

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 12/11/2025
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)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. (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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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews during an abbreviated survey (2619941), the facility did not ensure a resident right to voice a grievance, and to make prompt efforts to resolve grievances the resident may have for 1 out of 3 residents (Resident #1) reviewed for grievances. Specifically, Resident #1's representative informed the Patient Relations Concierge #1 that Resident #1 had several items that went missing from their room. Resident # 1's representative stated that they did not receive any follow-up from the facility regarding the missing items and no grievance was completed by the facility. The findings are: The facility Grievance/Concerns policy dated 02/14/2023 documented the residents and their representatives have the right to file grievances, either orally or in writing, to the facility staff or to the agency designated to hear grievances. The administrator and staff will make prompt efforts to resolve grievances to the satisfaction of the resident and/or representative. Any resident, family member, or appointed resident representative may file a grievance or complaint concerning care, treatment, behavior of other residents, staff members, theft of property, or any other concerns regarding their stay at the facility. Resident # 1 admitted to the facility on [DATE] with diagnoses including but not limited to Fracture of Neck of Right Femur, Depression, Muscle Weakness. An admission Minimum Data Set assessment dated [DATE] documented Resident #1 had a moderate cognitive impairment. The resident had impairment to the lower extremity on one side and used a walker for local motion. The resident required supervision for eating, maximal assistance for bed mobility, and was dependent for toileting and transfers. Resident was frequently incontinent of bladder and bowel. During a telephone interview on 09/18/2025 at 11:39 AM, Resident #1's representative stated that several items including a fleece blanket and nail manicure kit had gone missing from Resident # 1's room. Resident #1's Representative stated that they reported this to the Patient Relation Concierge #1 who stated they would relay that information to Resident # 1's social worker. Resident #1's representative stated that they did not receive any follow-up from the facility regarding the missing items. Resident #1's representative stated that no grievance was completed by the facility. Resident #1's representative stated the facility did eventually offer to reimburse Resident # 1 for the missing items, but it was not about the money or the items, it was the principle that someone was taking the residents things. There was no documented evidence of a grievance on file regarding Resident #1's missing items. During an interview on 09/18/2025 at 1:03 PM, the Patient Relations Concierge #1 stated they remember Resident #1's representative expressing concern over missing items from the resident's room. The Patient Relations Concierge #1 stated that they received two text messages from Resident #1's representative regarding Resident #1's missing items. The Patient Relations Concierge #1 stated when they were made aware of the of the grievance, they reached out to the Assistant Administrator #1 and the Director of Social Services via WhatsApp to inform them but never received any word back. They stated they would do a better job of following up in the future, but prior to the 09/18/2025, the day of the interview they were not given clear directives. They were unaware of any official grievance process; they did not have any documentation of past grievances. The Patient Relations Concierge # 1 stated that they are now learning about the grievance process and going forward they will have written documentation for all grievances. Patient Relations Concierge #1 specifically stated that they were told by the administration today (09/18/2025) that the Department of Health was in the building and that Patient Relations Concierge #1 needed to learn the grievance process. During an interview on 09/18/2025 at 5:13 PM, the Administrator returned and stated they attempted to reach the Assistant Administrator #1 regarding the grievance with no success. The Administrator stated the Director of Social Services is their grievance officer and should have documented the report of the missing items on an official grievance form. The Administrator stated the facility staff were using the WhatsApp platform to communicate, but they are in the process of changing this because it is not an effective method. During an interview on 09/19/2025, the Director of Social Services stated there is no documented grievance for Resident #1's missing items and they were made aware about the missing items on 09/18/2025 by the Director of Nursing. The Director of Social Services stated the Patient Relations Concierge #1 must have worked on the grievance with someone else, because they knew nothing about this. The Director of Social Services stated