

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335261	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/10/2025
NAME OF PROVIDER OR SUPPLIER  The Paramount at Somers Rehab and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  Route 100 Somers, NY 10589	

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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>(continued on next page)</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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F 0657  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and interviews conducted during an abbreviated survey (NY00385588/568719, NY00373004/568714) the facility did not ensure that the comprehensive care plan was updated and revised for 2 out of 4 residents (Resident #1, Resident #3) reviewed for falls. Specifically, (1) Resident #1 had a fall from the Hoyer lift while being transferred by Certified Nurse Aide #1 and Certified Nurse Aide #2 on 07/02/2025. Review of Resident #1's fall risk care plan revealed it was not updated to reflect the actual fall. (2) On 03/10/2024, Resident #3 had an unwitnessed fall in their room and sustained laceration to their left eyebrow. Review of Resident #3's care plans revealed their risk for fall care plan was not updated with the actual fall that occurred on 03/10/2024. The findings are: The facility Fall Prevention protocol policy created 08/20/2018 documented a goal of the facility is to provide a safe and healthful environment for residents, visitors and employees. A comprehensive approach to safety, which considers the hazards identified in the environment and individual resident risk factors and then adjusts interventions accordingly. If a fall occurs the plan of care will be reviewed and revised to include the fall and new interventions placed to prevent further falls with each incidence of falls, quarterly, upon significant change and at admission/readmission. 1) Resident #1 had diagnoses including but not limited to Dementia, Cognitive Communication Deficit and Bipolar Disorder. A Quarterly Minimum Data Set, dated [DATE] documented Resident #1 had severe cognitive impairment. The resident is bedridden and requires moderate assistance with eating, dependent for toileting, bed mobility and transfers. Review of a risk for falls care plan initiated 09/23/2024 documented Resident #1 was at risk related to decreased mobility and a history of falls prior to admission. Interventions listed included keep bed in lowest position, maintain a clutter-free environment, call bell/personal items within reach and encourage resident to stay in a supervised area while out of bed. The care plan was updated 07/03/2025 with staff education and Physical Therapy evaluation. There was no documented evidence of Resident #1's risk for fall care plan being updated with their actual fall from the Hoyer lift on 07/02/2025. During an interview on 08/18/2025 at 1:11 PM, Licensed Practical Nurse #1 stated they were unaware that Resident #1 needed their care plan updated to reflect they had an actual fall after the incident occurred. 2) Resident #3 had diagnoses including but not limited to Dementia, Muscle Weakness and Difficulty in Walking. A Quarterly Minimum Data Set, dated [DATE] documented Resident #3 was cognitively intact and exhibited verbal behavioral symptoms directed towards others. Resident #3 had impairment to their upper extremity on one side and used a walker for locomotion. The resident required supervision for eating, moderate assistance with bed mobility and maximal assistance with toileting and transfers. Review of an accident/incident report dated 03/10/2024 at 10:23 AM documented the writer was informed by the assigned nurse on the unit that Resident #3 was on the floor and bleeding. Upon arriving to Resident #3's room, the writer found the resident sitting on the floor, resting with their back against the frame of the bed, facing the door, and touching the left side of their face. Wheelchair located next to Resident #3. Resident #3 was noted to have a laceration to their left eyebrow and complained of excruciating pain to the site. Resident #3 was also noted to have two small skin tears to the left forearm. Review of a risk for falls care plan initiated 02/07/2024 documented Resident #3 was at risk for falls due to ambulatory dysfunction, muscle weakness and joint pain. Interventions listed included call bell/personal items within reach, investigate cause of falls and evaluate patterns if more than one, keep bed in lowest position and maintain a clutter free environment. Review of Resident #3's care plans revealed their risk for fall care plan was not updated with the fall that occurred on 03/10/2024. During an interview on 08/18/2025 at 1:53 PM, the Director of Nursing stated they do not list the falls on the care plan, they write a progress note corresponding with the incident and implement interventions dated from the day of the incident. The Director of Nursing stated the care plan for Resident #1 was updated with staff education and a Physical Therapy evaluation the day after the fall and this was the care plan update. During a telephone interview on 09/02/2025 at 9:00 AM, Registered Nurse #1 stated most of the time the unit manager is responsible to update the care plans, but they work as a team, and they could update the care plans as well. Registered Nurse #1 stated the care plans should be updated immediately following a fall. Registered Nurse #1 stated if a resident has an actual fall, the care plan has to be updated depending on what led to the fall. Registered Nurse #1 stated the fall risk care plan would be updated and also any care plan that is related to the cause of the fall, example behaviors. 