

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335257	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/18/2025
NAME OF PROVIDER OR SUPPLIER  Fort Tryon Center for Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE  801 W 190th St New York, NY 10040	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, record review, and interviews, the facility failed to ensure that necessary housekeeping and maintenance services were provided to maintain a safe, clean, comfortable and homelike environment for residents. This was evident for one (1) (3rd Floor) of five (5) resident units observed. Specifically, accumulation of dust, dirt, and stains were noted on bedside tables, intravenous poles, feeding pumps, oxygen concentrators and suction machines; and torn arm rests and soiled wheelchairs were observed in resident rooms on the 3rd Floor. The findings include: The facility policy titled Environmental Policy and Procedure, Subject: Safe, Clean, Comfortable and Home-Like Environment documented that housekeeping and maintenance services are provided to maintain a sanitary, orderly, and comfortable interior. The following were observed from 12/11/2025 through 12/16/2025: 1.) room [ROOM NUMBER]B:a. The wheelchair's front and back end of both arms rests were torn, exposing portions of the inner material. The wheelchair seat cushion was soiled and stained. b. The oxygen concentrator had layered dust and dirt. c. The feeding pump had brownish stains and streaks. d. The intravenous pole had brownish stains and streaks. The floor had stains underneath the pole. e. The bedside table was layered with dust and debris. f. The suction machine and nebulizer on the bedside table had accumulated dust and debris. 2. room [ROOM NUMBER]A and 310B:a. The wheelchairs had accumulated dirt and dust, the wheels, brake handle and metal attachments had debris. 3. room [ROOM NUMBER]A:a. The feeding pump had brownish stains and streaks. b. The oxygen concentrator had had layers of accumulated dirt and dust. c. The bedside table had accumulated dirt and dust. d. The suction machine had layers of dust and debris. On 12/18/2025 at 10:30 AM, the Director of Housekeeping Services was interviewed and stated that the housekeepers are responsible for the upkeep of the unit and that they make rounds to ensure that the housekeeping staff are performing their duties. The Director stated that the housekeepers are responsible for daily wiping and disinfecting the equipment such as feeding pumps, intravenous poles, and bedside tables, oxygen concentrators, suction machines, and nebulizers. They stated that there are two (2) porters in the evening that are responsible for cleaning the wheelchairs. On 12/18/2025 at 12:50 PM, the Director of Maintenance was interviewed and stated that there is a logbook in each unit where staff can log what needs to be repaired. They stated that they and their staff check this logbook several times a day. They stated that the staff calls them if there is a need for an urgent repair and that it is immediately addressed. 10 NYCRR 415.5(h)(2)</p>

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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