STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335261	A. Building B. Wing	05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Paramount at Somers Rehab and Nursing Center	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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews during survey, the facility failed to ensure a resident's right to be free from physical abuse. This was evident for one (1) (Resident #1) of six (6) residents reviewed for abuse. Specifically, on 04/25/2026, between 8:24PM and 8:28PM (actual time) Certified Nurse Aide #1 is observed on facility video surveillance using an overbed table to restrict Resident #1 from getting out of their wheelchair to ambulate. Further review of the footage showed Certified Nurse Aide #1 hitting and pinching the resident on their left arm, then spitting at the resident as the resident attempted to move the table. This resulted in physical abuse to Resident #1 and Immediate Jeopardy to all 48 residents on the behavioral unit. The findings include:The Facility Abuse Prevention Program policy dated 11/14/2024 documented it is the policy of the facility that residents have the right to be free from abuse neglect, misappropriation of the resident's property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms.Resident # 1 was admitted to the facility with diagnoses that included vascular dementia (a type of dementia caused by reduced or blocked blood flow to the brain leading to cognitive decline and memory problems) with agitation, subarachnoid hemorrhage (bleeding in the space between the brain and the tissues that cover it) and depression (persistent feelings of sadness and loss of interest in activities once enjoyed.) The admission Minimum Data Set (a resident assessment tool) dated 04/19/2026 documented Resident #1 had severe impaired cognition with no documented behaviors. The resident had impairment on one side of the upper extremity and required moderate assistance with toileting/bed mobility and set up assistance with eating. Review of the Hospital Discharge summary dated [DATE] documented Resident #1 attacked their spouse and needed to have delirium precautions.The Comprehensive Care Plan related to falls dated 04/15/2026 documented Resident #1 was at risk for falls and has a history of falls. Interventions included getting the resident up at 7:30AM to be brought to the common area for increased supervision, reality orientation and encouraging resident to stay in a supervised areaReview of a behavioral note dated 04/17/2026 documented Resident #1 was restless, physically combative and agitated in the evening. Resident #1 was placed on one-to-one supervision.Review of Resident #1's Kardex (a quick reference that provides concise information on the resident's care plan, medical history and daily needs) documented no instructions for how to address behavioral symptoms prior to the incident on 04/25/2026. Review of the Comprehensive Care Plans revealed no documented behavior care plan to address Resident #1's behavior until after the incident on 04/25/2026. The Facility video surveillance dated 04/25/2026 with time stamp between 7:24PM and 7:28PM (due to daylight savings time, the clock on the surveillance was not updated and is one hour behind the actual time of occurrence) revealed Certified Nurse Aide #1, with their cell phone in hand, seated next to Resident #1 in the unit hallway. Certified Nurse Aide #1 and Resident #1 are observed in a verbal exchange, with the resident attempting to push the overbed table away. Certified Nurse Aide #1 is observed forcibly placing/repositioning the overbed table in front of the resident several times as the resident is trying (continued on next page)

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	to push the overbed table away. Certified Nurse Aide #1 is observed hitting the resident on their left arm followed by pinching the resident and then spitting at and hitting the resident again three (3) minutes later at 7:27PM. Licensed Practical Nurse #2 is seen at the nurse's station located directly across from where the incident was occurring and responds to the situation after Certified Nurse Aide #1 spits at the resident and then hits the resident for the second time at 7:27PM.In an interview with Certified Nurse Aide #1 they reported that they were instructed to place the overbed table in front of the resident to prohibit them from getting out of the chair or moving, as the resident had a history of falls. There was no documented evidence that Certified Nurse Aide #1 received behavior management training prior to caring for Resident #1.A review of the facility's 5-day report submitted to the Department of Health on 05/01/2026 documented a conclusion that the abuse was verified. Corrective actions taken because of the verified abuse included Certified Nurse Aide #1 was removed from the unit immediately and had no further contact with residents. Additionally, 911 was notified and State Troopers arrived; Certified Nurse Aide #1 was removed from the premises by State Troopers pending an appearance in court. Resident #1 was immediately assessed, and no physical injuries (no new redness and no new bruising) were observed. The resident's physician was notified. The resident's family was notified. Resident #1 was placed on every 30-minute observation rounds for 72 hours. All residents on Certified Nurse Aide #1's assignment were assessed for any new bruising or emotional distress injuries; no negative findings were identified. Staff were interviewed and statements obtained. The Staffing Agency (Clipboard Agency Staffing) that scheduled Certified Nurse Aide #1 was notified and the facility requested that Certified Nurse Aide #1 be placed on the do not return list for the facility. The 5-day report documented the resident was assessed by a Provider and was also assessed by a psychiatrist and there were no negative findings. The residents plan of care was updated. Staff were educated on abuse prevention and deescalating behaviors. During a telephone interview with Certified Nurse Aide #1 on 04/30/2026 at 2:01PM they stated that they had worked in the facility for three (3) weeks as agency staff. They stated they were not provided with any training by the facility. Certified Nurse Aide #1 stated they had to go to other certified nurse aides for information about the residents on their assignment or use common sense to care for the residents. Certified Nurse Aide #1 stated on the day of the incident Resident #1 began to stab them with the pen and spit on them while they were providing 1:1 supervision and they reported to Licensed Practical Nurse #1, who told them they needed to sit with Resident #1 because that is what they signed up to do. Certified Nurse Aide #1 stated they should not have tapped the resident; they looked for a supervisor but could not find one because it is difficult to find a supervisor in the facility.During an interview conducted on 04/30/2026 at 10:00AM the Director of Nursing stated Resident #1 had challenging behaviors. They were a high fall risk and were difficult to redirect. Resident #1 tried to stab their spouse and became unmanageable at home and was hospitalized . The Director of Nursing stated that as Resident #1's dementia progressed their behavior became increasingly aggressive. Since Resident #1 was admitted to the facility, they have had multiple falls. On the day of the incident, someone at the nurses' station was trying to redirect the resident. Resident #1 was restless, stabbed Certified Nurse Aide #1 with a pen, and hit Certified Nurse Aide #1. The Director of Nursing stated Certified Nurse Aide #1 informed them that as a reflex response, they spit on Resident #1 and then swatted the resident on the left arm. Other facility staff were in the area and heard a commotion and witnessed some portions of the incident. Licensed Practical Nurse #2 separated Certified Nurse Aide #1 away from the resident and Registered Nurse Supervisor #1 removed Certified Nurse Aide #1 from the unit, notified Administration and called 911. State Troopers arrived, interviewed Certified Nurse Aide #1 and Resident #1. State Troopers took Certified Nurse Aide #1 into custody. Clipboard Agency Staffing was notified via email that Certified Nurse Aide #1 should no longer be scheduled to work for the facility. The Director of Nursing stated the facility reached out to the Licensing board to report the incident. The facility began in-service training of staff on abuse. On 05/01/2026 at 11:26 AM and 05/07/2026 at 2:53 PM, the Medical Director was interviewed and stated they were the (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	primary care physician for the Westminster Unit but gave this responsibility over to Physician #1 approximately one month ago. The Medical Director stated any indication on Resident #1's chart that the Medical Director was the resident's primary care physician was a mistake and would be corrected immediately by the facility. The Medical Director stated the Director of Nursing called to inform them of the incident involving Resident #1 and Certified Nurse Aide #1 on 04/25/2026. The Medical Director stated they assessed Resident #1 the following day, 04/26/2026, and found the resident to be in a good mood with no injuries from or memory of the incident. The Medical Director stated they did not watch the facility video footage of the incident and was told by the Director of Nursing that the aide only tapped the resident on their shoulder and did not cause the resident harm. The Medical Director stated staff should not touch a resident unless they were providing care. Resident #1 should have been assessed by a psychiatrist following the incident and stated they would have to check Resident 1's record to see if a Psychiatry Consult was done. The Medical Director stated the facility had a robust behavior management program that included strong communication with the Psychiatrist and the availability of psychiatric telehealth services for emergencies. The Medical Director stated they reviewed and signed every facility Incident Investigation at its conclusion to ensure accuracy and a determination clearly indicated whether resident abuse had been ruled out. The Medical Director stated they reviewed the facility investigation for Resident #1 and determined that abuse did occur when Certified Nurse Aide #1 struck Resident #1. During a follow up interview on 05/01/2026 at 1:05PM the Director of Nursing stated that the facility did not ensure agency staff received education on behavior management prior to working in the facility. During an interview conducted on 05/01/2026 at 2:40PM, the Administrator stated they were notified by the Director of Nursing on 04/25/2026 at 9:17PM about the incident with Resident #1. They received a snippet of the surveillance video from the Assistant Director of Nursing 30 minutes after notification, and they did review it. They observed the Certified Nurse Aide's hand on Resident #1. They arrived at the unit at 10:40PM and did not allow Certified Nurse Aide #1 to leave. The Resident was assessed by Registered Nuse Supervisor #1 and local law enforcement was notified. After local law enforcement reviewed the surveillance video footage, they informed them that based on what they saw they would be removing Certified Nurse Aide #1 to bring them to the precinct. The Administrator stated they reviewed the video surveillance several times and determined that abuse could not be ruled out because they saw