STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335256	A. Building B. Wing	07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Pines at Catskill Center for Nursing & Rehab	154 Jefferson Heights Catskill, NY 12414

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Based on record review and interviews conducted during recertification and abbreviated (Case # NY00376034) survey, the facility failed to ensure residents were free from neglect for one (1) (Resident #5) of three (3) residents reviewed for neglect. Specifically, on 03/24/2025, Certified Nurse Aide #1 did not use a two-person assist for transfer mobility as required in Resident #5's Comprehensive Care Plan while transferring the resident. Certified Nurse Aide #1 attempted to transfer the resident without assistance from another staff member. Resident #5 fell onto the floor and sustained fractures (bone breaks) to both legs. This resulted in actual harm that was not Immediate Jeopardy.This is evidenced by:The Policy and Procedure titled, Abuse, last revised December 2023, documented that each resident had the right to be free from abuse, neglect and misappropriation of resident property and exploitation. This included but was not limited to freedom from corporal punishment, involuntary seclusion and physical or chemical restraint not required to treat the resident's symptoms. It was the philosophy of all the National Health Care Associates facilities to encourage an environment that recognized the special qualities of their residents and provide them with a safe environment. The policy further documented that neglect meant the failure of the facility, its employees or service providers to provide goods and services to a resident that were necessary to avoid physical harm, pain, mental anguish, or emotional distress.Resident #5 was admitted to the facility with diagnoses including heart failure (a condition in which the heart muscle cannot pump enough blood to meet the body's needs for blood and oxygen), osteoarthritis of hip (a condition where the cartilage in joints gradually wears away, leading to pain, stiffness, and reduced mobility), and unspecified glaucoma (a group of eye diseases that can cause vision loss and blindness by damaging the optic nerve). The Minimum Data Set (an assessment tool) dated 03/11/2025, documented the resident was cognitively intact, could be understood, and could understand others. The Care Plan for Daily Living initiated 07/27/2022, documented Resident #5 was dependent on physical assistance from two (2) or more staff to perform transfers.The Facility Investigation dated 03/24/2025, documented Resident #5 required the assistance of two (2) nursing staff to transfer the resident in and out of bed. It further documented that on 03/24/2025 at approximately 7:20 AM, Certified Nurse Aide #1 attempted to transfer the resident from their bed to a chair without the assistance of another staff member. During the transfer attempt, Resident #5 was unable to follow Certified Nurse Aide #1's directions; the resident fell to the floor with slide assistance from Certified Nurse Aide #1. Licensed Practical Nurse #4 assisted Certified Nurse Aide #1 in calling Registered Nurse #2 to come and assess Resident #5. Resident #5 reported pain at the time of the event; the physician was notified as well as the family, and the resident was transferred to the hospital for further evaluation. The facility investigation report documented that hospital records confirmed Resident #5 sustained fractures (bone breaks) in both legs. The facility's investigation report documented that Certified Nurse Aide #1 did not follow Resident #5's care plan. Certified Nurse Aide #1 was suspended immediately and taken out of work during the investigation. Certified Nurse Aide #1 was terminated after choosing to not return to work. Record review of a Facility Incident Report submitted to the New York State Department of Health on 03/24/2025 at 4:08 PM, documented that on 03/24/2025 at 7:20 AM, Resident #5 was being transferred by Certified Nursing Aide #1 from their bed to their chair, the transfer was unsuccessful, and the resident was lowered to the floor. The report further documented that the resident had not been moved due to complaints of back pain and was displaying non-verbal signs of discomfort as well. Emergency Medical Services was called, and the resident was sent to the hospital for evaluation.An Investigation Statement dated 03/24/2025 written by Certified Nurse Aide #1 acknowledged they were aware Resident #5 required two (2) staff for transfer, however, they thought they were capable of providing the care by themself.A Hospital Radiology Report dated 03/24/2025 documented Resident #5 had an intertrochanteric femur fracture (a break in the upper part of the thigh bone) in their right leg, and a distal femoral meta-diaphyseal fracture (a break in the thigh bone) in their left leg.The hospital discharge paperwork dated 04/08/2025 documented Resident #5's plan of care summary listed the diagnoses of closed intertrochanteric fracture of right femur, closed bicondylar fracture of distal end of left femur (break in the lower part of the thigh bone), status post left hip gamma nail and right open reduction internal fixation surgery (hip surgery).A Nursing Note dated 03/24/2025 at 3:28 PM documented Licensed Practical Nurse #5 had called the hospital where Resident #5 was sent in order to give report to the hospital staff regarding what had happened to Resident #5 and was informed that the resident was admitted with a urinary tract infection, and fractures of the right femur and left hip. The note further documented that Family