they are the grievance officer in the facility and all grievances should be directed to them. The Director of Social Services stated they receive communication face to face, by email or in-person. The Director of Social Services stated if a grievance was initiated there would have been a progress note. It would also be documented on an official</p>		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews conducted during an abbreviated survey (2619941), the facility did not ensure all relevant resident information necessary to meet the resident's needs was conveyed to avoid risk of complications at time of discharge to the home for 1 (Resident #1) of 3 residents reviewed for discharge planning. Specifically, Resident #1 was scheduled to be discharged from the facility on 08/09/2025 with home care services. Resident #1's home care services were delayed due to the late submission of necessary information to the home care agency. Resident #1's home care services was not initiated until 08/14/2025. The findings are: The facility Discharge/Summary and Plan dated 01/27/2025 documented when a resident's discharge is anticipated, a discharge summary and post discharge plan is developed to assist the resident with discharge. The post-discharge plan is developed by the care planning/interdisciplinary team with the assistance of the resident and their representative. Residents who are discharged to a home health agency, the data is used to help the resident select an appropriate facility include the receiving facility's: standardized patient assessment data, quality measures data and data on resource use. Resident # 1 was admitted to the facility on [DATE] with diagnoses including but not limited to Fracture of Neck of Right Femur, Depression, Muscle Weakness. An admission Minimum Data Set assessment dated [DATE] documented Resident #1 had a moderate cognitive impairment. The resident had impairment to the lower extremity on one side and used a walker for local motion. The resident required supervision for eating, maximal assistance for bed mobility, and was dependent for toileting and transfers. Resident was frequently incontinent of bladder and bowel. Review of a discharge planning care plan dated 06/03/2025 documented Resident #1 resided in a home with their representatives and previously required assistance with activities of daily living and had an aide five days a week for six hours a day. Interventions listed included make arrangements with required community resources to support independence post discharge. Review of a home health rapid referral form dated 08/13/2025 documented the reason for the referral medication management/education, disease management/education, therapeutic exercises, physical therapy and occupational therapy. The patient was an inpatient in the facility within the last 14 days. The form documented to fax the following documents back with the form: most recent exam notes, current medication list and a demographic sheet. During an interview on 09/18/2025 at 1:45 PM, the Director of Social Services stated they start sending discharge referrals for aftercare services two or three weeks before resident's discharge date. The Director of Social Services stated the documentation sent to referral agencies is not kept in the Point Click Care (the electronic medical record) and that it is emailed or faxed to the referral agencies and kept in paper records. During an interview on 09/18/2025 at 2:53 PM, the Registered Nurse Care Manager #1 stated home care services are usually initiated within 48 hours after discharge. During a telephone interview on 09/25/2025 at 11: 32 AM, Home Care agency representative #1 stated they did not receive everything that was needed from the facility to initiate services for Resident #1, as they needed the resident's demographics and had only received the clinicals from the facility. The Home Care agency representative #1 stated on 08/11/2025 they requested Resident #1's orders from the facility which detail what disciplines the resident needs at home as well as the patient's demographics. The Home Care agency representative #1 stated they cannot process/initiate services if they do not receive all needed information such as : disciplines needed, demographics and insurance information. The Home Care agency representative #1 stated they only received Resident #1's clinical information, so they could not tell if they provided services in the area Resident #1 lives or if they can provide the services the resident needs. The Home Care agency representative #1 stated Resident #1 started home care services on 08/14/2025, which was delayed due to the fact they did not have the required documentation from the facility. 10 NYCRR 415.11(d)(3)</p>		

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

