STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335265	A. Building B. Wing	06/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Van Rensselaer Manor	85 Bloomingrove Drive Troy, NY 12180

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 - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observation, interview, and record review conducted during the Abbreviated survey (Complaint #NY00379718) completed on 6/10/2025, the facility did not ensure the resident's right to be free from abuse, neglect or mistreatment for one (1) (Resident #2) of three (3) residents reviewed for abuse, neglect and mistreatment. Specifically, a Certified Nurse Aide #3 did not follow Resident #2's care plan for dietary meal consistency when they provided Resident #2 with a regular chicken consistency that caused Resident #2 to choke and required back thrusts and mouth sweeps to clear their throat and mouth. This is evidenced by: The facility policy and procedure titled, Abuse/Neglect, revised 4/2025, documented the following: it is the policy of the facility that all residents have the right to be free from neglect, verbal, sexual, physical or mental abuse, corporal punishment, exploitation and involuntary seclusion. The facility education titled, Reportable Incidents / Examples, undated, provided by Director of Nursing #1, documented the following: Neglect may include, but is not limited to: failure to carry out physician orders, failure to follow the care plan, or failure to provide adequate hydration and nutrition. The facility policy and procedure titled, Dining Room Duties: Serving Meal Trays, revised 11/2016, documented the following: it is the policy of the facility that each resident will be provided with a dignified, pleasant dining experience at each meal to enhance socialization, increase mental awareness, stimulate appetite, provide optimal nutritional intake (based on individual preferences and needs); and foster the highest level of independence - safely and efficiently. Serving meal trays included check meal ticket (resident specific information identifying resident name, diet, and food items on tray) to assure the correct resident, item and consistency. Residents unhappy with the meal should be offered a substitute. Call kitchen to order substitutes as necessary, state you name, the unit you are calling from, the resident's name who needs a substitute and item requested. The facility policy and procedure titled, Therapeutic Dining, revised 3/2025, documented the following: it is the policy of the facility that each resident will be evaluated for a diet consistency and need for feeding strategies to allow safe nutritional intake, to provide staff with concise instructions for resident diet restrictions and feeding strategies. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #2 had diagnoses including dementia with agitation (a behavior change characterized by restlessness, excessive movement, and sometimes aggression, often triggered by changes in routine, environment, or cognitive decline), chronic obstructive pulmonary disease (a condition caused by damage to the airways or other parts of the lung, causing breathing problems), and malignant neoplasm of the bladder (bladder cancer). The Minimum Data Set (a resident assessment tool) dated 2/23/2025 documented Resident #2 was cognitively severely impaired, sometimes understood and sometimes understands, did not exhibit behaviors of rejection of care, required supervision or touching assistance for eating (helper provides verbal cues and / or touching / steadying and / or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.) and required a mechanically altered diet (a change in texture of food or liquids). Review of the comprehensive care plan dated 8/22/2023 documented the following: Nutrition / Hydration Comfort Care as evidenced by dysphagia (difficulty swallowing foods or liquids, arising from the throat or esophagus, ranging from mild difficulty to complete and painful blockage). Documented interventions included provide the least restrictive diet necessary to allow optimal intake, mechanically altered diet. Review of the Dietary - Quarterly Nutritional Assessment for Resident #2 dated 2/24/2025 documented the following: regular diet, mechanical soft consistency with ground meats, thin liquids, had impaired swallowing, and required partial / moderate assist with supervision or touching assistance. Review of Resident #2's meal ticket, undated identified by Director of Nursing #1 as the meal ticket that was on Resident #2's meal tray on 5/04/2025 supper meal documented regular mechanical soft with ground meats, extra sauce / gravy, included three (3) each chicken tenders - must be minced. Review of, Nursing Home Investigative Report, completed by Director of Nursing #1 on 5/04/2025 at 9:06 PM, revealed the following: • The alleged abuse, neglect or mistreatment occurred as a result of a care plan violation on 5/04/2025 resulting in Resident #2 having a choking episode and required back thrusts and mouth sweeps to clear their throat and mouth of chicken. This was related to Resident #2 being given the wrong food consistency; served regular consistency chicken tenders and resident's diet is mechanical soft with ground meats. • Facility initiated an investigation and suspended Certified Nurse Aide #3 pending the investigation. • (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility investigation statements revealed Certified Nurse Aide #4 reported they witnessed Certified Nurse Aide #3 swap out a tray that belonged to Resident #2 and before they could report what they witnessed to the nurse, Resident #2 started to choke, and they immediately reported what they witnessed. A statement by Licensed Practical Nurse #2 documented, Certified Nurse Aide #4 notified them Certified Nurse Aide #3 swapped out Resident #2's meal tray with someone else's whose food was not of mechanical sot / minced consistency, and they asked Certified Nurse Aide #3 if they had swapped out Resident #2's tray and Certified Nurse Aide #3 informed them they may have but they do not remember because they get confused. • The facility's investigation conclusion documented statements were obtained from all staff involved, the findings of the investigation documented, Certified Nurse Aide #3 was feeding Resident #2 the wrong meal consistency food (served regular and diet is mechanical soft, minced meat). The facility concluded that Resident #2 choked from Certified Nurse Aide #3 feeding them the wrong food consistency. During a telephone interview on 6/05/2025 at 12:42 PM, Certified Nurse Aide #3 stated during the supper meal on 5/04/2025, Resident #3 was served a fish sandwich, and requested chicken, they noticed Resident #2 had minced chicken on their plate, so they took the food plate from Resident #2's tray and gave it to Resident #3. They stated Resident #4 had regular chicken tenders on a plate and didn't want them because they were eating pancakes, so they took Resident #4's food plate of chicken tenders and gave it to Resident #2. They stated they did intentionally swap the meal plates but mistakenly did not read Resident #2's meal ticket consistency and provided them with the wrong consistency and they choked and needed attention from the nurse to clear their mouth and throat. They stated they should not have swapped