STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335257	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fort Tryon Center for Rehabilitation and Nursing	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)
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to ensure that a resident was treated with respect and dignity and cared for each resident in a manner and in an environment that promotes maintenance or enhancement of their quality of life, recognizing each resident's individuality. This was evident for two (2) (Residents #42 and #9) of three (3) residents reviewed for Dignity out of 35 total sampled residents. Specifically, Residents #42 and #9 were observed wearing hospital patient gowns on multiple occasions.The findings are: The facility's policy titled Residents Rights: Dignity dated 12/01/2025 documented that it is the policy of the facility to ensure that all residents are treated with respect and dignity, including the right to retain and use personal possessions, including furnishings, and clothing as space permits. 1. Resident #42 was admitted to the facility with diagnoses which included Cerebral Infarction, Hemiplegia, Hypertensive Heart Disease and Chronic Atrial Fibrillation. The Minimum Data Set (a resident assessment tool) dated 07/21/25 documented that the resident was severely impaired and was dependent on staff for all activity of the daily living. From 12/11/2025 through 12/18/2025, Resident #42 was observed on several occasions wearing hospital patient gowns. On 12/16/2025 at 11:18 AM, Registered Nurse #9 was interviewed and stated that Resident #42's clothes were sent to the laundry. On 12/16/2025 at 2:17 PM, Registered Nurse #8 was interviewed and stated that Resident #42 had no family member who can bring them clothes. 2. Resident #9 had diagnoses of Non-Alzheimer's Dementia and Coronary Artery Disease. The Minimum Data Set, dated [DATE] documented that Resident #9 had severe impairment in cognition, with no triggered behaviors. Preferences for Customary Routine and Activities (Section F) documented, somewhat important to choose clothes to wear. On 12/11/2025 at 10:50 AM, Resident #9 was observed in the dining room wearing two (2) hospital patient gowns covering their front and back. On 12/15/2025 at 11:23 AM, Resident #9 was observed in the dining room wearing hospital patient gown. (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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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/17/2025 at 11:00 AM, Resident #9 was observed in bed wearing hospital patient gown. On 12/17/2025 at 11:10 AM Certified Nurse Aide #5 was interviewed and stated that they had never seen clothes in Resident #9's closet and that they always see Resident #9 wearing hospital patient gown. They stated they put 2 gowns together to cover the resident's front and back. On 12/18/2025 at 7:45 AM, the Director of Nursing was interviewed and stated if residents need clothes, the staff should contact the Social Worker and the Housekeeping Department for clothes donation. They stated they rely on the Certified Nursing Assistants to report the need for residents' clothes and hat nursing supervisors are to ensure that residents are properly dressed when their making rounds. 10 NYCRR 415.5 (a)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on 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)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to ensure that a comprehensive care plan was developed to address a resident's sleep pattern disturbance. This was evident for one (1) (Resident #187) of 38 sampled residents. Specifically, Resident #187 who was receiving Ambien for Insomnia had no care plan developed and implemented to address the resident's ongoing difficulty staying asleep. The findings include:The facility's policy titled Care Plan Development with a last reviewed date of 12/12/2024 documented the facility shall develop, implement, and maintain a comprehensive, person-centered care plan for each resident. It also documented the care plan shall address the resident's medical, nursing, psychosocial, functional, and safety needs; promote dignity and quality of life; and reflect the resident's goals, preferences, strengths, and choices.Resident #187 had diagnoses of Insomnia, Generalized anxiety disorder, and Depression.The Quarterly Minimum Data Set assessment dated [DATE] documented Resident #187 was cognitively intact, had diagnosis of Primary insomnia, and took hypnotic medication. It also documented Resident #187, and their representative participated in the assessment. The physician's order dated 04/16/2025 and was last renewed on 12/09/2025 documented that Resident #187 was ordered to receive one (1) tablet of Ambien 10 mg by oral daily at bedtime for Primary insomnia. The psychiatry consult dated 09/13/2025, 