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews conducted during an abbreviated survey (2619941) the facility did not ensure a comprehensive care plan was developed and implemented to maintain the resident's highest practicable physical, mental, and psychosocial well-being for one (1) of four (4) residents (Resident # 1) reviewed for constipation. Specifically, Resident # 1 was admitted to the facility on [DATE] and had a diagnosis of constipation with no care plan in place to address the constipation until 6/15/2025. On 8/9/2025, Resident # 1, was discharged from the facility and admitted to the hospital on [DATE] with a diagnosis of severe sepsis. Review of the Facility Care Plan Policy last revised March 2022 documented that Resident Care Plans are developed according to the timeframes and criteria established by S483.21.The facility's undated Treat in Place Guidelines for Constipation and Bowel Protocol documented Symptoms and Interventions: -if no bowel movement for six shifts, give 30 ml, sorbitol by mouth for one dose or via gastrostomy tube for feeding resident times one dose- if no movement in eight hours after sorbitol listen for bowel sounds; notify provider if no bowel sounds; give Dulcolax suppository rectally times one dose for constipation-if no bowel movement eight hours after Dulcolax suppository, give fleet enema rectally for one dose for constipation. Notify provider if fleet enema is not effective.-notify provider for increased pain and/or abdominal distention or if no bowel soundsResident #1 was admitted to the facility on [DATE] with diagnoses including but not limited to Fracture of Neck of Right Femur, Depression, Muscle Weakness. An admission Minimum Data Set assessment dated [DATE] documented Resident #1 had a Brief Interview Mental Status score of 12; indicating the resident had moderate cognitive impairment. Resident requires set up or clean up assistance with eating and toileting. Resident was frequently incontinent of urine and always continent of bowel.A review of Comprehensive Care plan dated 6/15/2025 revealed that resident was at risk for constipation. The goal was that Resident #1 would have normal bowel pattern every two days for 90 days. The interventions listed included assist to the toilet per resident's bowel routine, direct care staff to monitor and track bowel movements, and nursing staff to initiate the bowel protocol, if there were no bowel movement in two days. Review of Resident # 1's Facility's Diagnosis did not list Constipation as a diagnosis.Review of medication administration records for June 2025, July 2025, and August 2025 documented that bowel protocol was not initiated for Resident # 1 until 08/08/2025. On 8/8/2025 the medication administration record documented Resident # 1 received 30 milliliters of Milk of Magnesia.Resident # 1 was triggered on the facility bowel alert lists on 6/7/2025-6/11/2025, 6/22/2025-6/30/2025, 7/18/2025, 7/22/2025-7/24/2025, 7/30/2025-7/31/2025, 8/2/2025, 8/3/2025, 8/6/2025, 8/7/2025 and 8/8/2025 with a response of no bowel movement.Review of Resident # 1's medication administration record for June and July 2025 there was no documented evidence that the bowel protocol was initiated.Review of a Medical Progress Note dated 6/1/2025 at 2:44pm documented that Resident #1 had a current diagnosis of constipation.Review of Nursing Progress Notes from 06/01/2025-08/09/2025 did not document the initiation of the bowel protocol until 08/08/2025. Resident # 1 was administered 30 milliliters of Milk of Magnesia with no documented evidence to show the administration of the Milk of Magnesia was effective.Review of a Medical Progress Note dated 6/3/2025 at 3:16 pm documented a plan for constipation to discontinue the Senna two (2) tablets two (2) times a day because of declining use.Review of the Medication Administration Record for June 2025 did not document that Resident # 1 refused Senna.Review of a Medical Progress Note dated 7/30/2025 at 12:28 pm documented the Resident # 1 complained of constipation. Resident # 1 had a small bowel movement in the morning and wanted a stool softener.Review of a Medical Progress Note dated 07/30/2025 at 12:34 pm documented for Constipation to add Colace 200 milligrams at bedtime.Review of Resident # 1's medication administration record for August 2025 there was documentation that bowel protocol was initiated on 8/8/2025. Resident # 1 was administered 30 ml of Milk of Magnesia for constipation.Resident #1 was discharged home from the facility on 08/09/2025 and was admitted to the hospital on [DATE] with a diagnosis of severe sepsis. Review of the Hospital Record dated 8/10/2025 documented a computed tomography of the abdomen and pelvis without contrast revealed large amounts of stool seen in the rectum with rectal mural thickening concerning for the developing stercoral colitis.During an interview on 9/30/2025 at 11:40 AM Licensed Practical Nurse #3 stated the baseline care plans are initiated by the nursing supervisor during the admission process. Licensed Practical Nurse #3 stated the baseline care plan is initiated at admission and one of the Registered Nurses in the facility then reviews the care plans to ensure the appropriate care plans are initiated. Licensed Practical</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>(continued on next page)</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews conducted during an abbreviated survey (2615374), the facility did not ensure that services being provided meet professional standards of quality in clinical practice for 1 out of 3 residents (Resident #8) reviewed for quality of care/treatment. Specifically, Resident #8 