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview conducted during a recertification and abbreviated survey (Case # NY00344590), the facility did not ensure each resident was free from misappropriation of resident property and exploitation for one (1) (Resident #136) of three (3) residents reviewed. Specifically, a former Certified Nurse Aide took property from Resident #136 after they had died without permission.This is evidenced by: Resident #136 was admitted with the diagnoses of respiratory failure with hypoxia (occurs when the lungs cannot adequately oxygenate the blood, leading to low blood oxygen levels), chronic congestive heart failure (a long-term condition where the heart struggles to pump enough blood to meet the body's needs, leading to fluid buildup and congestion in various parts of the body), and chronic kidney disease (a condition where the kidneys are damaged and lose the ability to filter blood effectively, leading to a buildup of waste and excess fluid in the body). The Minimum Data Set (an assessment tool) dated [DATE], documented that the resident had intact cognition, could be understood, and understand others.The Facility's Abuse Policy and Procedure, revised 12/2023, documented that each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. Misappropriation of property was defined in the policy as: the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent. The policy further documented that staff would refrain from all actions that could be considered abuse, mistreatment, and/or neglect.The Facility's Investigative Report dated [DATE] documented that Administrator #2 was notified by Director of Housekeeping #1 on [DATE] that they had concerns that Certified Nurse Aide # 3 wanted to retrieve items, a watch and bracelet, from Resident #136's personal belongings before they packed the room up for the resident's family. Administrator #2 and Director of Housekeeping #1 searched the packed belongings on [DATE], and the mentioned items were not present in the box. Administrator #2 met with Certified Nursing Aide #3 and inquired about the items. Certified Nurse Aide #3 stated that they purchased the items for Resident #136 and retrieved them without permission. They stated that they felt they could take them back as they purchased the items for Resident #136but could not provide proof that the purchase was made. Administrator #2 instructed Certified Nurse Aide #3 to return the items immediately, which they did on the evening of [DATE], and were terminated at that point.An attempted interview on [DATE] at 1:15 PM with Administrator #2 was unsuccessful, and no return phone call was made.An attempted interview on [DATE] at 1:20 PM with Certified Nurse Aide #3 was unsuccessful, and no return phone call was made.Past Non-compliance -F602 Based on the following corrective action taken, there was sufficient evidence that the facility corrected the noncompliance and was in substantial compliance with this specific regulatory requirement at the time of this survey: A thorough investigation was completed, and it was determined there were no other victims of misappropriation. The misappropriated property was returned and given to the resident's family. The family expressed no other concerns at that time. The alleged perpetrator was terminated and not permitted entrance to the facility to protect the residents from further misappropriation. The incident was reported appropriately to the State Survey Agency. Education was provided on [DATE] to all facility staff on abuse, abuse reporting, misappropriation of property, exploitation, and updated facility policy and procedures. At the time of the survey, there were no additional incidents of misappropriated personal property identified. 