Certified Nurse Aide #1 spit their gum at the resident and strike the resident. Abuse did occur. As part of the facility's investigation, they conducted staff interviews and collected statements. Every resident on Certified Nurse Aide #1's assignment was assessed. Resident #1 was evaluated by their provider after the incident.During an interview with Licensed Practical Nurse #2 on 05/04/2026 at 10:36AM, they stated they had worked with Certified Nurse Aide #1 prior to the incident without any issues. On the day of the incident (04/25/2026) Resident #1 was agitated and had a fall earlier that day. Resident #1 has behaviors where they try to get up and stand, and they scratch and spit on staff. On 04/25/2026 at around 8:00PM they finished their medication pass and were documenting. They turned their head and saw Resident #1 spitting, so they got up to de-escalate the situation. They approached the resident and spoke to them in a calm tone and the resident calmed down. Licensed Practical Nurse #2 stated after the resident calmed down, they went back to documenting and then heard a slap and observed Certified Nurse Aide #1's hand in a motion retracted back, but they did not observe the slap. Registered Nurse #1 on the unit called Registered Nurse Supervisor #1 and Certified Nurse Aide #1 was removed, and Resident #1 was assessed by Registered Nurse Supervisor #1. Licensed Practical Nurse #2 reported that Certified Nurse Aide #1 told them that in [NAME] they do not tolerate anyone spitting on them. Licensed Practical Nurse #2 acknowledged that the spitting could have been a trigger for Certified Nurse Aide #1, but they did not unassign the task of sitting with Resident #1 when they expressed that spitting was an issue. As the Nurse on the floor, they oversee everything. Licensed Practical Nurse #2 stated their last in-service was about two (2) weeks ago on abuse prevention. The educator gave them a 2-page handout with a multiple-choice quiz. The abuse training (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	did not consist of a webinar presentation, or video training. Licensed Practical Nurse #2 stated the facility did not give them an in-service on how to identify and deal with staff that are at an increased risk of becoming abusive.During an interview with Certified Nurse Aide #7 on 05/05/2026 at 5:15PM, they stated they work in the facility as an agency staff. They have worked in the facility four (4) times. The facility did not train them on abuse, dementia care, or how to manage residents with behaviors. Certified Nurse Aide #7 stated they do not receive any of these training courses through their staffing agency. They have worked for other facilities through the agency, and some facilities provided training, but it depends on the facility. On 05/11/2026 at 11:19 AM, Nurse Practitioner #1 was interviewed and stated they were responsible for overseeing physician services on Resident #1's unit. Nurse Practitioner #1 stated they evaluated Resident #1 on 04/25/2026 earlier in the day after the resident had a fall and required x-rays. Nurse Practitioner #1 was unable to provide documented evidence of their visit with Resident #1 after the resident fell in the morning on 04/25/2026. Nurse Practitioner #1 stated they were not involved in any abuse investigations conducted by the facility and did not assess Resident #1 after they were struck by Certified Nurse Aide #1 on the evening of 04/25/2026. Nurse Practitioner #1 stated they answered directly to the Medical Director and conferred with the Medical Director via telephone about any concerns. Nurse Practitioner #1 stated Physician #1 was not assigned as the attending physician on Resident #1's unit and only completed admission assessments, discharge assessments, and sometimes completed a monthly assessment of the residents in compliance with physician services but Physician #1 did not manage the acute and daily medical needs of the residents on the Westminster Unit. The facility used a third-party vendor to provide on-call telehealth physician services when the facility nurse practitioners and medical doctors were not present in the building in the evening, at night, or on the weekend.There was no documented evidence Nurse Practitioner #1 evaluated Resident #1 on 04/25/2026 following their fall incident in the morning and following their incident with Certified Nurse Aide #1. The Facility implemented the following to remove the immediacy:The facility implemented the following training: Abuse prevention/restraints, staff wellness and burnout prevention and behavior management of residents with dementia for all facility and agency staff prior to providing direct care to residents. Audits were initiated to ensure all potentially affected residents with a diagnosis of dementia and behaviors had resident centered physician ordered care plansFacility Leadership (Director of Nursing/Nursing Supervisors and Unit Managers began scheduled rounding/monitoring of licensed practical nursing staff and certified nurse aides on the unit to oversee that residents receive quality care and are free from abuseThe facility policy titled Staff Orientation was revised to include ongoing in-service and education for scheduled agency staff and mandatory education provided be maintained in individual employee filesFacility provided in-service attendance/lesson plan provided to facility staff at 97% and 14 of 14 agency staff at100%.The facility will implement a tracking system with Human Resources, Nursing and facility educators to ensure employee files are complete with records of employment, competencies and ensure they are readily available for review.Interviews were conducted with Registered Nurses/Licensed Practical Nurses/Certified Nurse Aides/Physical Therapists/Housekeepers/Director of Nursing and Medical Director who confirmed receiving in-service on abuse prevention/restraints, staff wellness and burnout prevention and behavior management of residents with dementiaIJ was removed on 05/09/2026 at 4:20PM. 10 NYCRR 415.4(b)(1)(i)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility did not ensure the resident's right to be free from physical restraints imposed for purposes of discipline or convenience. This was evident for one (Resident #1) of seven residents reviewed for abuse. Specifically, video surveillance dated 04/25/2026 showed Certified Nurse Aide #1 use an overbed table to prevent Resident #1 from getting up out of their wheelchair without documented evidence of restraint assessment or physician orders for such use.The findings are:The facility policy titled Physical Restraint Use dated 11/14/2024 documented restraints shall only be used to treat the resident's medical symptom(s) and never for the prevention of falls. Resident # 1 was admitted to the facility on [DATE] with diagnoses of vascular dementia with agitation and depression. The Minimum Data Set 3.0 (an assessment tool) dated 4/19/2026 documented Resident #1 was severely cognitively impaired, and required moderate assistance from staff for toileting, bed mobility, and transfers. The Comprehensive Care Plan related to falls dated 04/15/2026 documented Resident #1 had falls on 04/15/2026, 04/21/2026, 04/24/2026, and 04/25/2026. Interventions implemented on 04/15/2026 included getting the resident up at 7:30 AM to be brought to the common area for increased supervision and encouraging the resident to stay in a supervised setting. On 04/21/2026, interventions to place Resident #1 back into bed at 11PM were implemented. On 04/24/2026, staff to use footrest during propulsion and remove the footrest when Resident #1 was parked and locked because the resident tended to trip over their footrest. On 04/25/2026, Resident #1 was placed on 30-minute monitoring for 72 hours.There was no documented evidence Resident #1 was assessed for restraint use related to a medical condition or that a physician's order was in place for restraint use for Resident #1. The facility's video surveillance dated 4/25/2026 from 8:24 PM to 8:28 PM showed Certified Nurse Aide #1 seated next to Resident #1 in the unit hallway across from the nursing station. An overbed table was in front of Resident #1 while the resident was seated in their wheelchair. wheelchair. Resident #1 attempted to push the overbed table away from them six times and Certified Nurse Aide #1 pushed the overbed table back in front of Resident #1 each time. Resident #1 became increasingly agitated and, at 8:26 PM, began using their feet to push the overbed table away from them. Certified Nurse Aide #1 rose from their seat and grabbed Resident #1's feet, and raised them up, allowing Certified Nurse Aide #1 to push the overbed table closer to Resident #1's upper body. At 8:27 PM, Resident #1 attempted to raise the height of the overbed table and Certified Nurse Aide #1 lowered the table back down so that it was the height of Resident #1's wheelchair armrests, boxing the resident in their wheelchair seat and preventing them from moving around freely. On 04/30/2026 at 2:01 PM, Certified Nursing Aide #1 was interviewed and stated that they were assigned by Licensed Practical Nurse # 2 to sit with Resident #1 and provide one-to-one supervision. Certified Nurse Aide #1 stated they were instructed to make sure Resident #1 did not get up out of their wheelchair because the resident had a fall earlier in the day on 04/25/2026.On 05/04/2026 at 10:36 AM, Licensed Practical Nurse # 2 was interviewed and stated they assigned Certified Nurse Aide #1 to sit with Resident #1 because Resident #1 was at high risk for falls and had a fall earlier in the day on 04/25/2026. Licensed Practical Nurse #2 stated the facility did not use restraints on residents and they did not notice the overbed table being used as a restraint Resident #1 when Licensed Practical Nurse #2 was seated across from Certified Nurse Aide #1 at the nursing station on 04/25/2026. On 05/11/2026 at 3:56 PM, the Director of Nursing was interviewed and stated that they watched the surveillance video and did not see the overbed table as a restraint. Resident # 1 had a paper and pen and was using the table to write on. Resident # 1 was also able to move the table from in front of them; therefore, they did not view the overbed table as a restraint.There was no documented evidence Resident #1 used the overbed table for diversional activities on video surveillance or as a care plan intervention in the resident's record. On 05/11/2026 (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 5:40 PM, the Administrator was interviewed and stated that they watched the video surveillance from the incident on 04/25/2026 multiple times. They did not identify concerns related to the overbed table being used as a restraint until the surveyors brought it to the facility's attention. The Administrator stated they can see how the overbed table was used as a restraint. 