residents' meal plates and should have called the kitchen for an alternative plate for Resident #3 when they asked for a different meal. During a telephone interview on 6/05/2025 at 1:38 PM, Certified Nurse Aide #4 stated they heard Certified Nurse Aide #3 state they were going to switch Resident #2's plate and they observed the plate that was in Certified Nurse Aide #3's hand and informed Certified Nurse Aide #3 not to give Resident #2 the food (regular chicken) that was on that plate because it wasn't the correct consistency for Resident #2. Certified Nurse Aide #4 stated they did not know where Certified Nurse Aide #3 got the plate of food from and didn't realize they were going to feed Resident #2 after they informed them it was the wrong consistency. They stated Resident #2 started coughing and choking and the nurses had to respond to assist Resident #2 to clear their throat. During a telephone interview on 6/05/2025 at 2:16 PM, Licensed Practical Nurse #2 stated on 5/04/2025 Resident #2 was choking on regular chicken at supper and stated they were unable to continue the interview at this time. During a telephone interview on 6/05/2025 at 2:50 PM, Registered Nurse #3 stated they interviewed staff on 5/04/2025 related to Resident #2's choking incident. They stated upon investigating the staff interviews, they learned Certified Nurse Aide #3 swapped out three (3) resident's meal plates and mistakenly didn't identify Resident #2 was to have minced meat and was not to receive regular chicken fingers, which caused Resident #2 to choke, and Director of Nursing #1 was aware. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During another telephone interview on 6/09/2025 at 12:35 PM, Licensed Practical Nurse #2 stated they were in the dining room, heard Certified Nurse Aide #3 shout 'spit it out' and observed them pulling Resident #2 away from the dining room table. Upon assessing Resident #2, they observed the resident flushed and unable to communicate. They were unable to provide the Heimlich maneuver because of the high back wheelchair, so they instead completed a finger sweep and pulled two (2) pieces of chicken out of the resident's mouth. They stated Certified Nurse Aide #4 informed them Certified Nurse Aide #3 took another resident's plate of food that was a regular consistency, told Certified Nurse Aide #3 they were not to feed Resident #2 that consistency, and yet Certified Nurse Aide #3 started feeding Resident #2 the regular consistency anyway. This resulted in Resident #2 choking on the food. Licensed Practical Nurse #2 stated they immediately informed Registered Nurse #3. During an interview on 6/09/2025 at 11:53 AM, Nurse Practitioner #1 stated they assessed Resident #2 after the choking episode and was aware they received the wrong meal consistency. They further stated that they would have expected Certified Nurse Aide #3 to have read the meal ticket and provided the meal consistency that was indicated on their meal ticket. They stated they were not aware Certified Nurse Aide #3 swapped three (3) resident meal plates and stated Certified Nurse Aide #3 was negligent with their actions. During a telephone interview on 6/10/2025 at 10:37 AM, Medical Director #1 stated Certified Nurse Aide #3 should have ensured they provided the correct consistency meal according to their plan of care and meal ticket. They stated they were not aware Certified Nurse Aide #3 swapped three (3) resident meal plates and stated Certified Nurse Aide #3 was negligent with their actions. During an interview on 6/10/2025 at 11:36 AM, Director of Nursing #1 stated they would have expected Certified Nurse Aide #3 to have called to the kitchen when Resident #3 wanted an alternative meal. They stated staff should not swap resident meals plates because of specific diet plans, food consistencies and potential food allergies. They stated Certified Nurse Aide #3 was negligent with their actions. During an interview on 6/10/2025 at 12:08 PM, Administrator #1 stated they would have expected Certified Nurse Aide #3 to have called to the kitchen when Resident #3 wanted an alternative meal. They stated staff should not swap resident meals plates because of specific diet plans, food consistencies and potential food allergies. They stated Certified Nurse Aide #3 was negligent with their actions. 10 New York Codes, Rules and Regulations 415.4 (b)(1)(i)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on observation, interview and record review conducted during an Abbreviated survey (Complaint #NY00378218) completed on 6/10/2025, the facility did not ensure that all alleged violations involving abuse, neglect, mistreatment including injuries of unknown source, were reported immediately, but not later than two hours after the allegation was made to the facility's Administrator and the State Survey Agency for one (1) (Resident #5) of three (3) residents reviewed. Specifically Resident #5 was found to have an injury of unknown source to their right eye, and it was not reported within the required timeframe. This is evidenced by: The facility policy and procedure title, Resident Incident / Accident Reporting, date revised 9/2023 documented the following: all resident incident / accidents are reported, investigated and documented at the time of the incident / accident or upon discovery, in an effort to prevent or decrease recurrence. Accident - any happening that results in bodily injury, including but not limited to falls, fractures, lacerations, burns, skin tears and bruises. At the time of an incident / accident or upon discovery, staff are to notify the Nursing Supervisor. The Registered Nurse is responsible to assess and assure appropriate medical attention follow-up. The facility policy and procedure titled, Abuse/Neglect, revised 4/2025, documented the following: it is the policy of the facility that all residents have the right to be free from neglect, verbal, sexual, physical or mental abuse, corporal punishment, exploitation and involuntary seclusion. Investigate all reported incidents and accidents and resident complaints for potential abuse, neglect and possible crime. Once an incident has been reported, notify the Director of Nursing or Administrator and begin the investigation. As soon as the investigation begins and there is reasonable cause to believe it is reportable to the Department of Health using the current annual, a determination must be made if it meets the two (2) hour or twenty-four (24) hour reporting mandate. If physical injuries, provider to be notified to determine level of follow-up needed. Review of facility form undated titled, Reportable Incidents/Examples, documented the following: Notify the Supervisor and Administrator immediately - Reportable incidents must be reported to the Department of Health by Administration Immediately, examples included injury of unknown origin; resident has a new bruise, fracture, skin tear without explanation. Resident #5 had diagnoses including dementia (a generalized term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), hypertension (a condition in which the force of the blood against the artery walls is too high), and Peripheral Vascular Disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). The Minimum Data Set (a resident assessment tool) dated 4/25/2025 documented Resident #5 was cognitively severely impaired, usually understands and usually understood. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The undated comprehensive care plan for Resident #5 identified as current by Director of Nursing #1 documented that Resident #5 required substantial / maximal assistance with dressing and may be resistant to care; cognition deficit as evidenced by short term memory loss with difficulty with decision making and difficulty memory recall and behavior symptoms dated physical / verbal abuse with resistance to care as evidenced by refusal of hands on care, verbally and physically aggressive to staff and others. Review of Resident #5 ' s Progress Notes dated 3/01/2025 through 6/09/2025 documented the following: - Dated 4/08/2025 at 5:26 PM: Registered Nurse #4 documented the following: purpura (is a medical term describing purple - colored spots or patches on the skin caused by bleeding under the skin due to broken blood vessels) noted below the resident ' s right eye, no pain noted when assessed. - Dated 4/14/2025 at 4:33 PM: Nurse Practitioner #2 documented the following: ecchymosis (the medical term for bruises) to right lower eye, per nursing they rub vigorously. - Dated 4/16/2025 at 8:22 PM: Registered Nurse #3 documented the following: bruise right eye Nurse Practitioner assessed resident ' s right eye and determined a bruise. The bruise is purple with yellow area surrounding and fading in color, measures six (6) centimeters by three (3) centimeters under right eye. The area above the right eye lid measures two (2) centimeters by (0.5) centimeters. Resident denies pain or discomfort and resident denies any harm or wrongdoing. Family was aware last week while visiting resident and states the purple has been there for over a week and resident did not know how it happened as they had already asked him. - Dated 4/16/2025 at 9:22 PM: Nurse Practitioner #2 documented the following: ecchymosis below left eye is resolving turning purple/green/yellow, on better view can now observe ecchymosis to upper medial lid. Resident has no pain on palpation, no asymmetry of the periorbital ring. Resident does not recall how this developed. - Dated 4/18/2025 at 9:59 AM: Medical Director #1 documented the following: Visit date 4/17/2025, resident was seen as requested by Director of Nursing regarding the new skin lesion around Resident #5 ' s eye. Per Director of Nursing, no report of a fall, Nurse Practitioner #2 ' s progress notes reviewed from 4/14/2025 and 4/16/2025. Assessment documented, a small and dissipating ecchymosis (a discoloration of the skin resulting from bleeding underneath) below the right lower eyelid is present and Resident #5 was unable to recall what had happened. Etiology questionable (the cause or origin of the condition was not clearly understood or identified). Review of the facility ' s Accident form dated 4/16/2025 Registered Nurse #3 documented, estimated date 4/11/2025 at 12:00 PM bruise right eye, possible cause resident rubbed their eye too hard and the multiple eye scrubs made the area further purple. Registered Nurse #3 was on unit doing rounds and Nurse Practitioner #2 and administration were looking at Resident #5 ' s right eye and requested them to complete an incident report for area noticed last week. Statements documented on the Accident report included the following: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Dated 4/17/2025 Licensed Practical Nurse #3: On 4/08/2025, Resident #5 had a linear dark red/purple area, intact skin under right eye. The area was slightly crescent in shape and followed the large droopy bag under their right eye. Registered Nurse #4 was made aware, daughter was present the next day and inquired with staff, explained the area was referred to as a purpura area. - Dated 4/17/2025 Certified Nurse Aide #5: They saw Resident #5 ' s eye and asked Registered Nurse #4 what happened to their eye and Registered Nurse #4 informed them they had a purpura area. - Dated 4/17/2025 Nurse Practitioner #1: Was told by staff on 4/16/2025 they suspected a bruise to Resident #5 ' s eye that staff were calling a purpura and informed Administration as soon as possible. - Dated 4/18/2025 Nurse Practitioner #3: They observed Resident #5 walking past them and observed their eye and asked Nurse Practitioner #2 what happened to Resident #5 ' s eye. Nurse Practitioner #2 replied that it was being documented as purpura by nursing but the way it was shaped it looked like they may have had an injury to their right eye, and it appeared to be bruised. Nurse Practitioner #2 agreed it was a bruise but does not know where it came from. During an interview on 6/10/2025 at 9:05 AM, Nurse Practitioner #1 stated Registered Nurse #4 should have reported the discoloration around Resident #5 ' s eye to the provider for an assessment and the Director of Nursing or Administrator because it was an injury of unknown origin on 4/08/2025, and the facility should have reported it to the New York State Department of Health within the regulatory guidelines. During an interview on 6/10/2025 at 9:46 AM, Registered Nurse #3 stated Registered Nurse #4 should have reported the discoloration around Resident #5 ' s eye to the provider for an assessment and the Director of Nursing or Administrator because it was an injury of unknown origin on 4/08/2025, and the facility should have reported it to the New York State Department of Health within the regulatory guidelines. During an interview on 6/10/2025 at 10:16 AM, Medical Director #1 stated they were not aware Registered Nurse #4 identified Resident #5 had a discolored area on their right eye on 4/08/2025 and would have expected Registered Nurse #4 to have reported the discoloration around Resident #5 ' s eye to the provider for an assessment and the Director of Nursing or Administrator because it was an injury of unknown origin on 4/08/2025, and the facility should have reported it to the New York State Department of Health within the regulatory guidelines. During an interview on 6/10/2025 at 11:35 AM, Director of Nursing #1 stated Registered Nurse #4 should have reported the discoloration around Resident #5 ' s eye to the provider for an assessment and the Director of Nursing or Administrator because it was an injury of unknown origin on 4/08/2025, and the facility should have reported it to the New York State Department of Health within the regulatory guidelines of 24 hours. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/10/2025 at 11:56 AM, Administrator #1 stated they were not aware Registered Nurse #4 identified Resident #5 had a discolored area on their right eye on 4/08/2025 and would have expected Registered Nurse #4 to have reported the discoloration around Resident #5 ' s eye to the provider for an assessment and the Director of Nursing or them because it was an injury of unknown origin on 4/08/2025, and the facility should have reported it to the New York State Department of Health within the regulatory guidelines of 24 hours. 