10 New York Codes, Rules, and Regulations: 415.4(b)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and interview conducted during a recertification and abbreviated survey (Case # NY00344590), the facility did not ensure they reported the results of all investigations to the administrator or their designated representative, and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident for one (1) (Resident #136) of three (3) residents reviewed. Specifically, a 5-day investigation report was not submitted to the state agency. This is evidenced by: Resident #136 was admitted with the diagnoses of respiratory failure with hypoxia (occurs when the lungs cannot adequately oxygenate the blood, leading to low blood oxygen levels), chronic congestive heart failure (a long-term condition where the heart struggles to pump enough blood to meet the body's needs, leading to fluid buildup and congestion in various parts of the body), and chronic kidney disease (a condition where the kidneys are damaged and lose the ability to filter blood effectively, leading to a buildup of waste and excess fluid in the body). The Minimum Data Set (an assessment tool) dated 3/06/2024, documented that the resident had intact cognition could be understood, and understand others.The facility's Abuse Policy and Procedure, revised 12/2023, documented that each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. Misappropriation of property was defined in the policy as: the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent. The policy further documents that staff will refrain from all actions that could be considered abuse, mistreatment, and/or neglect.The facility's investigative report dated 6/07/2024 documented that the Administrator #2 was notified by Director of Housekeeping #1 on 6/06/2024 that they had concerns that Certified Nursing Aide # 3 wanted to retrieve items (a watch and bracelet) from Resident #136's personal belongings before they packed the room up for the resident's family. Administrator #2 and Director of Housekeeping #1 searched the packed belongings on 6/07/2024, and the mentioned items were not present in the box. Administrator #2 met with Certified Nursing Aide #3 and inquired about the items. Certified Nurse Aide #3 stated that they purchased the items for Resident #136 and retrieved them without permission. They stated that they could take them back as they purchased the items for Resident #136 but could not provide proof that the purchase was made. Administrator #2 instructed Certified Nurse Aide #3 to return the items immediately, which they did on the evening of 6/07/2024, and were terminated at that point.A review of the facilities investigation documents showed that the facility did report the incident on 6/07/2024 at 12:47 PM through the electronic Nursing Home Facility Incident Report program.A review of the facilities investigation documents showed that a thorough investigation and education were completed. The outcome of the investigation was not submitted to New York State through the electronic Nursing Home Facility Incident Report program within 5 days as required.During an interview on 7/02/2025 at 1:00 PM, Administrator #1 stated that if the investigation findings were sent, the report would have been in their investigation file. They stated that they would expect that if it were done, then it would have been in the file. They stated that if the report of submission was not in the folder, then it must not have been done. Administrator #1 stated that the only person who would have known that it was completed was Administrator #2.An attempted interview on 7/02/2025 at 1:15 PM with Administrator #2 was unsuccessful, and no return phone call was made. 10 New York Codes of Rules and Regulations 483.12 (C)(4)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews conducted during the recertification survey (NY00376034), the facility did not develop and implemented comprehensive person-centered care plans for each resident that included measurable objective and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for two (2) (Resident #'s 5 and 27) of 28 residents reviewed for care plans. Specifically, (a.) Resident #5 was care planned for 2- person assist for when transfer. Certified Nurse Aide #1 did not follow care plan resulting in Resident #5 falling and breaking both legs; (b.) Resident #27 had difficulty hearing and had hearing aids. There was no documented evidence that a comprehensive person-centered care plan was developed and implemented for their hearing impairment. This is evidenced by:A facility policy and procedure titled, Baseline/Comprehensive Person-Centered Care Plan dated 3/2023, documented that the comprehensive care plan would utilize the process to address resident strengths, needs and/or problems as identified on the admission discharge summary, as well as other professional assessments and orders from the healthcare provider, dietary team, therapy, social services and Preadmission Screening and Resident Review (PASARR) and Minimum Data Set. The Person-Centered Care Plan was developed to include information necessary to properly care for the resident and would address the resident's preferences, goals, desired outcomes, and plan for discharge. All clinical department heads were responsible to ensure that there was a system for monitoring implementation of the resident care plans. This was accomplished via quality assurance auditing, observation on rounds, and interview with staff, residents, and families. Corrective action would be carried out when problems with implementation of care plans have been modified. Resident #5:Resident #5 was admitted to the facility with diagnoses of heart failure (a