10 NYCRR 415.3(d)(1)(vii)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review conducted during survey, the facility failed to ensure procedures were developed and maintained to include screening and abuse prevention training of prospective staff. This was evident for five of five facility/agency staff (Certified Nurse Aides #1, #2, and #5, Licensed Practical Nurses #1 and #2) employee files reviewed. Specifically, there was no documented evidence that Certified Nurse Aides #1, #2, #5, and Licensed Practical Nurse #1 and #2 were screened or received training to competently address residents with behaviors and to prevent abuse.The findings are:The Facility assessment dated [DATE] documented a list of their outside contracts that did not include agency nursing staff.The facility policy and procedure titled Abuse, Neglect, Exploitation, and Misappropriation Prevention Program dated 11/14/2024 documented background checks were a part of abuse prevention. The policy did not document the procedure for screening and training prospective and current agency and facility staff.1) The employee file for Certified Nurse Aide #1, agency staff, was reviewed and did not contain documented evidence that the employee was fingerprinted, had their references checked, or had a review of their previous and current employment prior to their hire date on 04/16/2026. There was no documented evidence that Certified Nurse Aide #1 received in-service training related to abuse prevention for residents with behaviors.2) The employee file for Certified Nurse Aide #2, agency staff, was reviewed and did not contain documented evidence a background check was conducted, fingerprinting was done, references were checked, or previous and current employment was reviewed prior to their hire date of 01/20/2026. There was no documented evidence that Certified Nurse Aide #2 received in-service training related to abuse prevention for residents with behaviors. 3) The employee file for Licensed Practical Nurse #2, facility staff, was reviewed and did not contain evidence that a background check was conducted, fingerprinting was done, references were checked, or previous and current employment was reviewed prior to their hire date on 11/20/2025. There was no documented evidence that the facility obtained the status and disciplinary actions from other licensing and registry boards for Licensed Practical Nurse #2. There was no evidence Licensed Practical Nurse #2 received abuse prevention in-service training to competently identify, prevent, and address staff abuse of residents with behaviors.On 04/30/2026 at 3:54 PM, Human Resource Coordinator #1 was interviewed and stated their department received notification from nursing administration when prospective new hires were being considered. Human Resources Coordinator #1 stated they ran some agency personnel through a criminal history record check, and some agency nursing staff already come with background checks completed by their agency. Human Resources Coordinator #1 stated they were only responsible for employee screening assigned to her by the former Human Resources Director. The former Human Resources Director, who shared this responsibility with Human Resources Coordinator #1, was no longer employed by the facility. The former director was responsible for handling and maintaining record of staff disciplinary actions and writeups in each employee's file. Human Resources Coordinator #1 stated they were not familiar with Certified Nurse Aide #1 or Certified Nurse Aide #5 and did not screen them before they were hired by the facility. On 04/30/2026 at 4:12 PM, the new Human Resources Director #1 was interviewed and stated they were still in training and just started working for the facility on 04/13/2026. The facility's third-party vendor kept electronic records of pre-employment screening and tracked pre-employment and ongoing in-service education for facility staff. Human Resources Director #1 stated they were not involved in screening prospective nursing or agency staff. Human Resources Coordinator #1 was responsible for screening agency staff and maintaining these records in the employee files. The Human Resources Director #1 looked through the employee file records in their office and on their computer and stated they could not locate an employee file for Certified Nurse Aide #5. Human Resources Director #1 then stated that the staffing agency, not the facility, was responsible for screening and maintaining employee files for agency (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	staff. Human Resources Director #1 stated license verification was done for Licensed Practical Nurse #2 prior to their hire date and there were no disciplinary actions associated with their nursing license in New York State.There was no documented evidence that the facility screened Licensed Practical Nurse #2 for the status and disciplinary actions from other licensing and registry boards in other states. On 05/01/2026 at 4:43 PM, a follow up interview was conducted with Human Resources Director #1 who stated Human Resources Coordinator #1 was responsible for all employee fingerprinting. Human Resources Director #1 stated they were unfamiliar with the facility's fingerprinting procedure for prospective new hires. Human Resources Director #1 stated the staffing agency was responsible for screening agency staff, including conducting background checks, and the facility did not have a system in place to screen agency staff before they began working at the facility.During an interview on 05/01/2026 at 1:05 PM, the Director of Nursing stated that the staffing coordinator was responsible for interviewing and hiring the certified nurse aides and the Assistant Director of Nursing interviews and hires the licensed nurses. The Director of Nursing stated that the Human Resources Department is responsible for the screening of prospective facility staff during the onboarding process prior to the employee's start date. Prospective agency staff were required to sign and complete forms that included information related to behaviors and abuse prevention prior to being able to schedule any shifts with the facility. The Director of Nursing stated that the training, education, and screening process for prospective facility staff was not the same for the agency staff. The Director of Nursing stated that agency staff did not receive orientation to the facility's systems and processes and were expected to start their first shift in the facility by going straight to the unit and getting report on their assignment by the charge nurse. The Director of Nursing stated they were not involved with screening or training prospective new hires and did not think there was an issue with the current screening and training process for agency staff.On 05/11/2026 at 5:40 PM, an interview was conducted with the Administrator who stated they began working for the facility seven months ago and identified staffing and new employee onboarding concerns via quality assurance performance improvement program meetings in January 2026 and April 2026. The Administrator stated the facility has begun the process of making changes to address areas of concern. The Administrator stated the facility recently hired Human Resources Director #1 to reshape the department and address the concerns identified during quality assurance performance improvement meetings.10 NYCRR 415.3(d)(1)(vii)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Paramount at Somers Rehab and Nursing Center	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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review conducted during a survey, the facility did not ensure all alleged violations involving abuse, including injuries of unknown origin, were reported immediately to the State Survey Agency and that reports submitted were accurate with all significant details. This was evident for four (4) Residents #3, # 4,#6, and #7) of six (6) residents reviewed for abuse reporting. Specifically, 1) the facility received an alleged incident of abuse that occurred on 04/10/2026 involving Resident #3, from a visitor. The facility submitted a report which documented a police report having been filed. During the onsite investigation, the facility Incident Investigation dated 04/10/2026 was reviewed and contained a Police Report filed on the morning on 04/10/2026, at 7:26 AM, while facility incident report documented Resident #3's incident occurred on 04/10/2026 between 4:00 PM and 4:30 PM, 2) Resident #7 had an unwitnessed fall on 2/22/2026 and was found on the floor with a head injury requiring hospitalization and four (4) staples. The facility did not report the incident to New York State Department of Health. 3) Resident 4 who had a history of behaviors including wandering and going through other residents' items was found in bed with Resident #6 on 02/11/2026. There was no incident report provided by the facility when requested and the incident was not reported to the New York State Department of HealthThe findings are:Resident #3 Resident #3 had diagnoses of dementia, depression, and unspecified mood disorder.The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #3 was moderately cognitively impaired and displayed no behaviors.The Director of Nursing reported to the New York State Department of Health on 04/10/2026 at 7:20 PM that a family member reported hearing screaming from Resident #3's room between 4:00 PM and 4:30 PM, after staff entered and closed the door. Resident #3 was heard screaming stop, don't hit me. Resident #3 was interviewed and stated they were hit. A police report was filed.The facility Incident Investigation dated 04/10/2026 contained a Police Report filed in the morning on 04/10/2026, at 7:26 AM, when Resident #3's incident occurred on 04/10/2026 in the afternoon between 4:00 PM and 4:30 PM.There was no documented evidence that a police report was filed after the incident for the allegation of abuse involving Resident #3. Resident #4Resident #4 had diagnoses of dementia and syncope, anxiety dementia.The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #4 had moderate cognitive impairment.The Nursing Note dated 02/11/2026 documented Resident #4 and Resident #6 were observed lying in bed together.There was no documented evidence Resident #4 and Resident #6's allegations of sexual abuse were reported to the New York State Department of Health.Resident # 6Resident # 6 was initially admitted to the facility with diagnosis that include Dementia with behavioral disturbances, psychosis, and anxiety.A quarterly minimum data set (an assessment tool) dated 11/24/2025 documented Resident # 6 had a brief interview for mental status score of 04, indicating severe cognitive impairment. Resident # 6 had disorganized thinking and no behaviors noted.The Nursing Note dated 02/11/2026 documented Resident #4 and Resident #6 were observed lying in bed together.There was no documented evidence Resident #4 and Resident #6's allegations of sexual abuse were reported to the New York State Department of Health.Resident # 7Resident # 7 was admitted with diagnosis that include congestive heart failure (chronic condition where the heart is unable to pump blood effectively leading to a fluid buildup in lungs and other parts of the body), insomnia (a sleep disorder that can make it hard to sleep), and muscle weakness.A quarterly minimum data set (an assessment tool) dated 02/23/2026 documented Resident # 7 had a brief interview of mental status score a 3; indicating the resident was severely cognitively impaired, had two (2) or more falls since last assessment (one with injury) and required supervision when toileting and transferring in and out of bed.Review of a Nursing Progress Note dated 2/22/2026 at 2:56 PM wrote by the Director of Nursing documented Director of Nursing was called to unit to assess Resident # 7 who had a fall. Blood observed from left temporal area, (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	laceration present. Gauze and ice applied; pressure dressing placed which controlled bleeding. 