and 4:00 PM, the daily nurse staffing information was not posted in the main lobby, on the main entrance doors, or down the main hallway in between both units. The daily nurse staffing information was posted on the wall in a clear plastic frame in the main hallway across from the Administrator's office and did not include the resident census or actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care on 04/15/2026 at 1:11 PM; on 04/16/2026 at 8:18 AM and 5:00 PM; and on 04/17/2026 at 8:19 AM.During an interview on 04/17/2026 at 11:30 AM, Nursing Scheduler #18 stated they were responsible for making the nursing schedule and for posting the daily nurse staffing information for the day and evening shift. The nursing supervisor was responsible for posting the night shift and weekend nurse staffing when they were not working, and it was supposed to be posted in the hallway outside of the Administrator's office. They thought they had posted the nurse staffing on 04/14/2026 but could not recall. They were not aware the daily census or actual hours worked by licensed and unlicensed nursing staff were required. 10 New York Codes, Rules, and Regulations 415.13

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F 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews the facility did not provide the appropriate liability and appeal notices to Medicare beneficiaries for one (1) of three (3) residents (Resident #93) reviewed. Specifically, Resident #93 remained in the facility after discontinuation of Medicare Part A services and the facility did not provide the resident with timely Notice of Medicare Non-Coverage (Centers for Medicare and Medicaid Services-10123) when Medicare Part A coverage was ending, nor a Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (Centers for Medicare and Medicaid Services-10055) for Medicare Part A, as required.Findings include: The undated facility policy Advance Beneficiary Notification and Notice of Medicare Non-Coverage, documented the facility follows the Centers for Medicare and Medicaid Services guidelines for both the Advance Beneficiary Notification and Notice of Medicare Non-Coverage. When a resident is no longer eligible for skilled coverage under Medicare Part A, the facility must issue an Advance Beneficiary Notification and Notice of Medicare Non-Coverage to the resident or their legal representative with a minimum notice of two days. If a resident is competent the facility may deliver the Advance Beneficiary Notification/Notice of Medicare Non-Coverage in person and obtain the residents' signature and date and leave a signed copy with the resident. If the resident is incompetent, the facility may deliver the Advance Beneficiary Notification/Notice of Medicare Non-Coverage to the resident's legal representative. The facility must also notify the representative in person if available or via phone. The staff is to document the representative's name, phone number, date and time you spoke with them and send certified mail on the same day you spoke with them. When a resident is on Medicare Part A and has a planned discharge a Notice of Medicare Non-Coverage must be delivered to the resident or their legal representative with a minimum notice of two days.The Centers for Medicare and Medicaid form instructions for the Notice of Medicare Non-Coverage (CMS Form 10123; expiration date 11/30/2027) documents a Medicare provider must give a completed copy of this notice to beneficiaries receiving services from skilled nursing facilities not later than two (2) days before the termination of services.The Centers for Medicare and Medicaid Services form instructions for the Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage Center for Medicare and Medicaid Services-10055 (10/31/2024 Edition), documented a Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (form 10055) must be issued by providers to beneficiaries in situations where Medicare payment was expected to be denied. The Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage must be delivered far enough in advance that the beneficiary or representative had time to consider the options and make an informed choice prior to services ending.Resident #93 had diagnoses including stroke and right side paralysis and weakness. The 12/14/2025 Minimum Data Set assessment documented it was a Skilled Nursing Facility Part A Prospective Payment System (a method of reimbursement used by Medicare that pays a predetermined amount for a service) discharge assessment, and the resident had a Medicare-covered stay with a start date of 10/01/2025 and an end date of 12/13/2025. The resident had intact cognition. There was no documented evidence Centers for Medicare and Medicaid Services Forms 10055 and 10123 were provided to Resident #93 when Medicare benefits ended. During an interview on 04/16/2026 at 12:18 PM, the Rehabilitation Director stated they were responsible for providing the Centers for Medicare and Medicaid Services Form- 10123, and the Notice of Medicare Non-Coverage and Centers for Medicare and Medicaid Services Form 10055 Advance Beneficiary Notification to residents. They stated they assumed this responsibility after the facility's Minimum Data [NAME] Coordinator left the organization, but they did not receive any training for the task. The Centers for Medicare and Medicaid Services Form 10055 was not provided to Resident #93 but should have been. The Centers for Medicare and Medicaid Services Form 10123 was provided to Resident #93, but the facility was unable to locate the copy. Due to a system process previously in place, many of the (continued on next page)

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F 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	Centers for Medicare and Medicaid Services Forms 10123 and 10055 provided to residents were lost, and the facility was unable to locate them. They stated it was important to provide these notices to residents to provide adequate notice their coverage would be ending; to ensure residents were aware of out of pocket costs for continued services; to ensure the resident had the opportunity to appeal the decision; and to ensure residents would not receive a bill for services they could not afford to pay. During an interview on 04/17/2026 at 11:34 AM, the Administrator stated they were familiar with the Notice of Medicare Non-coverage and Advanced Beneficiary Notices, however, they were not involved in the process. The Administrator stated they were aware the facility had a problem with locating the Centers for Medicare and Medicaid Services Form 10123 and Centers for Medicare and Medicaid Services Form 10055 provided to residents, and that was a deficient practice of the facility. They stated providing these notices to residents was important to make sure residents were aware of their options in case their benefits ran out; to prevent residents from incurring charges they were not prepared for, creating hardship for the residents; and to provide the residents peace of mind. 10 New York Codes Rules and Regulations 483.10 (g) (18)