who had a history of stroke was noted to have a sudden onset of slurred speech by Licensed Practical Nurse #6 on 12/07/2024. Nurse Practitioner #3 was informed by Registered Nurse #1 of Resident #8's slurred speech and instructed the staff to place the resident back to bed for rest. Resident #8's slurred speech continued and was reported to Nurse Practitioner #3 and they ordered to treat the resident with intravenous fluids and obtain a speech evaluation done. Resident #8 continued with slurred speech and weakness on 12/07/2025 and was not transferred to the hospital for evaluation until 12/08/2025, after their representative demanded their transfer to rule out a stroke. Resident #8 was admitted to the hospital on [DATE] with a diagnosis of bilateral scattered infarcts. The findings are:The facility Medical Services policy dated 05/20/2023 documented the medical director oversees all medical care within the facility and coordinates with the attending physicians. The Medical Director intervenes on standards of care if a physician's or practitioner's medical care is inconsistent with current standards, the medical director is responsible for discussing and, if necessary, intervening in the care plan.Resident #8 had diagnoses including but not limited to Unspecified Sequelae of Cerebral Infarction, Peripheral Vascular Disease and Parkinson's disease.A Quarterly Minimum Data Set, dated [DATE] documented Resident # 8 had moderate cognitive impairment. The resident used glasses, a hearing device and had clear speech. The resident required a wheelchair for locomotion, supervision with eating, maximal assistance with toileting and bed mobility and dependent for transfers. Review of an impaired cognition: social skills care plan initiated 12/07/2024 documented Resident #8 spoke in fragmented sentences related to Parkinson's disease. Interventions listed included allow increased time for resident to respond and encourage to speak clearly and slowly.Review of a Licensed Practical Nurse #5's progress note dated 12/07/2024 at 04:42 PM documented Resident #8 was having a conversation with the writer, when they noticed the resident had a sudden onset of slurred speech. The nursing supervisor was notified and came immediately to assess Resident #8. Nurse Practitioner #3 was notified and instructed the staff to place the resident in bed to get some rest. Review of Licensed Practical Nurse #6's progress note dated 12/07/2024 at 11:09 PM documented Resident #8 was alert and still noted with slurred speech. Nurse Practitioner #3 was notified and ordered intravenous fluids and lab work.Review of Registered Nurse #1's progress note dated 12/08/2024 at 12:52 PM documented Resident #8 was noted with slurred speech. Nurse Practitioner #3 informed and ordered for Speech evaluation. Review of Registered Nurse #1's progress note dated 12/08/2024 at 01:37 PM documented Nurse Practitioner #3 advised for Resident #8 to be sent to the hospital to rule out Stroke due to Slurred Speech. Review of Nurse Practitioner #3's progress note dated 12/08/2024 at 02:44 PM documented they called Resident #8's representative, as per Registered Nurse #1's request and discussed the resident's slurred speech and general weakness, which was improving with intravenous fluids. Resident #8 had no facial drop or other neurologic deficits noted by the nurse supervisor's assessment. Resident #8's representative stated they were concerned about the resident having a stroke and requested the resident be sent to the hospital for a computed tomography of the head to rule out a stroke. The nurse supervisor was instructed to transfer the resident to the hospital as per their representative's request. Review of the Assistant Director of Nursing progress note dated 12/08/2024 at 07:21 PM documented they spoke with the hospital staff regarding Resident #8's status and per staff, Resident #8 was being admitted with a diagnosis of stroke. Nurse Practitioner #3 was informed.Review of the Medical Director's progress note dated 12/13/2024 at 10:01 PM documented Resident #8 had a new cerebrovascular accident with slight slurred speech/ bilateral scattered acute infarcts: status post hospitalization 12/08/2024 to 12/12/2024 for slurred speech.During a telephone interview on 09/24/2025 at 11:00 AM, Resident #8's representative stated the facility called them and informed them Resident #8 had slurred speech and they responded for them to transfer the resident to the hospital now. Resident #8's representative stated Nurse Practitioner #3, either the day of or the day before, saw and assessed the resident. Resident #8's representative stated the facility reported the wrong information to the emergency medical services stating Resident #8's symptoms started two hours before they arrived. Resident #8's representative stated the resident informed them they had been slurring their speech since breakfast. Resident #8's representative stated the resident was treated for their</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews during an abbreviated survey (2619941), the facility did not ensure that the resident received treatment and care in accordance with professional standards of practice for one (1) of four (4) residents