911 called and resident's family was notified of transfer to hospital.There was no documented evidence Resident # 7's unwitnessed fall with head injury was reported to the New York State Department of Health.During an interview on 05/11/2026 at 3:56 PM, the Director of Nursing stated they did not know the reporting guidelines for injuries of unknown origin. They did not know that facial and head injuries were suspicious in nature. The Director of Nursing stated they would have to refer to the reporting manual guidelines. Regarding the incident with Resident #4's wrist fracture, they stated they could not recall the specific details of the injury, and they could not recall Resident #4's sexual encounter with Resident #6.10 NYCRR 415.4(b)(2)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review conducted during a survey, the facility did not ensure allegations of abuse, neglect, exploitation, or mistreatment, including injuries of unknown source were thoroughly investigated for three (3) (Residents #1, # 4, and #6) of seven (7) sampled residents. Specifically, 1) the facility's investigation into staff-to-resident abuse involving Resident #1 and Certified Nurse Aide #1 did not identify failures leading up to the abuse 2) Resident #4 sustained a left distal impact fracture on 02/2026. There was no documented evidence that the facility investigated Resident #4's fracture of unknown origin. 3) Resident #4 and Resident #6, both cognitively impaired and unable to consent, were found in bed together on 02/11/2026 and the facility did not conduct an investigation or report the incident to the New York State Department of Health. The findings are:1) Resident #1 was admitted to the facility on [DATE] with diagnoses of vascular dementia with agitation and metabolic encephalopathy.The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #1 was severely cognitively impaired. The Facility video surveillance dated 04/25/2026 with time stamp between 7:24PM and 7:28PM (due to daylight savings time, the clock on the surveillance was not updated and is one hour behind the actual time of occurrence) revealed Certified Nurse Aide #1, with their cell phone in hand, seated next to Resident #1 in the unit hallway. Certified Nurse Aide #1 and Resident #1 are observed in a verbal exchange, with the resident attempting to push the overbed table away. Certified Nurse Aide #1 is observed forcibly placing/repositioning the overbed table in front of the resident several times as the resident is trying to push the overbed table away. Certified Nurse Aide #1 is observed hitting the resident on their left arm followed by pinching the resident and then spitting at and hitting the resident again three (3) minutes later at 7:27PM. Licensed Practical Nurse #2 is seen at the nurse's station located directly across from where the incident was occurring and responds to the situation after Certified Nurse Aide #1 spits at the resident and then hits the resident for the second time at 7:27PM.The Director of Nursing reported to the New York State Department of Health on 04/25/2026 at 11:39 PM that Resident #1 attempted to hit and spit on Certified Nurse Aide #1 who attempted to redirect the resident. Certified Nurse Aide #1 tapped Resident #1 on the shoulder. The Director of Nursing submitted a 5-day report to the New York State Department of Health on 05/01/2026 at 4:33 PM documenting that camera footage was reviewed and demonstrated Certified Nurse Aide #1spit in the direction of Resident #1 and made some type of contact with the resident's left arm. Certified Nurse Aide #1 tried numerous times to redirect Resident #1. The report documented Resident#1 was assessed by a physician and psychiatrist. There was no documented evidence this assessment was done following Resident #1's incident. Refer to F600, F604, F607, and F940. There was no documented evidence the facility conducted a thorough investigation into an incident of staff-to-resident abuse involving Resident #1 and Certified Nurse Aide #1 on 04/25/2026, failing to identify systemic failures leading up to the abuse incident.2) Resident #4 had diagnoses of dementia and syncope. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #4 had moderate cognitive impairment, had two or more falls since the last assessment, required supervision with transfers, and required moderate assistance from staff for toileting.Review of Resident #4 Physician Orders dated 02/25/2026 documented left-hand x-rays were ordered for Resident #4 for unspecified fracture of left radius (one of two long bones in the forearm). Review of a Nursing Progress Note dated 02/25/2026 at 9:35 PM documented x-ray results reviewed by the provider revealed Resident #4 had a left distal radius impact fracture. The Physician Note dated 03/02/2026 documented Resident #4 had a fall with a left wrist fracture and fall precautions should continue. There was no documented evidence that Resident #4's wrist fracture of unknown origin was investigated by the facility to rule out abuse. 3) Resident #4 had diagnoses of dementia and syncope. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #4 had moderate (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	cognitive impairment, had two or more falls since the last assessment, required supervision with transfers, and required moderate assistance from staff for toileting. for locomotion. The Nursing Note dated 02/11/2026 documented Resident #4 and Resident #6 were observed lying in bed together, caring for each other, and the activity appeared consensual. The residents were separated, and the Administrator and Director of Nursing were made aware. The Comprehensive Care Plan developed on 02/13/2026 identified that Resident #4 exhibited hypersexual behavior and had no personal boundaries.The Facility did not provide an investigation for the incident on 02/11/2026 between Resident #4 and Resident #6. The incident was not reported to the New York State Department of Health.On 05/11/2026 at 3:56 PM, the Director of Nursing stated they could not recall the specific details of Resident #4's wrist fracture and physical activity and contact with Resident #6. The Director of Nursing stated they did not know why an investigation was not completed for Resident #4 and Resident #6.On 05/11/2026 at 5:40pm, the administrator stated they will be hiring an outside consultant to review their polices and procedures on abuse including reporting and investigating10 NYCRR 415.4(b)(3)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews conducted during survey, the facility failed to ensure that two (2) of six (6) residents (Residents #7 and #1) received adequate supervision and interventions to prevent accidents. Specifically, 1) On 02/22/2026 Resident #7 had an unwitnessed fall sustaining a facial laceration requiring hospitalization and four staples to the resident's left temporal lobe and on 05/07/2026 had a fall and sustained bruising to the left side of their face and laceration to their left eye. Interventions to prevent falls were not developed and implemented following falls on 05/02/2026, 05/04/2026 and 05/05/2026. 2) Resident #1 had unwitnessed falls on 04/15/2026 and 04/21/2026, a witnessed fall on 04/24/2026, and another unwitnessed fall on 04/25/2026 where they sustained a right eyelid abrasion (cut) with bruising and swelling to their nose and right side of their face. This resulted in actual harm to Resident #7 and Resident #1 that was not Immediate Jeopardy.The findings are:The policy titled Fall Risk Managing dated 10/07/2025 documented the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Resident #7Resident #7 had diagnoses of congestive heart failure (a chronic condition where the heart is unable to pump blood effectively leading to a fluid buildup in the lungs and other parts of the body) and insomnia (a sleep disorder that can make it hard to fall asleep).The Minimum Data Set (a resident assessment tool) dated 02/23/2026 documented Resident #7 was severely cognitively impaired, had two (2) or more falls since the last assessment (one with injury), and required supervision when toileting and transferring in and out of bed.The Comprehensive Care Plan related to fall risk created 08/16/2025 documented Resident #7 had falls on 11/01/2025, 11/26/2025, 02/22/2026, and 02/23/2026. Interventions included reminding Resident #7 to use their call bell for assistance and encouraging the resident to stay in the common area when awake.The Nursing Note dated 02/22/2026 documented Resident #7 was found on their bedroom floor bleeding from their head and was sent to the hospital for evaluation.The Hospital Discharge summary dated [DATE] documented Resident #7 had a facial laceration.The Nursing Note dated 02/23/2026 documented Resident #7 was readmitted from the hospital with four staples to their left temporal lobe. The Fall Risk Evaluation dated 02/23/2026 documented Resident #7 was at high risk for falls.The care plan was revised 02/23/2026 to include an intervention to toilet Resident #7 every three (3) hours.The Incident Investigation dated 02/23/2026 documented Resident #7 just returned from the hospital and had an unwitnessed fall while trying to transfer themselves into bed.There was no documented evidence the facility evaluated the effectiveness of interventions.Nursing Notes and Incident Investigations by Registered Nurse #2 dated 05/02/2026, by Registered Nurse Supervisor #1 dated 05/04/2026, and by Registered Nurse Supervisor #1 dated 05/05/2026 respectively documented Resident #7 had unwitnessed falls on 05/02/2026, 05/04/2026, and 05/05/2026. There was no documented evidence that the care plan related to falls was reviewed or revised following Resident #7's falls on 05/02/2026, 05/04/2026, and 05/05/2026.The Nursing Note dated 05/07/2026 at 8:01 AM by Licensed Practical Nurse #2, documented Resident #7 was found on the floor with a laceration and bruising to their face.The Facility Incident Investigation dated 05/07/2026 documented Resident #7 was found on the floor in their room at 4:00 AM and stated they were trying to get up and tripped and fell. The resident had a wound to the left side of face on their eyebrow and bruises to the left side of face and right side of knee, left middle finger and a bump on the left shoulder. Stat (immediate) Xray ordered.During an observation 05/07/2026 at 10:56 AM, Resident #7 was observed with facial bruising on the left side of their face and eye. Resident #7 was grimacing in pain and grabbing their left shoulder. Registered Nurse #2 was present during observation and stated Resident #7 had an unwitnessed fall in their room early this morning on the night shift and x-rays were ordered.On 05/07/2026 at 1:30 PM, Certified (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Nurse Aide #8 was interviewed via telephone and stated they were regularly scheduled to work the night shift on the Westminster Unit. There were two aides scheduled to work and they split 51 beds on the unit on the night shift. Certified Nurse Aide #8 stated they rounded on their assigned residents and placed beds in the lowest position for their fall risk residents. Certified Nurse Aide #8 stated many of the fall risk behavioral residents wanted to be toileted between 4:00 AM and 5:00 AM and this was when the shift had a lot of their fall incidents. Certified Nurse Aide #8 stated the assignment was impossible to complete with two) aides on the unit.On 05/07/2026 at 2:29 PM, Certified Nurse Aide #9 was interviewed via telephone and stated they worked the night shift last night and were assigned to Resident #7. Certified