10 New York Codes, Rules and Regulations 415.4(b)(2)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on observation, interview and record review conducted during an Abbreviated survey (Complaint #NY00379718 and #NY00378218) completed on 6/10/2025, it was determined the facility did not ensure that all violations of abuse, neglect, mistreatment were thoroughly investigated for two (2) (Resident #2 and #5) of three (3) residents reviewed. Specifically, (1.) An incident involving Resident #2, who was fed regular chicken consistency by Certified Nurse Aide #3, was not thoroughly investigated to determine where the Certified Nurse Aide retrieved the regular consistency meal; and (2.) Resident #5's injury of unknown origin was not investigated thoroughly. Reference F 600 D and F 609 D This is evidenced by: The facility policy and procedure titled, Abuse/Neglect, revised 4/2025, documented the following: it is the policy of the facility that all residents have the right to be free from neglect, verbal, sexual, physical or mental abuse, corporal punishment, exploitation and involuntary seclusion. Investigate all reported incidents and accidents and resident complaints for potential abuse, neglect and possible crime. Statements from staff must be done immediately, and the person conducting the investigation will use the employee statement to determine the need for an interview. The facility policy and procedure titled, Resident Incident / Accident Reporting, revised 9/2023, documented the following: Accident - any happening that results in bodily injury, including but not limited to falls, fractures, lacerations, burns, skin tears and bruises. The purpose is to document occurrence of incident / accidents, identify unsafe practices, reduce preventable incident / accidents through root cause analysis, and provide education and follow-up to prevent further occurrences. Obtain resident and staff statements regarding the event, an investigation regarding the circumstance of the incident or accident must be conducted by the nursing supervisor by obtaining and reviewing statements from all staff who have the potential to be knowledgeable of the incident or accident. Follow up interviews will be conducted as necessary. (1.) Resident #2 had diagnoses including dementia with agitation (a behavior change characterized by restlessness, excessive movement, and sometimes aggression, often triggered by changes in routine, environment, or cognitive decline), chronic obstructive pulmonary disease (a condition caused by damage to the airways or other parts of the lung, causing breathing problems), and malignant neoplasm of the bladder (bladder cancer). The Minimum Data Set (a resident assessment tool) dated 2/23/2025 documented Resident #2 was cognitively severely impaired, sometimes understood and sometimes understands, did not exhibit behaviors of rejection of care, required supervision or touching assistance for eating (helper provides verbal cues and / or touching / steadying and / or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.) and required a mechanically altered diet (a change in texture of food or liquids). (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the comprehensive care plan dated 8/22/2023 documented the following: Nutrition / Hydration Comfort Care as evidenced by dysphagia (difficulty swallowing foods or liquids, arising from the throat or esophagus, ranging from mild difficulty to complete and painful blockage). Documented interventions included provide the least restrictive diet necessary to allow optimal intake, mechanically altered diet. Review of the Dietary Quarterly Nutritional Assessment for Resident #2 dated 2/24/2025 documented the following: regular diet, mechanical soft consistency with ground meats, thin liquids, had impaired swallowing, and required partial / moderate assist with supervision or touching assistance. Review of Resident #2's meal ticket, undated identified by Director of Nursing #1 as the meal ticket that was on Resident #2's meal tray on 5/04/2025 supper meal documented regular mechanical soft with ground meats, extra sauce / gravy, included three (3) each chicken tenders - must be minced. Review of, Nursing Home Investigative Report, completed by Director of Nursing #1 on 5/04/2025 at 9:06 PM, revealed the following: • The alleged abuse, neglect or mistreatment occurred as a result of a care plan violation on 5/04/2025 resulting in Resident #2 having a choking episode and required back thrusts and mouth sweeps to clear their throat and mouth of chicken. This was related to Resident #2 being given the wrong food consistency; served regular consistency chicken tenders and resident's diet is mechanical soft with ground meats. • The facility's investigation conclusion documented statements were obtained from all staff involved, the findings of the investigation documented, Certified Nurse Aide #3 was feeding Resident #2 the wrong meal consistency food (served regular and diet is mechanical soft, minced meat). The facility concluded that Resident #2 choked from Certified Nurse Aide #3 feeding them the wrong food consistency. Review of Resident #3's meal ticket, undated identified by Dietary Typist #1 as the meal ticket that was provided on 5/04/2025 supper meal documented, their diet: regular diet mechanical soft / hamburger ground on roll, extra sauce / gravy and food items included 1 fish sandwich, sweet potato tots and soup. Review of Resident #4's meal ticket, undated identified by Dietary Typist #1 as the meal ticket that was provided on 5/04/2025 supper meal documented, their diet: regular no added salt / mechanical soft / regular chicken and bacon and regular bagel with cream cheese / extra sauce / gravy and food items included (3) chicken tenders, mango sauce, dipping, sweet potato tots. (continued on next page)

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Van Rensselaer Manor	85 Bloomingrove Drive Troy, NY 12180

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 6/05/2025 at 12:42 PM, Certified Nurse Aide #3 stated during the supper meal on 5/04/2025, Resident #3 was served a fish sandwich, and they requested to have chicken. Certified Nurse Aide #3 stated they noticed Resident #2 had minced chicken on their plate, so they took the food plate from Resident #2's tray and gave it to Resident #3. They stated Resident #4 had regular chicken tenders on a plate and didn not want them because they were eating pancakes, so they took Resident #4's food plate of chicken tenders and gave it to Resident #2. They stated they did intentionally swap the meal plates but mistakenly did not read Resident #2's meal ticket consistency and provided them with the wrong consistency and they choked and needed attention from the nurse to clear their mouth and throat. They stated they should not have swapped residents' meal plates and should have called the kitchen for an alternative plate for Resident #3 when they asked for a different meal. During a telephone interview on 6/05/2025 at 2:50 PM, Registered Nurse #3 stated they interviewed staff on 5/04/2025 related to Resident #2's choking incident. They stated upon investigating the staff interviews, they learned Certified Nurse Aide #3 swapped out three (3) resident's meal plates and mistakenly did not identify Resident #2 was to have minced chicken tenders and was not to receive regular chicken tenders, which caused Resident #2 to choke. They stated Director of Nursing #1 was aware that Certified Nurse Aide #3 swapped out three (3) resident meal plates. They stated they did not request Certified Nurse Aide #3 to update their written statement to clarify they swapped out three (3) resident meal plates and they did not