reviewed. Specifically, Resident #1 who had moderate cognitive impairment and a history of constipation was triggered on the facility bowel list report in June, July, and August 2025 for no bowel movement. The facility bowel protocol was not initiated for the resident. Prior to discharge on [DATE] the resident received a dose of Milk of Magnesia on 08/08/2025 with no documented evidence of the effectiveness of the Milk of Magnesia. Subsequently Resident # 1 was admitted to the hospital on [DATE] after discharge and was found to have large amounts of stool seen in the rectum with rectal mural thickening on Computed Tomography of the abdomen. The Findings are: The facility's undated Treat in Place Guidelines for Constipation and Bowel Protocol documented the following Symptoms and Interventions: -if no bowel movement for six shifts, give 30 ml, sorbitol by mouth for one dose or via gastrostomy tube for feeding resident times one dose- if no movement in eight hours after sorbitol listen for bowel sounds; notify provider if no bowel sounds; give Dulcolax suppository rectally times one dose for constipation-if no bowel movement eight hours after Dulcolax suppository, give fleet enema rectally for one dose for constipation. Notify provider if fleet enema is not effective.-notify provider for increased pain and/or abdominal distention or if no bowel sounds Resident #1 was admitted to the facility on [DATE] with diagnoses including but not limited to Fracture of Neck of Right Femur, Depression, Muscle Weakness. Resident #1 was discharged home from the facility on 08/09/2025. An admission Minimum Data Set assessment dated [DATE] documented Resident #1 had a Brief Interview Mental Status score of 12/15 denoting moderate cognitive impairment. Resident was frequently incontinent of bladder and bowel functions. Review of the Constipation care plan dated 06/15/2025 documented a goal that the resident will have normal bowel pattern every 2 days for 90 days with interventions that included assist resident to toilet per resident's bowel routine, initiate bowel protocol if no bowel movement in two days, and monitor and track bowel movements. Review of the Hospital Medication List dated 06/01/2025 documented Senna 8.6 mg tablet take 1 tablet by mouth nightly as needed for constipation. This was last administered on 05/28/2025 at 2:02 PM prior to admission to the facility. Review of Resident #1 admission progress note dated 06/01/2025 at 2:44 PM documented the hospital discharge diagnosis included constipation and sepsis, and the resident's current diagnosis in the facility included constipation and sepsis. Review of the Physician Orders for June 2025 documented Senna-Time Oral Tablet 8.6 MG (Sennosides) give two tablets by mouth two times a day for constipation start date 06/01/2025 and it was discontinued on 06/03/2025. Review of the Physician Orders for July 2025 documented Colace Oral Capsule 100 milligram (Docusate Sodium) give 2 capsules by mouth at bedtime for constipation with an order start date of 07/30/2025 and discontinued on 08/09/2025. Review of the Physician Orders for August 2025 documented Colace Oral Capsule 100 milligram (Docusate Sodium) give 2 capsule by mouth at bedtime for constipation with an order start date of 07/30/2025 and discontinued on 08/09/2025 and a one-time order for Milk of Magnesia Suspension 400 milligrams/ 5 milliliters (Magnesium Hydroxide) give 30 milliliters by mouth one time only for Constipation for 1 Day with a start date of 08/08/2025. A review of the facility clinical alerts for June 2025 documented Resident # 1 was listed on clinical alerts for bowel movements on 06/07/2025-06/11/2025, 06/22/2025-06/30/2025 that meant the resident had no bowel movements on those dates. A review of the facility clinical alerts for July 2025 documented Resident # 1 was listed on the clinical alerts for bowel movements on 07/18/2025, 07/22/2025-07/24/2025, 07/30/2025-07/31/2025 with a response of no bowel movement. A review of the facility clinical alerts for August 2025 documented Resident # 1 was listed on the clinical alerts for bowel movements on 08/02/2025, 08/03/2025, 08/06/2025, 08/07/2025 and 08/08/2025 with a response of no bowel movement. Review of a progress note dated 06/01/2025 at 5:14 PM documented Resident #1 was alert and oriented times two. Resident #1's representative was present during the evaluation. Resident #1 on exam was noted to have a soft non-tender abdomen with positive bowel sounds. Resident #1's last bowel movement was reported on 06/01/2025. Review of Nurse Practitioner #2's progress note dated 06/03/2025 at 3:16 PM documented Resident #1's Senna two tablets two times a day was discontinued due to the resident was declining the use. Resident #1 was seen by the Nurse Practitioner #2 on 06/10/2025 at 3:37PM and there was no documented evidence that the resident's no bowel movement alert on 06/07/2025, 06/08/2025 and 06/09/2025 was</p>		

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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 0711</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit.</p> <p>(continued on next page)</p>