Nurse Aide #9 stated they knew Resident #7 was a fall risk and tucked the resident in with pillows so the resident could not get out of bed. Certified Nurse Aide #9 stated they found Resident #7 on the floor while performing rounds around 4:00 AM. Certified Nurse Aide #9 stated they had just toileted Resident #7 and that toileting the resident regularly did not prevent the resident from attempting to get up without assistance. Certified Nurse Aide #9 stated they received report from the charge nurse at the beginning of their shift and were not informed that Resident #7 had a fall on 05/05/2026 and were not aware of any special interventions to prevent falls for Resident #7.Resident #1Resident #1 was admitted to the facility on [DATE] with diagnoses of vascular dementia (disease caused by decreased blood flow to the brain leading to cognitive impairments that affects daily functioning) with agitation and metabolic encephalopathy (a change in how the brain works due to an underlying condition leading to confusion/memory loss).The Minimum Data Set (a resident assessment tool) dated 04/19/2026 documented Resident #1 was severely cognitively impaired and had no history of falls. The Nursing Note dated 04/15/2026 by the Director of Nursing documented the dentist found Resident #1 on the floor at 8:22 AM in their room with their brief half off and the bed sheets tangled around their legs.The Comprehensive Care Plan related to fall risk, created 04/15/2026, documented Resident #1 had a fall on 04/15/2026 and included interventions to get the resident up by 7:30 AM and bring them to common area for increased supervision, keep the resident's bed in the lowest position, and maintain a clutter-free environment.The Nursing Note dated 04/17/2026 by Licensed Practical Nurse #4 documented Resident #1 was combative and agitated and was placed at the nursing station for one-to-one monitoring.The Incident Investigation dated 04/21/2026 documented Resident #1 was found on the floor in their room at 10:00 PM and their sheets were tangled around their legs.The Comprehensive Care Plan related to falls was revised on 04/21/2026 to include the intervention to keep Resident #1 out of bed until 11:00 PM.The Nursing Note dated 04/24/2026 authored by Registered Nurse #2 documented Resident #1 fell in front of the nursing station at 8:53 AM after getting up from their wheelchair.The Comprehensive Care Plan related to falls was revised on 04/24/2026 to include the intervention for staff to use footrest during propulsion and remove the footrest when Resident #1 was parked and locked because the resident tended to trip over their footrest.There was no documented evidence that Nurse Practitioner #1 evaluated Resident #1 following each fall incident.There was no documented evidence that the facility evaluated the effectiveness of new interventions to prevent falls.There was no documented evidence of other effective interventions to adequately address Resident #1's restless agitated behaviors. The Nursing Note dated 04/24/2026 by Registered Nurse #2 documented an aide witnessed Resident #1 fall on the floor on their buttock at the nursing station.The Nursing Note dated 04/25/2026 authored by Registered Nurse #2 documented Resident #1 fell in front of the nursing station onto the right side of their face and sustained facial swelling, bruising and a right eyelid abrasion.On 05/04/2026 at 10:36 AM, Licensed Practical Nurse #2 was interviewed and stated they were the charge nurse on Resident #1's unit and created a one-to-one supervision log on 04/25/2026 assigning each aide on the unit to sit with Resident #1 for 30 minutes at a time (for 72 hours) to make sure the resident did not get up out of their wheelchair. Licensed Practical Nurse #2 stated they were not instructed to create the log by their supervisor, and it was not ordered by the physician. Licensed Practical Nurse #2 stated they decided to place Resident #1 on one-to-one supervision because the resident fell earlier in (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	the day and sustained injury to their face. On 05/05/2026 at 12:14 PM, Registered Nurse Supervisor #1 was interviewed via telephone and stated they were working on 04/25/2026 and was not aware Resident #1 received one-to-one supervision on their unit following a fall in the morning. Registered Nurse Supervisor #1 stated they were not responsible for placing residents on one-to-one supervision and did not know who was responsible for determining when increased supervision was necessary for residents at high risk for falls.On 05/01/2026 at 11:26 AM and 05/07/2026 at 2:53 PM, telephone interviews were conducted with the Medical Director who stated they were part of the quality assurance committee and falls were reviewed as part of the meeting topics. The Medical Director stated, contrary to the medical record for Resident #1 and Resident #7, they were not the attending physician responsible for overseeing the total plan of care for residents on the Westminster Unit.On 05/11/2026 at 11:19 AM, Nurse Practitioner #1 stated they were the attending physician for the residents on the Westminster Unit and was responsible for overseeing all their care. Nurse Practitioner #1 stated they were involved in discussions about falls with the interdisciplinary team at morning meeting. The team discussed interventions to prevent falls. Nurse Practitioner #1 stated the facility did not use restraints to prevent falls and this was the reason the residents had so many falls. Nurse Practitioner #1 stated Resident #7 was tricky because the resident was noncompliant and had a lot of falls because they got up without staff assistance. Nurse Practitioner #1 stated they decreased Resident #7's water pill to decrease their urinary frequency to address their falls but the resident started to retain too much fluid. Nurse Practitioner #1 stated they were not part of any fall prevention committee or care plan meetings to discuss residents at high risk for falls.During an interview on 04/30/2026 at 10:00 AM and 05/11/2026 at 3:56 PM, the Director of Nursing stated Resident #1 was a noncompliant resident with behaviors at risk for falls. Resident #1 had been placed at the nursing station for increased supervision on 04/25/2026 following a fall incident that morning. The Assistant Director of Nursing was responsible for conducting all the facility incident investigations and the Director of Nursing stated they were responsible for signing off on all investigations after reviewing them for completeness. The Director of Nursing stated they did not compile statistics and data on falls to compare across different shifts or different units. The Director of Nursing stated they did not know whether facility surveillance cameras were reviewed to determine how Resident #1 fell at the nursing station on 04/25/2026. The Director of Nursing stated they did not know about Resident #7's falls. On 05/11/2026 at 5:40 PM, the Administrator stated falls were not previously being tracked as part of the facility's quality improvement projects. The Administrator stated the facility now planned to have a falls committee to separately address residents that had frequent falls. 10 NYCRR 415.12(h)(2)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review conducted during the survey, the facility did not ensure sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and maintain the well-being of each resident. This was evident for one (1) (Westminster Unit) of seven (7) units. Specifically, 1) the Facility Assessment did not adequately reflect characteristics of the Westminster Unit adequately to determine the level of staff needed to care for the acuity and needs of its residents 2) lack of competent and skilled nursing staff and 3) a pattern of falls for Resident #1 and Resident #7 resulting in harm. The unit was staffed with two (2) certified nurse aides to care for up to 50 residents on the night shift.The findings are:The facility policy titled Staffing Sufficient Competent Nursing dated 10/07/2025 documented staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident assessment, residents plan of care, and the facility assessment.1) Refer to F838.The facility's daily nursing Staffing Sheets from 04/01/2026 through 04/30/2026 were reviewed and documented two (2) certified nurse aides worked the night shift on the Westminster Unit for 18 of 30 nights.2) Refer to F600, F607, and F940.3) Refer to F689. During an interview on 04/30/2026 at 11:55 AM, Resident #9 stated it took staff a long time to answer the call bell on the night shift on the Westminster Unit.During an interview on 05/1/2026 at 4:45 PM, the Staffing Coordinator stated the Administrator and Director of Nursing determined adequate nursing staffing levels for the facility based on the census and acuity in the building. The Staffing Coordinator stated these staffing levels changed daily, and they were unable to provide the current par levels for each shift on each unit that they used to make their schedule.During an interview on 05/04/2026 at 10:36 AM, Licensed Practical Nurse #2 stated they had a standard assignment of four (4) aides on the evening shift on 04/25/2026 when Resident #1 experienced a staff-to-resident abuse by Certified Nurse Aide #1. Licensed Practical Nurse #2 stated they devised the one-to-one assignment for Resident #1 and ensured that every aide on the unit sat with the resident at 30-minute interval rotations regardless of what they were doing for other residents. Resident #1 was confused, agitated, and at high risk for falls. Licensed Practical Nurse #2 stated the number of assigned aides on their shift did not increase to reflect the need for rotating one-to-one supervision for the high fall risk residents on the Westminster Unit.During a telephone interview on 05/05/2026 at 5:15 PM, Certified Nurse Aide #7 stated they were agency staff and their usual assignment was 15 residents on the day, and evening shifts was heavy, and they were unable to complete their task and needed to work over their allotted hours to complete all their tasks. Certified Nurse Aide #7 stated there is not enough aides scheduled to work across all shifts.During an interview on 05/07/2026 at 10:40 AM, Certified Nurse Aide #10 stated they work up to five (5) double shifts a week on the day and evening shifts. Certified Nurse Aide #10 stated they would not work the night shift because 2 aides for up to 50 residents on the Westminster Unit and for the dementia behavioral population on the [NAME] Unit was not manageable. Certified Nurse Aide #10 stated they arrived to work on the day shift to find night shift assignments not done and residents in bed that should have gotten up. Certified Nurse Aide #10 stated work not done on the night shift carried over to the day shift and they found themselves overwhelmed with their assignment because there were only 2 aides working the night shift. Certified Nurse Aide #10 stated this would have been manageable if the facility still staffed an average of 5 aides on the day shift but now the day shift had an average of four (4) aides scheduled.During a telephone interview on 05/7/2026 at 1:30 PM, Certified Nurse Aide #8 stated they worked up to seven (7) days a week covering on all shifts but especially the night shift because there was no regularly assigned certified nurse aide on the night shift. New staff were hired and then leave after seeing the amount of work assigned on the night shift. Certified Nurse Aide #8 stated there were usually two (2) aides scheduled to work the night (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Paramount at Somers Rehab and Nursing Center	Route 100 Somers, NY 10589