review Resident #3's and Resident #4's dietary plan to ensure they received the appropriate diet meal plan and correct consistency. Additionally, they stated they did not add Resident #3 and Resident #4 to the investigation. During an interview on 6/09/2025 at 10:06 AM, Therapy Department Director #1 stated they were not aware Certified Nurse Aide #3 swapped three (3) resident meal plates and was not aware how Resident #2 received regular consistency chicken which caused them to choke. They stated they would have expected Director of Nursing #1 to have informed them Resident #3 and Resident #4's supper plates were also swapped, and they would have assessed the meals they received to ensure the food was appropriate according to their meal plans. They stated all staff were expected if they want an alternative meal, they were to call the kitchen for a tray and should never swap resident meal plates between the residents to ensure consistency and diet restrictions are followed. They stated the facility did not complete a thorough investigation. During an interview on 6/09/2025 at 11:53 AM, Nurse Practitioner #1 stated they were not aware Certified Nurse Aide #3 swapped three (3) resident meal plates and would have expected a thorough investigation to include a review of Resident #3 and Resident #4's dietary plan to ensure they received the correct diet and consistency. During a telephone interview on 6/10/2025 at 10:37 AM, Medical Director #1 stated they were not aware Certified Nurse Aide #3 swapped three (3) resident meal plates and would have expected a thorough investigation to include where Certified Nurse Aide #3 obtained the regular chicken from that Resident #2 was fed. They stated they would have expected Director of Nursing #1 to have thoroughly investigated Resident #3 and Resident #4's meal tickets and dietary plan to ensure they also received the correct consistency and dietary plan and would have expected Director of Nursing #1 to have had the information documented in the investigation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/10/2025 at 11:36 AM, Director of Nursing #1 stated they were not aware where Certified Nurse Aide #3 got the regular chicken tenders from that they fed Resident #2. They stated they did not complete a thorough investigation to determine where they retrieved the regular consistency chicken tenders from. They stated they were informed Certified Nurse Aide #3 swapped out meal plates that also involved Resident #3 and #4 and identified they were all mechanical soft, and did not identify Resident #4 had regular chicken tenders on their meal plan, that was provided to Resident #2. They stated they had not completed a thorough investigation and should have thoroughly reviewed and included Resident #3's and Resident #4's information in the investigation based on the interviews. During an interview on 6/10/2025 at 12:08 PM, Administrator #1 stated the facility did not complete a thorough investigation and would have expected Director of Nursing #1 to have identified where Certified Nurse Aide #3 obtained the regular chicken tenders from that Resident #2 was fed and have thoroughly reviewed and included Resident #3's and #4's information in the investigation. They stated they were not aware Certified Nursing Aide #3 swapped out 3 resident meal plates and they should have been informed. (2.) Resident #5 had diagnoses including dementia (a generalized term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), hypertension (a condition in which the force of the blood against the artery walls is too high), and Peripheral Vascular Disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). The Minimum Data Set (a resident assessment tool) dated 4/25/2025 documented Resident #5 was cognitively severely impaired, usually understands and usually understood. The undated comprehensive care plan for Resident #5 identified as current by Director of Nursing #1 documented the following, Resident #5 required substantial / maximal assistance with dressing and may be resistant to care; cognition deficit as evidenced by short term memory loss with difficulty with decision making and difficulty memory recall and behavior symptoms dated of physical / verbal abuse with resistance to care as evidenced by refusal of hands on care, verbally and physically aggressive to staff and others. Review of Resident #5's Progress Notes dated 3/01/2025 through 6/09/2025 documented the following: • Dated 4/08/2025 at 5:26 PM Registered Nurse #4 documented the following: purpura a medical term describing purple - colored spots or patches on the skin caused by bleeding under the skin due to broken blood vessels) noted below the resident's right eye, no pain noted when assessed. • Dated 4/14/2025 at 4:33 PM Nurse Practitioner #2 documented the following: ecchymosis (the medical term for bruises) to right lower eye, per nursing they rub vigorously. • (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dated 4/16/2025 at 8:22 PM Registered Nurse #3 documented the following: bruise right eye Nurse Practitioner assessed resident's right eye and determined a bruise. The bruise is purple with yellow area surrounding and fading in color, measures six (6) centimeters by three (3) centimeters under right eye. The area above the right eye lid measures two (2) centimeters by (0.5) centimeters. Resident denies pain or discomfort and resident denies any harm or wrongdoing. Family was aware last week while visiting resident and states the purple has been there for over a week and resident did not know how it happened as they had already asked him. • Dated 4/16/2025 at 9:22 PM Nurse Practitioner #2 documented the following: ecchymosis below left eye is resolving turning purple/green/yellow, on better view can now observe ecchymosis to upper medial lid. Resident has no pain on palpation, no asymmetry of the periorbital ring. Resident does not recall how this developed. • Dated 4/18/2025 at 9:59 AM Medical Director #1 documented the following: Visit date 4/17/2025, resident was seen as requested by Director of Nursing regarding the new skin lesion around Resident #5's eye. Per Director of Nursing, no report of a fall, Nurse Practitioner #2's progress notes reviewed from 4/14/2025 and 4/16/2025. Assessment documented, a small and dissipating ecchymosis (a discoloration of the skin resulting from bleeding underneath) below the right lower eyelid is present and Resident #5 was unable to recall what had happened. Etiology questionable (the cause or origin of the condition was not clearly understood or identified). Review of the facility's Accident form dated 4/16/2025 Registered Nurse #3 documented, estimated date 4/11/2025 at 12:00 PM bruise right eye, possible cause resident rubbed their eye too hard and the multiple eye scrubs made the area further purple. Registered Nurse #3 was on unit doing rounds and Nurse Practitioner #2 and administration were looking at Resident #5's right eye and requested them to complete an incident report for area noticed last week. Statements documented on the Accident report included the following: • Dated 4/17/2025 Licensed Practical Nurse #3: On 4/08/2025 Resident #5 had a linear dark red/purple area, intact skin under right eye. The area was slightly crescent in shape and followed the large droopy bag under their right eye. Registered