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<p>F 0711</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews during an abbreviated survey (2619941), the facility did not ensure the physician reviewed the resident's total program of care, including treatments at each visit for 2 out of 3 residents (Resident #1 and #10) reviewed for follow up consultation visits. Specifically, (1) Resident #1 who was admitted to the facility status post a right hip fracture had a follow up Orthopedic consultation visit on 06/12/2025. The consultation report documented Resident #1 was to be scheduled for a follow up visit in six weeks. Resident #1 was discharged home on [DATE] without getting the Orthopedic consultation. There was no documented evidence of a Physicians order for the six week follow up visit that needed to be scheduled by the facility for Resident #. The resident was discharged home from the facility on 08/09/2025 and instructed to follow up post discharge with the Orthopedic.(2) Resident #10 was admitted to the facility status post a left hip fracture and had an Orthopedic consultation on 06/02/2025. The consultation report documented Resident #10 was scheduled for a follow up consultation visit on 08/04/2025 at 1 PM. There was no documented evidence of a Physician's order for Resident #10's scheduled follow up consultation visit. Resident #10 was discharged from the facility on 08/23/2025 without their follow up orthopedic visitThe findings are: The facility Physician Services policy dated 11/08/2024 documented the medical care of each resident is supervised by a licensed physician. Consultative services are made available from community-based consultants or from a local hospital or medical center. 1) Resident # 1 admitted to the facility on [DATE] with diagnoses including but not limited to Fracture of Neck of Right Femur, Depression, Muscle Weakness. An admission Minimum Data Set assessment dated [DATE] documented Resident #1 had a moderate cognitive impairment. The resident had impairment to the lower extremity on one side and used a walker for local motion. The resident required supervision for eating, maximal assistance for bed mobility, and was dependent for toileting and transfers. Review of Resident #1's report of consultation dated 06/12/2025 documented the reason for the consult was an Orthopedic follow up. Resident #1 was status post right intertrochanter fracture and would be monitored. Resident #1 would have an x-ray in six weeks, continue with physical therapy and weight bearing as tolerated. Resident #1's knee x-ray shows tricompartmental osteoarthritis and the resident was due for and received a cortisone shot injection today, activity as tolerated. Resident #1 to be scheduled for follow up visit in six weeks. Review of Nurse Practitioner #2's progress note dated 06/13/2025 at 2:09 PM documented Resident #1 was seen for an Orthopedic follow up and consult. Resident #1 to continue weight bearing as tolerated. Knee x-ray noted tricompartmental osteoarthritis. Resident #1 received a steroid injection to the right knee. Activity as tolerated and follow up in six weeks. Resident #1's representative was present at the bedside and all questions were answered. There was no documented evidence of a six week follow up being scheduled for Resident #1, which should have been scheduled on or after 07/24/2025. Resident #1 was discharged from the facility on 08/09/2025 without the Orthopedic consult. During an interview on 09/24/2025 at 9:30 AM, Unit Clerk #1 stated they would be the one responsible to schedule the residents follow up six-week appointments. The Unit Clerk #1 stated the six-week follow up appointment for Resident #1 was not made because the resident was discharged shortly after, either the beginning of August or the end of July. During an interview on 09/24/2025 at 9:45 AM, Licensed Practical Nurse #3 stated Unit Clerk #1 would call the Orthopedics office to schedule the follow up appointment. Licensed Practical Nurse #3 stated there should be a Physician's order for follow up consult. Licensed Practical Nurse #3 stated when the resident returns from a consult visit, Nurse Practitioner #2 is provided the consult documentation, and they order the follow up appointment. During a telephone interview on 09/24/2025 at 2:20 PM, Nurse Practitioner #2 stated they do not have anything to do with scheduling residents follow up appointments. Nurse Practitioner #2 stated they approve the recommendations made from the consultation visits, but they do not enter any orders in Point Click Care (the electronic medical record) for consultation visits. Nurse Practitioner #2 stated if a resident returned with recommendations from a consultation visit, they would have a discussion with the nursing staff on the unit and inform them the resident needs to have a follow up appointment scheduled. Nurse Practitioner #2 stated the process is a verbal communication with the nursing staff and if the Surveyor is looking for this information in the system, it is not there. During an interview on 09/25/2025 at 3:40 PM, Licensed Practical Nurse #3 stated when a consultation is ordered for a resident an order should be entered into Point Click Care (the electronic medical record) by the Nurse Practitioner or the Physician. During an interview on 09/25/2025 at</p>		