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	shift, and, with the showers and get-up assignment, they found this assignment unmanageable. Certified Nurse Aide #8 stated they expressed their workload concerns to the unit charge nurse and to their coworkers.During an interview on 05/07/2026 at 2:29 PM, Certified Nurse Aide #9 stated they worked the night shift, picked up a lot of shifts, worked at least three (3) double-shifts a week, and worked full-time hours even though they were a part-time employee. Certified Nurse Aide #9 stated the Westminster Unit had residents at high risk for or who have had actual falls, and they had their own system in place to make the workload manageable.During an interview on 05/01/2026 at 1:05 PM and 05/11/2026 at 3:56 PM, the Director of Nursing stated they were responsible for overseeing the nursing staffing par levels and based this on the acuity levels of residents on each unit. The Director of Nursing stated they did not know the current acuity levels for the facility's 7 units. The Director of Nursing stated the facility had difficulties with staffing 3 aides overnight on the Westminster or [NAME] Units and the Staffing Coordinator tried to schedule at least 2 aides on each unit, the facility's absolute lowest to be able to provide residents with quality care. The facility used a software program to pre-populate their staffing schedule weekly but there were glitches with this program and, if not caught by the Staffing Coordinator, the staffing schedule prints with omissions resulting in a shortage of staff. The Director of Nursing stated they have not heard of any concerns with staffing levels on the night shift and thought the assignments for 2 aides on the Westminster Unit was manageable.During an interview with the Administrator on 5/11/2026 at 5:40 PM they stated the Director of Nursing was responsible for communicating the acuity of each unit to the Administrator so that nursing staff par levels can be accurately set. The Administrator stated the facility should not be staffed for 2 aides overnight. Staffing would be part of their future quality assurance performance improvement projects. The Administrator stated the Facility Assessment developed by them in 11/2025 did not contain unique characteristics of each unit and did not account for the [NAME] Unit being a locked dementia unit or for the Westminster Unit's bed census of 50 as opposed to most other units with a bed census of 39 or 40.10NYCRR 415.13(A)(1) (i-iii)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews conducted during survey, the facility failed to ensure each resident received the necessary behavioral health care services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care for four) (Resident's #1, #2, #4, and #6) of six residents reviewed for behavioral health. Specifically, 1) there was no documented evidence agency staff were oriented to behavior management or that a care plan was developed and implemented to address Resident #1's behaviors prior to an incident of agency staff to resident abuse on 04/25/2026; 2) Resident #2's care plan was not developed or individualized and agency staff were not trained to address the resident's agitation and verbal abuse; 3) Resident #4's care plan was not revised to address adequate supervision and interventions following an incident of inappropriate sexual contact with Resident #6 on 02/11/2026, and 4) Resident #6's care plan was not developed or implemented to address an inappropriate sexual encounter with Resident #4 on 02/11/2026.The Findings are:The Facility policy titled Behavioral Health Services: dated 10/07/2025 documented that staff must promote dignity, monitor care plan interventions, and report changes in condition.1) Resident #1 was admitted to the facility on [DATE] with diagnoses of vascular dementia (disease caused by reduced blood flow to the brain leading to cognitive impairment that affects daily functioning) with agitation and depression.The Minimum Data Set (a resident assessment tool) dated 04/19/2026 documented Resident #1 was severely cognitively impaired and displayed no behaviors.Nursing progress note dated 04/13/2026 on admission documented Resident #1 tried to get out of bed/wheelchair several times unassisted. Physician Orders dated 04/14/2026 documented Resident #1 was ordered Depakote sprinkles (an anti-seizure medication) for agitation. The Physician Note dated 04/14/2026 documented an order for Resident #1 to receive a psychiatry consultation.There was no documented evidence that Resident #1 was evaluated by a psychiatrist.The Nursing Note dated 04/17/2026 by Licensed Practical Nurse #4 documented Resident #1 was placed on one-to-one supervision because they were restless, physically combative, and agitated.A review of the resident's medical record revealed no documented evidence a care plan was developed identifying the resident's behaviors or interventions implemented to address the resident becoming combative towards staff.The facility Incident Investigation dated 04/25/2026 documented Resident #1 had prior incidents of agitation, aggressive behavior including spitting at staff. There was no documented evidence of the facility providing Certified Nurse Aide #1 (agency staff) with education or training related to behavior management prior to being assigned to sit with Resident #1 or any other residents who exhibit combative behavior.During a telephone interview on 04/30/2026 at 2:01PM, Certified Nurse Aide #1 confirmed that three weeks prior to the incident, they were employed through an agency to work at the facility. They also confirmed that they did not receive orientation or education regarding Resident #1's combative behaviors or behavior management training prior to being assigned to work on the unit.2) Resident #2 was admitted to the facility with diagnoses of dementia (disease characterized by decline in cognitive function affecting memory, thinking/behavior and the ability to perform daily activities) with behavioral disturbance and altered mental status.The Admissions Minimum Data Set, dated [DATE] documented Resident #2 displayed no inappropriate behavior and did not identify the resident's severe cognitive impairments. There was no documented evidence in the Minimum Data Set, dated [DATE] of Resident #2's behaviors.The Comprehensive Care Plan developed on 04/03/2026 documented Resident #2 exhibited socially inappropriate behavior by yelling inappropriate words and racial slurs, and by sliding themselves to the edge of the bed despite frequent repositioning. Resident #2 was provided with a stuffed animal or baby doll to always hold to soothe the resident during behavior escalation. The care plan was not updated to reflect identified behaviors until 04/30/2026.The Nursing Note dated 04/06/2026 (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	documented Resident #2 ripped their intravenous hydration line out of their arm.The Nursing Note dated 04/13/2026 documented Resident #2 was shaking vigorously on their bedrails causing their intravenous pole to fall over and hit them in the head.The Incident Investigation dated 04/26/2026 documented Resident #2 was found sitting on the floor of their room and concluded the resident had a behavior of sitting at the edge of their bed.The Incident Investigation dated 04/28/2026 documented Resident #2 was found by the Nurse Practitioner on the unit hallway floor in front of their wheelchair with redness to their back. The investigation concluded Resident #2 had restless behaviors and placed themselves on the floor.On 04/30/2026 at 10:56 AM, Resident #2 was observed sitting upright in their bed screaming at Certified Nurse Aide #5 while the aide was providing one-to-one supervision for Resident #2's roommate, Resident #1. Certified Nurse Aide #5 closed the resident's door and then quickly opened it back up as Resident #2 could be heard continuing to scream through the closed door. Certified Nurse Aide #5 then went to retrieve two other aides on the unit to assist with Resident #2's screaming and agitation.During an interview on 04/30/2026 at 12:15 PM, Certified Nurse Aide #5 was interviewed and stated they were agency staff and had worked for the facility for three weeks. Certified Nurse Aide #5 stated they were pulled from their assignment on another unit to provide one-to-one supervision to Resident #1. Certified Nurse Aide #5 stated they were not provided with orientation to Resident #1 or Resident #2's behaviors or behavior management training prior to being assigned to work on the unit.During an interview with the representative for Resident #2 on 05/09/2026 at 2:46 PM, they stated they were upset that since admission to the facility, the resident has exhibited increased agitation and behaviors. Resident #2's representative stated they spoke to Nurse Practitioner #1, but nothing has been done to address their concerns.3) Resident #4 had diagnoses of unspecified psychosis (a state of impaired reality, which may include hallucinations and delusions), unspecified dementia (significant decline in thinking, memory, and other cognitive abilities that interfere with daily life), and anxiety. The Minimum Data Set, dated [DATE] documented Resident #4 was moderately cognitively impaired and did not display any wandering or physical behavior symptoms directed towards others.The Nursing Note dated 02/11/2026 documented Resident #4 and Resident #6 were observed lying in bed together and the activity appeared consensual. The residents were separated, and the Administrator and Director of Nursing were made aware. There was no documented evidence detailing the account of the activity taking place while both Resident #4 and Resident #6 were in bed together.The Comprehensive Care Plan created/initiated on 02/13/2026 identified that Resident #4 exhibited hypersexual behavior and had no personal boundaries. Interventions included removing the resident from situations that trigger them and orienting the resident to their daily routines. The was no documented evidence of what situations triggered the resident.There was no documented evidence Resident #4's care plan was updated to address supervision and protection of Resident #4 following their inappropriate physical contact with Resident #6.On 05/07/2026 at 10:30 AM, Resident #4 and Resident #6 were observed seated in an alcove on their unit across from the nursing station and Resident #4 and Resident #6 were observed affectionately holding each other's hands. There were no staff observed in the area providing ongoing monitoring of Resident #6 for any potential inappropriate behavior.During a telephone interview on 05/01/2026 at 11:26 AM, the Medical Director stated they oversaw the facility's behavior management program and believed it did a great job at ensuring residents on psychotropic medication saw the psychiatrist and had gradual dose reductions. Although there was no documented evidence, the Medical Director stated they believed that Resident #1 saw the psychiatrist following the incident of abuse Certified Nurse Aide #1. The Medical Director stated all residents with mental health diagnoses and/or on psychotropic medication were evaluated within the first week of their stay at the facility. The Medical Director stated Resident #1 should have been evaluated by a psychiatrist during their stay.During an