condition in which the heart muscle cannot pump enough blood to meet the body's needs for blood and oxygen), osteoarthritis of hip (a condition where the cartilage in joints gradually wears away, leading to pain, stiffness, and reduced mobility), unspecified glaucoma (a group of eye diseases that can cause vision loss and blindness by damaging the optic nerve). The Minimum Data Set (an assessment tool) dated 3/11/2025, documented the resident was cognitively intact, could be understood and could understand others. The Comprehensive Care Plan for Daily Living, initiated 7/27/2022, documented Resident #5 was dependent on physical assistance from two (2) or more staff to perform transfers. The care plan was updated 4/09/2025 to include that Resident #5 required a mechanical lift for transfers with two (2) staff and was dependent of two (2) staff members for all mobility-based activities of daily living. The Facility Investigation, dated 3/24/2025, documented Resident #5 required the assistance of two (2) nursing staff to transfer the resident in and out of bed. It further documented that on 3/24/2025 at approximately 7:20 AM, Certified Nurse Aide #1 attempted to transfer the resident from their bed to a chair without the assistance of another staff. During the transfer attempt, Resident #5 was unable to follow Certified Nurse Aide #1's directions; the resident fell to the floor with slide assistance from Certified Nurse Aide #1. Licensed Practical Nurse #4 assisted Certified Nurse Aide #1 in calling Registered Nurse #2 to come and assess Resident #5. Resident #5 reported pain at the time of the event; the physician was notified as well as the family, and the resident was transferred to the hospital for further evaluation. The facility investigation report documented that hospital records confirmed Resident #5 sustained fractures (bone breaks) in both legs. The facility's investigation report documented that Certified Nurse Aide #1 did not follow Resident #5's care plan. Certified Nurse Aide #1 was suspended immediately and taken out of work during the investigation. Certified Nurse Aide #1 was terminated after choosing to not return to work. An Investigation Statement dated 3/24/2025 written by Certified Nurse Aide #1 documented that Certified Nurse Aide #1 acknowledged they were aware Resident #5 required two (2) staff for transfer, however, they thought they were capable of providing the care by themself. Resident #27:Resident #27 was admitted with diagnoses of type 2 diabetes (a dysfunction of the endocrine system causing inability to regulate blood sugar), bilateral hearing loss, and chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe). The Minimum Data Set, dated [DATE] documented the resident was cognitively intact, could be understood, and understand others.The Minimum Data Set, dated [DATE] also documented that Resident #27 had hearing aids and glasses. The Comprehensive Care Plan initiated 7/02/2025, after the hearing aids were pointed out to the floor staff, documented that Resident #27 had a communication problem, hearing deficit. The goal documented that the

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interviews conducted during the recertification survey, the facility did not ensure drugs and biologicals were labeled and stored in accordance with professional standards of practice for one (1) (Passport unit) of three (3) medication carts reviewed. Specifically, (a.) two (2) open multi-dose Humalog (insulin) vials were not labeled with a resident's name and (b.) one (1) open multi-dose bottle of Lantus (insulin) was not clearly marked with an open date. This is evidenced by:During an observation on 6/30/2025 at 9:07 AM, the medication cart on the Passport unit was reviewed. Two opened multi-dose vials of Humalog were found in the first draw of the medication cart. A labeled multi-dose bottle of Lantus was also found with an unclear opened date. During an interview on 6/30/2025 at 9:07 AM, Licensed Practical Nurse #3 stated they were unable to state if the open date on the bottle of Lantus was 6/04/2025 or 6/11/2025. They also stated the two bottles of Humalog were pulled out of the emergency stock because a resident's medication had not yet arrived from pharmacy. They stated a resident name label should have been put on the bottles and stated each resident had a page of adhesive stickers with their names on it in each respective binder. During an interview on 7/02/2025 at 12:07 PM, Registered Nurse #1 stated that when a vial of insulin is taken out of the emergency stock for a resident, it should be immediately labeled. They stated that a vial of insulin, though multi-dose, should only be used for one resident and absolutely should not be shared among residents.During an interview on 7/02/2025 at 1:36 PM, Director of Nursing #1 stated that vials should be labeled with the resident's name when pulled from the emergency stock. They stated that opened dates should be clearly marked on each pen and vial. 10 New York Codes, Rules, and Regulations 415.18(d)