10 NYCRR 415.11 (c)(2)(iii)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and interviews during an abbreviated survey (NY00385588), the facility did not ensure the resident environment remained as free of accident hazards as is possible; and that each resident received adequate supervision to prevent accidents for 1 of 3 residents (Resident #1) reviewed for falls and supervision. Specifically, on 07/02/2025 Resident #1 who was dependent for transfers fell out of the mechanical lift while being transferred by Certified Nurse Aide #2. Resident #1 fell striking their head on the leg of the mechanical lift. Certified Nurse Aide #1 was in the room with their back turned getting the Resident #1's chair closer to the bed for transfer. The findings are: The facility Fall Prevention protocol policy created 08/20/2018 documented a goal of the facility is to provide a safe and healthful environment for residents, visitors and employees. A comprehensive approach to safety, which considers the hazards identified in the environment and individual resident risk factors and then adjusts interventions accordingly. All accidents and falls occurring in the facility will be reported and investigated in an effort to identify the root cause of the fall, prevent recurrence and to maintain a continued safe environment. Resident #1 had diagnoses including but not limited to Dementia, Cognitive Communication Deficit and Bipolar Disorder. A Quarterly Minimum Data Set, dated [DATE] documented Resident #1 had severe cognitive impairment. The resident is bedridden and requires moderate assistance with eating, dependent for toileting, bed mobility and transfers. Review of a risk for falls care plan initiated 09/23/2024 documented Resident #1 was at risk related to decreased mobility and a history of falls prior to admission. Interventions listed included keep bed in lowest position, maintain a clutter-free environment, call bell/personal items within reach and encourage resident to stay in a supervised area while out of bed. Review of an undated, unsigned facility investigation on 07/02/2025 documented Resident #1 had a fall from the Hoyer lift while being transferred by Certified Nurse Aide #1 and Certified Nurse Aide #2. Certified Nurse Aide #1 and Certified Nurse Aide #2 were interviewed regarding the fall. Certified Nurse Aide #1 stated they prepared Resident #1's chair while Certified Nurse Aide #2 hooked up the Hoyer pad. While Resident #1 was being lifted, they suddenly fell out of the Hoyer pad and fell directly down onto the floor, striking their head on the leg of the Hoyer lift. Upon entry to Resident #1's room the Hoyer pad was found still attached to the Hoyer lift while the resident was on the floor. Upon observation it was noted one of the straps may have slipped during the process of lifting, resulting in Resident #1 falling from the lift. During an interview on 08/18/2025 at 1:11 PM, Licensed Practical Nurse #1 stated Certified Nurse Aide #1 and Certified Nurse Aide #2 were doing Resident #1's transfer and Certified Nurse Aide #2 stated they hooked all the clips for the Hoyer lift. Licensed Practical Nurse #1 stated Resident #1 is rigid and fussy at times when transferring and when they entered the room there were three clips hooked, and one was hanging down. Licensed Practical Nurse #1 stated the Hoyer pad was inspected and there were no rips in the Hoyer pad. During an interview on 08/18/2025 at 2:11 PM, Certified Nurse Aide #1 stated they were written up and suspended for two days after the incident because Certified Nurse Aide #1 stated they were the one who set up the Hoyer pad to the machine. Certified Nurse [NAME] #2 stated Certified Nurse Aide #1 made it seem they transferred the resident by themselves while Certified Nurse Aide #2 was fixing up the chair, and that they moved the machine by themselves when Certified Nurse Aide #1's back was turned. During an interview on 08/20/2025 at 12:52 PM, Certified Nurse Aide #1 stated on 07/02/2025 they went in and provided care to Resident #1 on 07/02/2025. They needed assistance providing perineal care to the resident so Certified Nurse Aide #2 came into the room to assist them. Resident was dressed, placed on a Hoyer pad was ready to be transferred. Certified Nurse Aide #1 stated Certified Nurse Aide #2 went out of the room and got the Hoyer machine and placed the Hoyer machine over Resident #1 and hooked the Hoyer pad to the machine. Certified Nurse Aide #1 stated they noticed while Certified Nurse Aide #2 was lifting Resident #1 that the resident's chair was far away, so they turned to get the chair closer for transfer. Certified Nurse Aide #1 stated as they turned around with the resident's chair, they saw Resident #1 falling from the mechanical lift. Certified Nurse Aide #1 stated Certified Nurse Aide #2 applied the hooks on the pad to the mechanical lift machine. Certified Nurse Aide stated they were at the foot of the resident's bed. Certified Nurse Aide #1 stated when they are transferring a resident, they set the chair up so it is closer and not too far. Certified Nurse Aide #2 basically, began to transfer the resident without them being in position. During an interview on 08/22/2025 at 1:59 PM, the Assistant Director of Nursing stated it was determined that while Certified Nurse Aide #1 and Certified Nurse Aide #2 were transferring Resident #1 something caused the Hoyer pad strap to</p>		