interview on 04/30/2026 at 10:00 AM and 05/01/2026 at 1:05 PM, the Director of Nursing stated Resident #1 had challenging, aggressive behaviors and was difficult to redirect. Behavior management training should be added to agency staff orientation packets. The Director of (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Nursing stated that the facility did not ensure agency staff received education on behavior management prior to working for the facility. The Director of Nursing stated they did not know Resident #4 and Resident #6 were found in bed together and had an inappropriate sexual encounter. The Director of Nursing stated the registered nurses were responsible for creating care plans. The licensed practical nurses and/or the registered nurses were responsible for updating resident care plans when there was a change in their condition or a need for new intervention. The residents' care plans were reviewed regularly during their scheduled Minimum Data Set assessments. The Director of Nursing was unable to explain Resident #1's lack of a behavior care plan, that Resident #2's behavior care plan that was not revised, or Resident #4's behavior care plan that did not adequately address their sexual behavior. The Director of Nursing stated the nursing staff did behavior monitoring for residents in accordance with the physician's orders and residents were referred to the psychiatrist for evaluation as needed. The Director of Nursing stated they were under the impression Nursing Staff Educator #1 was doing an adequate job educating the facility staff on behavior management.On 05/11/2026 at 5:40 PM, the Administrator was interviewed and stated they were aware the facility required some personnel changes at key positions to ensure adequate behavior management training of new and existing staff. The Administrator stated the facility would be enlisting the services of an outside consultant to identify failures in their screening and education process to ensure staff knew how to address the facility's resident population. The Administrator stated they understood where it was necessary to adequately depict facility and resident population characteristics in their facility assessment to ensure adequate use of resources.10 NYCRR 415.12

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews during an abbreviated survey, the facility did not ensure residents diagnosed with dementia received the appropriate treatment and services for 1 (Residents #1) of 6 residents reviewed for dementia. Specifically, Resident #1's dementia care plan was not developed and implemented until 04/25/2026, after a staff-to-resident abuse involving Resident #1 and Certified Nurse Aide #1.The findings are:The facility's dementia policy dated 10/07/2025 documented the facility will strive to optimize familiarity through consistent staff-resident assignments and individualized care plans developed by the interdisciplinary team. Resident #1 was admitted to the facility on [DATE] with diagnoses of vascular dementia (disease caused by decreased blood flow to the brain leading to cognitive impairments that affects daily functioning) with agitation and metabolic encephalopathy (a change in how the brain works due to an underlying condition leading to confusion/memory loss).The Hospital Discharge summary dated [DATE] documented Resident #1required delirium precautions.The Minimum Data Set 3.0 (an assessment tool) dated 04/19/2026 documented Resident #1 was severely cognitively impaired and had history of falls.The Nursing Note dated 04/17/2026 documented Resident #1 had behaviors, was restless, and was physically combative and agitated in the evening. Resident #1 was placed on one-to-one supervision.The facility Incident Investigation dated 04/25/2026 documented Certified Nurse [NAME] #1 was monitoring Resident #1 on one-to-one supervision when an incident of staff-to-resident abuse occurred.The Comprehensive Care Plan related to dementia initiated 04/25/2026 documented Resident #1would maintain their current level of cognitive functioning with interventions that included breaking tasks into simple steps, encouraging self-performance in activities of daily living, providing leisure activities such as exercise groups, singing, etc., and using simple words or instructions.There was no documented evidence a care plan related to Resident #1's dementia diagnosis was developed and implemented upon Resident #1's admission to the facility on [DATE].During a telephone interview on 04/30/2026 at 2:01PM, Certified Nurse Aide #1 stated they were agency staff hired by the facility three weeks prior and they did not receive training and education related to dementia management.On 05/01/2026 at 1:05 PM, the Director of Nursing was interviewed and stated all facility employees were required to have orientation and annual mandatory inservices that included dementia management.On 05/11/2026 at 5:40 PM, the Administrator was interviewed and stated they were aware the facility required some personnel changes at key positions to ensure adequate behavior management training of new and existing staff. The Administrator stated the facility would be enlisting the services of an outside consultant to identify failures in their screening and education process to ensure staff knew how to address the facility's resident population.10 NYCRR 415.12

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review conducted during a survey, the facility assessment failed to adequately identify and indicate resource necessary to care for its residents. This was evident for seven (7) of 7 units during review of Administration. Specifically, the facility assessment did not include the resident population's behavioral health needs, necessary staff competencies and skill sets needed, the facility's structural needs, the use of third-party staffing agency, staffing needs for each individual unit, did not reflect changes to the nursing home leadership staff and resident assessments did not accurately reflect behaviors.The findings are:The Facility assessment dated [DATE] indicates the facility capacity of 300 residents split throughout seven (7) units. Out of an average daily census of 280 residents, the facility had 20 residents with behavioral health needs that included wandering, fall risk, and psychiatric needs. Services and care offered by the facility included fall prevention, mental and behavioral needs including psychiatry and psychological services, and assessment and early identification of infections.The Facility Assessment included a Staffing Plan for 10 licensed nurses providing direct care, 30 nurse aides, and four (4) registered nurse supervisors. The Staff Shortage Plan listed 8 licensed nurses providing direct care, 16 nurse aides, and 3 registered nurse supervisors. The Facility Assessment did not include staffing information detailing how staff would be dispersed on the units and the shift or shifts covered by the nursing staff listed.The Facility Assessment documented the facility was currently utilizing their Staffing Shortage Plan for loss of staff due to the COVID-19 virus. A rapid-onboarding system was implemented for agency staff.The Facility Assessment did not document the facility's use of a third-party staffing agency or significant changes to leadership in the position of Medical Director and Human Resources Director. The Facility Assessment did not document the facility's use of a locked dementia unit ([NAME]) and did not define the specific characteristics of the facility six (6) other units. The Facility Assessment did not document a staffing plan based on the facility population and unit characteristics. The facility did not document the different bed capacities of each unit- [NAME] - 39 beds, [NAME] - 39 beds, Berkshire - 39 beds, [NAME] - 41 beds , [NAME] - 41 beds, Westminster - 50, [NAME] - 51 beds.The Minimum Data Set 3.0 (an assessment tool) dated 03/20/2026 inaccurately documented Resident #4 did not display any wandering or physical behavior symptoms directed towards others. The Minimum Data Set 3.0 (an assessment tool) dated 04/09/2026 inaccurately documented Resident #2 displayed no inappropriate behavior.The Minimum Data Set 3.0 (an assessment tool) dated 04/19/2026 inaccurately documented Resident #1 displayed no behaviors.During an interview on 05/11/2026 at 5:40 PM, the Administrator stated they were responsible for revising and completing the Facility Assessment in 11/2025. The Administrator stated resident acuity was used to determine staffing levels presented in the Facility Assessment and the facility was still recovering from a significant number of staff lost during the COVID-19 pandemic. Each unit was able to operate with, at minimum, 2 (two) nurse aides on the night shift. The Administrator stated they understood the Facility Assessment did not include the characteristics and census of each unit in determining the staffing levels throughout the facility and acknowledged there was a larger population of residents in the facility that had behavioral health needs. The Administrator stated the facility has gone through several personnel changes, including the Human Resources Director and Medical Director, and would review the Facility Assessment to include new information and updates. 10 NYCRR 415.26

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F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review conducted during a survey, the facility did not ensure the medical director was responsible for coordinating the medical care of one (1) (Westminster Unit) of seven (7) units. Specifically, the Medical Director was not involved in the facility assessment, quality assurance committee meetings, and did not oversee the development of facility policies and procedures to prevent abuse. The findings are:The facility policy titled Physician Services dated 10/09/2025 documented the medical care of each resident was supervised by a licensed physician. The Medical Directo identifies attending physician qualifications and responsibilities, based on clinical and regulatory requirements and the recommendations of relevant professional associations. Please refer to F600, F604, F838, F689, and F740. There was no documented evidence the Medical Director reviewed the Facility assessment dated [DATE]. Nurse Practitioner #1 was interviewed on 05/11/2026 at 11:19 AM and stated they were employed by the Medical Director's third-party physician staffing agency. As part of that employment, Nurse Practitioner #1 stated were assigned in 02/2026 to work full-time as the Attending Physician for three (3) units at the facility - Westminster (50-bed capacity), [NAME] (51-bed capacity), and [NAME] (39-bed capacity). Nurse Practitioner #1 stated they worked full-time until about 5PM and the facility used a third-party telehealth service to cover any concerns that arose in the evening or at night when Nurse Practitioner #1 was not present in the facility. Nurse Practitioner #1 stated they answered directly to the Medical Director. Nurse Practitioner #1 stated the Medical Director was responsible for all the residents in the facility and thereby was also responsible for all the residents on the Westminster Unit. Telephone interviews were conducted with the Medical Director on 05/01/2026 at 11:26 AM and 05/07/2026 at 2:53 PM, who stated they were appointed as the facility's Medical Director and was the attending physician for the Westminster Unit until approximately one month ago. The Medical Director stated they were