10/03/2025, and 10/24/2025 documented Resident #187 reported ongoing difficulties with sleep and continued Ambien 10 mg by oral daily at bedtime for Primary insomnia. The Resident Medication Administration Record for November 2025 documented 1 tablet of Ambien 10 mg was administered to Resident #187 at 9:00 PM every day. There was no documented evidence that a comprehensive care plan related to sleep pattern disturbance was developed and implemented for Resident #187. On 12/17/2025 at 9:58 AM, Registered Nurse #3 was interviewed and stated they are responsible for initiating and updating the care plans in Resident #187's unit. Registered Nurse #3 stated Resident #187 had care plan for the use of psychoactive medications but had no care plan related to sleep pattern disturbance. On 12/17/2025 at 10:32 AM, the Director of Nursing was interviewed and stated that the Registered Nurse Supervisors are responsible for developing and reviewing the residents' care plans. The Director of Nursing reviewed Resident #187's care plan and stated that there was a care plan for psychoactive medication use documenting that Ambien is for insomnia, however, there was no non-pharmacological interventions to address Resident #187's difficulty sleeping. The Director of Nursing further stated Resident #187 should have a care plan related to sleep pattern disturbance with both pharmacological and non-pharmacological interventions.10 NYCRR 415.11(c)(1)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview the facility failed to ensure each resident's comprehensive care plans were reviewed and revised after each assessment to reflect the resident's changing needs. This was evident for one (1) (Resident #4) of five (5) residents reviewed for unnecessary medications. Specifically, Resident #4's comprehensive care plan for psychoactive drug use, Diabetes Mellitus, and bleeding potential were not reviewed and revised quarterly after each assessment. The findings include:The facility's policy titled Care Plan Development, Implementation, and Review which was last revised on 08/06/2024 documented that the purpose of the policy is to ensure compliance with the New York State Department of Health and Centers for Medicare and Medicaid Services requirements by establishing a standardized process for the comprehensive, person-centered development, implementation and ongoing review of each resident. The policy further documented for ongoing review and revision, the interdisciplinary team will monitor the resident response to care plan interventions, and the care plans shall be updated promptly to reflect changes in condition, new diagnosis, resident preference changes, and effectiveness or in effectiveness of the interventions. Resident #4 was admitted to the facility with diagnoses which included Alzheimer's Dementia, Depression, Bipolar disorder, Diabetes Mellitus, History of Embolism and Thrombus, and Hypertension. The quarterly Minimum Data Set assessment dated [DATE] documented that Resident #4 was moderately impaired in cognition and had diagnoses of Diabetes Mellitus; Bipolar Disorder; personal history of other venous thrombosis and embolism; and received insulin injections, antipsychotic, and anticoagulant medications. The Comprehensive Care Plan titled Psychoactive Medication use of any drug that affects brain activities associated with mental process and behavior was dated effective 11/04/2024 and was last reviewed on 07/16/2025. There was no documented evidence that the care plan was reviewed and revised after the quarterly assessment on 10/08/2025.The Comprehensive Care Plan titled bleeding potential/anticoagulant/antiplatelet, etiology: resident was at risk for bleeding secondary to the use of anticoagulant as evidenced by history of rectal bleeding, history of hematoma was dated effective 11/04/2024 and was last reviewed on 07/16/2025. There was no documented evidence that the care plan was reviewed and revised after the quarterly assessment on 10/08/2025.The Comprehensive care Plan titled Diabetes Mellitus related to diagnosis of Diabetes and non-compliant with diet dated effective 05/30/2019 and was last reviewed on 03/17/2025. There was no documented evidence that the care plan was reviewed and revised after the quarterly assessments on 05/05/2025, 07/09/2025, and 10/08/2025.On 12/16/2025 at 12:31 PM, Registered Nurse #1, who was the supervisor for Unit 3, was interviewed and stated they are responsible for reviewing and revising Resident #4's comprehensive care plan. They stated they are not sure if the comprehensive care plan was updated at least every quarter. On 12/17/2025 at 11:07 AM, the Director of Nursing was interviewed and stated the nursing supervisors are responsible for creating and updating the care plans and that they are aware that the care plans were not being updated. 10NYCRR 415.11(c)