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F 0760  Level of Harm - Actual harm  Residents Affected - Few	Ensure that residents are free from significant medication errors.  (continued on next page)

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and interviews during an abbreviated survey (NY00372705/568716), the facility failed to ensure residents were free from medication errors for one (1) out of four (4) residents (Resident #4) reviewed for medication administration. Specifically, on 02/20/2025, Resident #4 was administered crushed extended-release Morphine by Licensed Practical Nurse #4 at 9:00 AM. At 10:15 AM, Resident #4 was found in their room in bed lethargic by Speech Language Pathologist #1. Resident #4 was assessed and noted to be lethargic with decreased respirations, wheezing, and pinpoint pupils. Resident #4 was administered Naloxone to reverse the effects of the crushed extended-release Morphine and returned to baseline shortly after. This resulted in actual harm to Resident #4 that was not Immediate Jeopardy. The findings are: The facility Narcotic Handling and Administration policy, initiated 01/2020, documented it is the policy of the facility to ensure that all nursing staff charged with administering medications are proficient and compliant with handling and administration of narcotic medications within the facility. Nurses are to check the pharmacy label for all pertinent information including the resident's name, medication, dose, route of administration, and timing, as well as any specific instructions (ex: do not crush, take on an empty stomach, etc). Before administering the medication, the nurse is to check the order in the computer against the written instructions on the blister pack or container to ensure they match and instructions are being followed appropriately. Resident #4 had diagnoses including, but not limited to, muscle weakness, chronic obstructive pulmonary disease (lung and airway diseases that restrict your breathing), and pulmonary hypertension (high blood pressure that affects arteries in the lungs and heart). A Prospective Payment System Minimum Data Set (an assessment tool) dated 01/02/2025, documented Resident #4 was cognitively intact. The resident required supervision for eating, maximal assistance with toileting, bed mobility and transfers. Review of a Pain Care Plan initiated 02/12/2025, documented Resident #4 was at risk for pain due to thoracic spine fractures. Interventions listed included: administer medications, discuss with resident pain management, monitor behavior and assess pain/discomfort if change in behavior noted, and monitor for side effects and adverse reactions resulting from interventions rendered. The facilities undated, unsigned investigative summary documented the following: on 02/20/2025, Resident #4 received naloxone in response to receiving their Morphine Sulfate 30 mg extended-release medication crushed. Licensed Practical Nurse #4 was assigned to administer Resident #4 their medications on the day shift on 02/20/2025. Licensed Practical Nurse #4 stated Resident #4 was spitting out their medications and was known to become verbally disruptive and abusive if their pain medication was not given on time as per their preference. Licensed Practical Nurse #4 stated they wanted to ensure Resident #4 received their pain medication and inadvertently crushed their Morphine Sulfate. Resident #4 took the medication without issue and Licensed Practical Nurse #4 continued with their medication pass. Resident #4 was next seen by Speech and Language Pathologist #1; they entered the room at 10:15 AM to work with the resident and noted the resident was lethargic. Speech Language Pathologist #1 called Licensed Practical Nurse #4, who notified Licensed Practical Nurse #2 and Registered Nurse #2. Registered Nurse #2's assessment of Resident #4 revealed the resident had coarse crackles, wheezing and hypoxia. As a result, the Physician ordered 40 mg of Solumedrol (a steroid that acts on the immune system to suppress the body's inflammatory and allergic responses) and 40 mg of Lasix (a diuretic used to treat conditions involving fluid retention) intramuscularly. Both medications were administered, and Resident #4 was also noted with cool extremities and pinpoint pupils. At approximately 10:50 AM, Licensed Practical Nurse #4 reported they realized they had crushed the extended-release Morphine Sulfate and notified Registered Nurse #2 and Nurse Practitioner #2. Naloxone (medication that rapidly reverses the overdose effect of morphine) 0.4 mg intramuscular was ordered and administered to Resident #4's left deltoid at approximately 11:15 AM. Shortly after, Resident #4 returned to their mental baseline and was verbally responsive to staff. Resident #4 was further assessed by the Physician and their representative was made aware of the resident's clinical presentation and all medication administered to the resident and stated they wanted the resident to be treated in the facility over being sent to the hospital. During an interview on 08/22/2025 at 1:32 PM, Registered Nurse #2 stated they remember being called over to see Resident #4 after morning report, around 10:00 AM. Registered Nurse #2 stated they were often called to see Resident #4 due to their frequent exacerbations of chronic obstructive pulmonary disease. They stated the resident's usual signs and symptoms with their exacerbation were lethargy, low oxygen saturation, and bilateral rales</p>		