responsible for reviewing all the facility's Incident Investigations upon conclusion and ensuring they were complete with all the elements of determining the root cause analysis for why an incident occurred and they had no issues regarding the facility's current process of incident investigation or reporting to the New York State Department of Health. The Medical Director stated they were involved in the facility's development of resident care policies and reviewed all of them when they took on their role as medical director. The Medical Director stated they were involved in all the quality assurance committee meetings except for the facility's most recent one held on 04/23/2026. The Medical Director stated they did not know what topics were discussed at the most recent quality assurance meeting. Medical Director stated they assessed Resident #1 following an incidence of abuse but was unable to provide documented eivedence of an assessment. The Medical Director stated they signed off on the completeness of all incident investigaigons but was unaware that Resident #1 was not assessed by a Psychiatrist in accordance with their faciilitty Incdient Investigaiton dated 04/25/2026. The Medical Director provided no evidence they were involved in developing the Facility Assessment. During an interview on 05/11/2026 at 5:40 PM, the Administrator stated they would be employing the services of an outside consulting agency to help address the facility's resident care and abuse prevention and reporting policies to ensure regulatroy compliance. The Medical Director was fairly new and the facility was in the process of changing some personnel at key positions to ensure the facility improved it's systems and quality of care. 10 NYCRR 415.15(a)

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Develop, implement, and/or maintain an effective training program for all new and existing staff members. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review conducted during a survey, the facility did not ensure an effective training program was developed, implemented, and maintained for all new and existing staff consistent with their expected roles and based on a facility assessment. This was evident for five (5) (Certified Nurse Aide #1, #5, and #7, Licensed Practical Nurse #2, Registered Nurse #2) of five (5) staff sampled for education and training review. Specifically, 1) The Facility Assessment did not include a plan to ensure mandatory and ongoing in-service and competencies were provided to agency staff, including Certified Nurse Aides #1, #5, and #7, and 2) there was no documented evidence of effective training developed for facility staff Registered Nurse #1 and Licensed Practical Nurse #2 to ensure competence in abuse prevention, behavior management, and dementia management.The findings are:The Facility assessment dated [DATE] documented the facility admitted residents with psychiatric and mood disorders that need intervention and all forms of dementia. Corporate clinical support would provide the policy and procedure, and the facility Nursing Staff Educator would in-service staff as indicated. Mandatory training/education and competencies were provided upon hire and annually to all staff on topics including resident abuse prevention, accident prevention, dementia care, and behavioral health. The Facility Assessment did not include the nurse staffing agency used by the facility in the list of facility vendors. A facility in-service education dated 1/26/2023 titled Preventing Abuse, Neglect, Exploitation, and Misappropriation of Resident Property included instructions for staff to report to their supervisor, charge nurse, any department head, hospital police officer or risk manager if there was reasonable cause to believe abuse occurred. The in-service education defined reasonable cause as having seen or heard enough evidence to make a reasonable person conclude abuse occurred and that it should be investigated. 1) The employee file for agency staff, Certified Nurse Aide #2, was reviewed and contained no documented evidence Certified Nurse Aide #2 completed abuse preventions training prior to their hire date on 01/20/2026.The employee file for agency staff, Certified Nurse Aide #5, was reviewed and contained no documented evidence Certified Nurse Aide #2 completed abuse prevention training, dementia training, or behavior management training prior to their hire date on 04/01/2026.The employee file for agency staff, Certified Nurse Aide #1, was reviewed and contained no documented evidence Certified Nurse Aide #1 completed abuse prevention training prior to their hire date on 04/16/2026.During an interview on 4/30/2026 at 12:15 PM, Certified Nurse Aide # 5 stated they began working for the facility three weeks ago through a staffing agency. Certified Nurse Aide #5 stated they were not assigned to work on the Westminster Unit when they began their shift and were reassigned to provide one-to-one supervision of Resident #1. Certified Nurse Aide #5 stated they were unaware staff-to-resident abuse involving Resident #1 and Certified Nurse Aide #1 occurred on 04/25/2026. Certified Nurse Aide #5 stated they received abuse prevention in-service within the last week and submitted a post-test. Certified Nurse Aide #5 stated they were not oriented to Resident #1's behaviors and did not receive behavior management training prior to their employment with the facility. Certified Nurse Aide #5 stated they were told by unit nursing staff that Resident #1 frequently tried to get up.2) The facility Incident Investigation dated 04/25/2026 documented Certified Nurse Aide #1 tapped Resident #1 on the shoulder while trying to redirect the resident. A statement written by Licensed Practical Nurse #2 documented they observed Resdiietn #1 make inappropriate contact with Certified Nurse Aide #1, they intervened to de-escalate, and they spoke to the aide prior to the incident. A statement written by Registered Nurse #1 documented Certified Nurse Aide #1 complained that Resident #1 was spitting on them and Registered Nurse #1 advised the aide to distance themselves from the resident while still maintaining eye contact.The employee file for facility staff, Licensed Practical Nurse #2, was reviewed and contained an acknowledgement by Licensed Practical Nurse #2 that they received the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335261	A. Building B. Wing	05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Paramount at Somers Rehab and Nursing Center	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.

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	facility employee handbook, including the facility policy on reporting patient abuse, on 11/20/2025, their hire date. Page 36 of the employee handbook contained a paragraph on reporting patient abuse that documented never let a resident's insults cause you to lose control. Report such incidents at once to your supervisor.There was no documented evidence Licensed Practical Nurse #2 was provided with comprehensive abuse prevention, dementia management, and behavior management training prior to their hire date on 11/20/2025.There was no documented evidence that the facility had a system in place to track and record the training provided to each new and existing facility and agency staff consistent with their expected roles.During an interview on 04/30/2026 at 4:12 PM, Human Resources Director #1 stated that the employee files for facility staff contained the screening, onboarding, orientation packet, in-service education materials, disciplinary actions, and mandatory in-service tracking to ensure staff's timely completion. The facility used a third-party company to manage and track all the facility staff employee files and provided alerts and notifications when an employee misses a mandatory in-service. Human Resources Director #1 stated Licensed Practical Nurse #2 was facility staff and their file was readily available for review. Human Resources Director #1 stated the staffing agency, not the facility, was responsible for tracking and maintaining the employee records, including in-service and education training, for agency staff.During an interview on 05/04/2026 at 10:36 AM, Licensed Practical Nurse #2 stated that they were hired in November 2025, and they did not receive education that helped them to identify staff frustration and burnout to prevent instances of resident abuse. They stated that after reading written statement of Certified Nurse Aide #1 it did occur to them that they did observe Certified Nurse Aide #1 getting frustrated with Resident #1's behaviors while providing one-to-one supervision. Certified Nurse Aide #1 complained that Resident #1 called them racial slurs and was spitting on them prior to Certified Nurse Aide #1 hitting Resident #1 on their shoulder. Licensed Practical Nurse #2 stated they told Certified Nurse Aide #1 that their job as an aide was not meant for everyone and maybe it wasn't the job Certified Nurse Aide #1. Licensed Practical Nurse #2 stated that in hindsight, they should have addressed Certified Nurse Aide #1's behaviors prior to the incident with Resident #1 and they came to this determination from their own review of the events, not from facility in-service education after the incident occurred.During an interview on 05/4/2026 at 4:45 PM, Nursing Staff Educator #1 stated they did not know about the onboarding process the Human Resources Department had set up for agency staff. Nurse Staff Educator #1 stated they were only responsible for training the facility nursing staff. Department heads were responsible for training their respective employees and Nursing Staff Educator #1 stated they did not know who provided trainings for the agency staff. Nursing Staff Educator #1 stated in interview that they did not know how to track agency staff education, and they were unable to provide details of in-service education provided to facility staff throughout the last six months. During an interview on 05/06/2026 at 3:45 PM, Registered Nurse #1 stated they were facility staff and were present 04/25/2026 when Certified Nurse Aide #1 abused Resident #1. Registered Nurse #1 stated they observed Certified Nurse [NAME] #1 violate the employee policy and complain the Resident #1 was spitting on them and did not separate the resident and aide prior to the abuse incident. Registered Nurse #1 stated they did not receive in-service education to identify staff burnout and would not change how they interacted with Certified Nurse Aide #1 on 04/25/2026. During an interview on 05/01/2026 at 1:05 PM and 05/11/2026 at 3:56 PM, the Director of Nursing stated the Human Resources Department and the Nursing Staff Educator #1 were responsible for onboarding and providing in-service education on facility policies to new hires. The Director of Nursing stated behavior management in-service education was missing from the list of mandatory items for agency staff to complete. The Director of Nursing stated they were responsible for overseeing Nursing Staff Educator #1 and they believed education was being adequately provided.During an interview on 05/11/2026 at 5:40 PM, the Administrator stated they were in the process of changing the facility in-service and education program so there can be facility-wide tracking of trainings completed by staff. The Administrator stated they planned to also use sign-in sheets or digital signature sheets to ensure training records were organized and readily available for review.10 NYCRR 415.26(c)(1)(iv)