Nurse #4 was made aware, daughter was present the next day and inquired with staff, explained the area was referred to as a purpura area. • Dated 4/17/2025 Certified Nurse Aide #5: They saw Resident #5's eye and asked Registered Nurse #4 what happened to their eye and Registered Nurse #4 informed them they had a purpura area. • (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dated 4/17/2025 Nurse Practitioner #1: Was told by staff on 4/16/2025 they suspected a bruise to Resident #5's eye that staff were calling a purpura and informed Administration as soon as possible. • Dated 4/18/2025 Nurse Practitioner #3: They observed Resident #5 walking past them and observed their eye and asked Nurse Practitioner #2 what happened to Resident #5's eye. Nurse Practitioner #2 replied that it was being noted as purpura but the way it was shaped it looked like they may have had an injury to their right eye, and it appeared to be bruised. Nurse Practitioner #2 agreed it was a bruise but does not know where it came from. During an interview on 6/10/2025 at 9:05 AM Nurse Practitioner #1 stated they recalled staff were referring Resident #5's eye discoloration as a purpura area and it looked like a bruise, therefore they reported it to either the Deputy Administrator or the Director of Nursing, unable to recall who they reported it to. They stated Registered Nurse #4 should not have diagnosed it as a purpura area and reported it to the provider for an assessment and initiated an investigation on 4/08/2025. During an interview on 6/10/2025 at 9:05 AM Certified Nurse Aide #6 stated they worked the night shift providing care to Resident #5 on 4/07/2025 into the morning of 4/08/2025 and they were not interviewed or asked any questions from the facility concerning the bruise on Resident #5's right eye. They stated they do not know how the resident's eye was bruised. During an interview on 6/10/2025 at 9:33 AM Certified Nurse Aide #8 stated they were assigned to Resident #5 on 4/08/2025 day shift and they were not asked any questions for the investigation of Resident #5's bruised right eye. They stated they had not observed Resident #5 rubbing their eyes and did not know how the bruise was obtained. During an interview on 6/10/2025 at 9:46 AM Registered Nurse #3 stated they were notified by the Deputy Administrator #1 and Assistant Director of Nursing #1, Resident #5 had a bruise on their right eye and the nursing staff were identifying it as a purpura area and was directed to complete the Accident / Incident form and investigation. They stated the facility's process for investigating an injury of unknown origin is to interview all staff members assigned to the Resident's unit for the date the unknown injury is identified and the previous 24 hours to rule out abuse. They stated they believed the staff were aware of the area approximately one (1) week prior to Nurse Practitioner #2 determined it was a bruise / injury of unknown origin. They stated they picked the date 4/11/2025 and did not review the progress notes prior to 4/11/2025 and did not identify Registered Nurse #4 had documented on 4/08/2025 Resident #5 had a purpura area beneath their right eye. They stated they had not interviewed Registered Nurse #4 because they were no longer employed at the facility, and did not interview Certified Nurse Aide #6, #7, and #8 the assigned staff members for Resident #5 for the 24 hours prior to the documented purpura and they should have. They stated they did not complete a thorough investigation to rule out abuse. Additional interview attempts contact Registered Nurse #4, Nurse Practitioner #2, and Certified Nurse Aide #6 were not successful. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/10/2025 at 10:16 AM, Medical Director #1 stated they were not aware Registered Nurse #4 identified Resident #5 had a discolored area on their right eye on 4/08/2025 and would have expected Registered Nurse #4 to have notified a provider to assess the area and should not have diagnosed it as a purpura area. They stated they would have expected Director of Nursing #1 to have ensured a thorough investigation was completed by interviewing staff on 4/08/2025 and 4/07/2025 on the unit to rule out abuse and potentially determine how the injury of unknown origin occurred. During an interview on 6/10/2025 at 11:35 AM, Director of Nursing #1 stated they would have expected Registered Nurse #4 to have notified the provider on 4/08/2025 to assess Resident #5's discolored right eye and to have initiated an investigation. They stated Registered Nurse #3 should have reviewed the progress notes and completed a thorough investigation starting with staff scheduled on 4/08/2025. Upon review of the staff assignment sheets dated 4/08/2025 and 4/07/2025 they stated Certified Nurse Aide #6, #7, and #8 were assigned to Resident #5 and should have been interviewed and were not. They stated the facility did not complete a thorough investigation to rule out abuse. During an interview on 6/10/2025 at 11:56 AM, Administrator #1 stated they were not aware Registered Nurse #4 had documented Resident #5 had a purpura area beneath their right eye on 4/08/2025 and would have expected them to have notified a provider to complete an assessment and determine if the discoloration was a purpura area or bruise. They stated since Registered Nurse #4 had identified the discoloration of Resident #5's eye on 4/08/2025 they would have expected the facility investigation to have obtained statements or interviews from staff assigned to Resident #5 on 4/08/2025 and 4/07/2025. Upon review of the assignment sheets and the Accident Report of staff interviewed, they stated Certified Nurse Aide #6, #7, and #8 were assigned to Resident #5 and should have been interviewed and were not. They stated the facility did not complete a thorough investigation to rule out abuse. 1010 New York Codes, Rules and Regulations 415.4(b)(3)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview and record review conducted during an Abbreviated survey (Compliant #NY00379178) completed on 6/10/2025, the facility did not ensure that all residents comprehensive person-centered care plans were implemented as planned, consistent with resident's rights and meet their preferences, goals and medical, physical, and psychosocial needs that are identified in the comprehensive assessment for one (1) (Resident #1) of three (3) residents reviewed. Specifically, the resident was not provided with two (2) staff members for incontinent care and bed mobility as care planned. This is evidenced by: The facility policy and procedure titled Care Planning revised date 5/2023 documented that residents will have a comprehensive person-centered care plan identifying resident ' s strengths, goals, life history and preferences in place to guide their care and Certified Nurse Assistant instructions provide detailed information and instructions to meet each resident ' s individual needs. Resident #1 had diagnoses including dementia with agitation, generalized anxiety disorder and major depressive disorder. The Minimum Data Set (a resident assessment tool) dated 4/11/2025 documented Resident #1 was cognitively severely impaired, rarely / never understood and rarely / never understands, does not exhibit behaviors of rejection of care, and is dependent and requires assistance of two (2) or more helpers for toileting hygiene (maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement) and requires assistance of two (2) or more helpers for bed mobility (roll from lying on back to left and right side and return to lying on back on the bed). The comprehensive care plan identified as current by the Director of Nursing documented at risk for skin breakdown as evidenced by decreased mobility and incontinence, interventions dated 7/01/2023 included toilet use required support of two (2) plus person physical assist, incontinent bowel and bladder and bed mobility support of two (2) plus person physical assist. The Certified Nurse Assistant Assignments Summary (a guide used by staff to provide care) identified as current by the Director of Nursing documented Resident #1 was incontinent and required two (2) plus person physical assist incontinent care and bed mobility. During an incontinence care observation on 6/04/2025 at 10:11 AM, Certified Nurse Aide #1 was observed to remove Resident #1 ' s soiled brief and provide incontinent care of feces and urine cleaning Resident ' s buttocks and peri area turning and positioning Resident #1 from back to right side, to back to left side while providing incontinent care and applied a clean brief turning and positioning Resident #1 without a second person assist. While being turned and positioned Resident #1 observed to intermittently state. ' hey, hey, hey. ' During an interview on 6/04/2025 at 1:50 PM, Certified Nurse Aide #1 reviewed Resident #1 ' s care plan and stated the care plan documented the resident required two (2) persons assist for incontinent care and bed mobility. They stated they did not ask for any assistance to provide the observed incontinent care and should have. They stated Resident #1 required two (2) persons assist for incontinent care and bed mobility because the resident was totally dependent and often has behaviors, therefore a second assist is for the resident ' s safety. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/04/2025 at 2:01 PM, Certified Nurse Aide #2 stated Resident #1 required two (2) persons assist for incontinent care and bed mobility because the resident was totally dependent and would have expected Certified Nurse Aide #1 to have asked for assistance and followed the plan of care. During an interview on 6/04/2025 at 2:10 PM, Licensed Practical Nurse #1 stated Resident #1 requires two (2) persons assist for incontinent care and bed mobility because the resident is totally dependent on staff and doesn ' t assist with turning and positioning. They stated it is for the resident ' s safety that two (2) persons provide the care and would have expected Certified Nurse Aide #1 to have asked staff for assistance and followed the plan of care. During an interview on 6/04/2025 at 2:24 PM, Registered Nurse #1 stated Resident #1 required two (2) persons assist for incontinent care and bed mobility because the resident was totally dependent on staff and did not assist with turning and positioning. They stated it was for the resident ' s safety that two (2) persons provided the care and would have expected Certified Nurse Aide #1 to have asked staff for assistance and followed the plan of care. During an interview on 6/04/2025 at 3:16 PM, Director of Nursing #1 stated care plans were developed based on resident needs. Upon review of Resident #1 ' s plan of care, they stated the resident required two (2) persons assist for incontinent care and bed mobility and would have expected Certified Nurse Aide #1 to follow the plan of care and have a second person assisting with the care provided. During an interview on 6/10/2025 at 12:13 PM, Administrator #1 stated they expected all staff to follow a resident ' s plan of care. 10 New York Code, Rules and Regulations 415.11 (c)(1)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and record review conducted during an Abbreviated survey (Compliant #NY00379178) completed on 6/10/2025, the facility did not ensure provision of a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for one (1) (Resident #1) of one (1) resident reviewed for infection control practices. Specifically, Resident #1 was on Enhanced Barrier Precautions (interventions designed to reduce transmission of multi-drug-resistant organisms including mask, gown and glove use during high contact resident care activities) and staff did not wear proper personal protective equipment while providing incontinent care of urine and feces. Additionally, the facility did not have transmission-based precaution policies to prevent the spread of infections, when and how isolation should be used for a resident; including but not limited to the type and duration of the isolation, depending upon the infectious agent or organism involved. This is evidenced by: The facility policy and procedure titled, Infection Control, revised 10/2024, documented the following: it is the policy of the facility to follow the Federal regulations, and the purpose is to adhere to principles and rules of infection control, to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. The Medical Director, Infection Control Nurse and Nursing Supervisors determine what procedures (such as isolation) should be applied to an individual resident. Control Specific Isolation is used by facility - see Specific Card(s) which explain what is to be used and for what purpose per Centers for Disease Control and Prevention (the national public health agency of the United States) recommendations. Preventing the spread of infection included, initiate appropriate isolation and/or control in a timely manner and *Enhanced Barrier Precautions per Centers for Disease Control and Prevention. *Note to reader: Enhanced Barrier Precautions is an infection control strategy that uses targeted gown and glove use during high-contact resident care activities to reduce the transmission of multidrug-resistant organisms; it is a supplement to standard precautions and existing isolation guidelines, aiming to reduce the spread of microorganisms that can cause infections. The facility specific card (signage) for Enhanced Barrier Precautions, documented everyone must clean their hands, including before entering and when leaving the room, providers and staff must also: Wear gloves and gown for the following high-contact resident care activities included dressing, providing hygiene, changing briefs or assisting with toileting. Resident #1 had diagnoses including dementia with agitation (a behavior change characterized by restlessness, excessive movement, and sometimes aggression, often triggered by changes in routine, environment, or cognitive decline), generalized anxiety disorder (a mental health condition characterized by excessive worry and anxiety about a wide range of everyday situations) and major depressive disorder (a mood disorder characterized by persistent low mood, loss of interest or pleasure in activities, and other symptoms that interfere with daily functioning). The Minimum Data Set (a resident assessment tool) dated 4/11/2025 documented Resident #1 was cognitively severely impaired, rarely / never understood and rarely / never understands, did not exhibit behaviors of rejection of care, and was frequently incontinent of bowel and bladder (having no or insufficient voluntary control over urination or defecation). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the comprehensive care plan identified as current by the Director of Nursing documented the following: Infection Control Precautions dated 9/04/2024 as evidenced by Multidrug-Resistant Organisms, extended-spectrum beta-lactamase-producing bacteria (these are bacteria that produce an enzyme that makes them resistant to certain common antibiotics) in urine. Documented interventions included staff to wear personal protective equipment per precaution card posted outside resident room. Review of the Physician Order Activity Detail Report for Resident #1 dated 4/01/2025 through 6/04/2025 documented the resident had extended-spectrum beta-lactamase-producing bacteria in urine and was on Enhanced Barrier Precautions as of 8/30/2024. During an observation on 6/04/2025 at 10:11 AM, an Enhanced Barrier Precaution signage was posted on the wall outside of Resident #1 ' s room under their name tag. A bin with personal protective equipment next to Resident #1 ' s room door included gloves and gowns. During an incontinence care observation on 6/04/2025 at 10:11 AM, Certified Nurse Aide #1 was observed to enter Resident #1 ' s room, apply gloves, and did not put on appropriate personal equipment (a gown). Certified Nurse Aide #1 then removed Resident #1 ' s soiled brief, provided incontinent care by cleaning Resident #1 of feces and urine, turned and positioned the resident during care, and applied a clean brief. At no time did Certified Nurse Aide don (put on) a gown as recommended by the Enhanced Barrier Precaution signage. During an interview on 6/40/2025 at 10:19 AM, Certified Nurse Aide #1 stated the Enhanced Barrier Precaution signage outside Resident #1 ' s room door - hanging beneath Resident #1 ' s name tag - meant staff were to wear gloves and a gown while providing any hands-on care to a resident who was on precautions in that room. They stated they did not know if Resident #1 was on precautions or if it was their roommate. They stated they would need to ask the charge nurse. During another interview on 6/04/2025 at 1:50 PM, Certified Nurse Aide #1 stated they were informed precaution signage for a particular resident was posted under the resident ' s nametag located on the wall outside the resident ' s room. They stated they were informed Resident #1 was on precautions related to their history of urinary tract infections, and that they should have worn a gown while providing care to Resident #1 to prevent cross contamination to their uniform and potentially cross contamination to other residents. During an interview on 6/04/2025 at 2:24 PM, Registered Nurse #1 stated Certified Nurse Aide #1 informed them they were not wearing a gown while providing incontinent care to Resident #1 during the observation this morning and they should have. They stated Resident #1 was on Enhanced Barrier Precautions related to history of urinary tract infections and has extended-spectrum beta-lactamase-producing bacteria in their urine and expected all staff to follow the precaution guidelines posted outside the resident ' s rooms for infection control purposes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/04/2025 at 3:16 PM, Director of Nursing #1 stated Resident #1 was on Enhanced Barrier Precautions and would have expected Certified Nurse Aide #1 to have worn a gown while providing care for infection control purposes, to prevent the potential of cross contamination to other residents. They stated they would have expected Certified Nurse Aide #1 to know Resident #1 was on Enhanced Barrier Precautions because the signage was posted beneath Resident #1 ' s name outside the room. Director of Nursing #1 stated they did not have a specific facility policy and procedure for Enhanced Barrier Precautions, and that the facility did not have specific infection control policies and procedures for each type of transmission-based precaution such as airborne precautions, droplet precautions, and contact precautions. During an interview on 6/05/2025 at 10:18 AM, Deputy Administrator #1 stated the facility did not have specific infection control policies and procedures for each type of transmission precaution, such as contact precaution, airborne precaution, droplet precaution and Enhanced Barrier Precautions. They further stated the facility ' s Infection Control Program referred staff to follow the Centers for Disease Control guidelines for Enhanced Barrier Precautions. During an interview on 6/05/2025 at 10:50 AM, Registered Nurse #2 stated they were the facility ' s Infection Preventionist, and Certified Nurse Aide #1 should have been wearing a gown while providing care to Resident #1 because the resident was on Enhanced Barrier Precautions related to Multidrug-Resistant Organisms in their urine. They stated the requirement to wear a gown while providing care was to prevent any cross contamination to another resident. They stated the facility did not have an Enhanced Barrier Precaution Policy. Additionally, they stated the facility did not have specific infection control policies and procedures for each type of transmission-based precaution such as airborne precautions, droplet precautions, and contact precautions. During a phone interview on 6/10/2025 at 10:16 AM, Medical Director #1 stated they would have expected Certified Nurse Aide #1 to wear a gown while providing care to Resident #1 and follow the Enhanced Barrier Precautions procedure to prevent cross contamination for infection control. They stated they recall reviewing specific signage the facility uses to notify staff what type of personal protective equipment to wear depending on the type of precaution such as airborne precautions, contact precautions, droplet precautions and Enhanced Barrier Precautions, but did not recall reviewing specific policies for each transmission-based precaution. They stated they were not aware the facility did not have transmission-based precautions, when and how isolation should be used for a resident, including but not limited to the type and duration of the isolation, depending on the infectious agent or organism involved. During another interview on 6/10/2025 at 11:36 AM, Director of Nursing #1 stated they did not know why the facility did not have policies and procedures written for each transmission-based precaution to prevent the spread of infections and they had initiated a process to develop the policies and procedures. During an interview on 6/10/2025 at 12:13 PM, Administrator #1 stated they would have expected Certified Nurse Aide #1 to wear a gown while providing care to Resident #1 and follow the Enhanced Barrier Precautions procedure to prevent cross contamination for infection control. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335265	A. Building B. Wing	06/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Van Rensselaer Manor	85 Bloomingrove Drive Troy, NY 12180

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	They stated they were not aware the facility did not have transmission-based precautions policies, including a policy for airborne precaution, droplet precaution, contact precaution, and enhanced barrier precaution. They stated they would have expected the Infection Control Preventionist Nurse and Director of Nursing #1 to have policies in place. 10 New York Codes, Rules and Regulations 415.19(a)(2)