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	03/18/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on record review and interviews conducted during an abbreviated survey, the facility did not ensure each resident was treated with respect and dignity, and care in a manner and in an environment that promoted maintenance or enhancement of their quality of life for one (1) (Resident #1) of four (4) residents reviewed. Specifically, Resident #1 was left alone on the floor after fall for upwards of four (4) minutes after Certified Nurse Aide #1 physically abused them by causing the resident to fall from their wheelchair.This is evidenced by:Cross referenced to F600The facility's undated Resident Handbook, presented as the facility dignity policy, documented ?as a nursing home resident, you have the right to: dignity, respect and a comfortable living environment; quality of care and treatment without discrimination; freedom of choice to make your own, independent decisions; be informed in writing about services and fees before you enter the nursing home; the safeguard of your property and money; safeguards in admission transfer and discharge; privacy in communications; choose your own schedule, activities and other preferences that are important to you; receive visitors of your choosing at the time of your choosing; an easy to use and responsive complaint procedure; be free from abuse including verbal, sexual, mental and physical abuse; be free from restraints; exercise all of your rights without fear of reprisals. Resident #1 was admitted to the facility with diagnoses of Parkinson's Disease with Dyskinesia, with Fluctuations (a condition that causes muscle tremors and rigidity along with involuntary writhing movements) and Unspecified Dementia, Unspecified Severity, without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance (a degenerative neurological disease-causing memory loss and cognitive decline with psychological issues like agitation), and Anxiety. Minimum Data Set (MDS, an assessment tool) dated 08/08/2025, documented Resident #1 could be understood, could understand others and had intact cognition for decisions of daily living.^ Resident #1's Comprehensive Care Plan titled, Vision, dated 11/04/2024,documented encourage resident to ask for assistance as needed, and orient resident to changing surroundings. Resident #1's Comprehensive Care Plan titled Activity Participation, dated 11/15/2024, documented to respect resident's right to refuse participation or attendance in recreational activities, initiate conversation with resident as frequently as possible, maintain preferred independent leisure activity, and provide escort or transportation as needed. Resident #1's Comprehensive Care Plan titled Falls, dated 11/04/2024, documented to investigate cause of fall immediately, provide reality orientation, attempt to maintain a high-profile area as often as possible, and report any unsafe behavior to nursing. A facility provided incident and accident report dated 8/02/2025 documented that Certified Nurse Aide #1 noticed Resident #1 standing in their room, Certified Nurse Aide #1 assisted the resident to their wheelchair and when they were exiting the resident's room together, Resident #1 grabbed the wall handrail and pulled themselves from the wheelchair. The report documented Certified Nurse Aide #1's accounting was while attempting to reseat the resident, Resident #1 needed to be lowered to the floor to prevent them from falling to the floor. Resident #1's self-propelled standing out of the wheelchair was attributed to gastric distress.The facility's abuse investigation dated 8/26/2025 through 9/15/2025, included video footage dated 8/02/2024 starting at 10:48 AM. Per the video footage, Resident #1 was standing unsupervised in their room. Certified Nurse Aide #1 was (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	viewed entering Resident #1's room without knocking, placing their hands on Resident #1's arms and pulling the resident into their wheelchair. Resident #1 appeared to resist Certified Nurse Aide #1 but was eventually maneuvered into their wheelchair. Resident #1 stood again in their room and Certified Nurse Aide #1 again pulled the resident into their wheelchair. While pulling Resident #1 into their wheelchair a second time, Resident #1 appeared to almost miss the wheelchair and nearly fall. As the video footage continued, Resident #1 was observed being pushed in their wheelchair by Certified Nurse Aide #1 but attempted to block the front wheel with their foot. Certified Nurse Aide #1 was observed turning the wheelchair around so that the resident and the chair could be moved backwards out into the hallway. Certified Nurse Aide #1 continued to pull the wheelchair backwards, and while the wheelchair was moving, Resident #1 stood up, resulting in Resident #1 falling to the floor, and onto their side. Certified Nurse Aide #1 appeared to throw their hands down at their sides and then walk away leaving the resident lying on the floor. As the video footage continued, Resident #1 was observed to have laid on the floor alone for 2 minutes before Certified Nurse #1 comes back into the viewing area, pushing a mechanical Hoyer lift towards where the resident was laying. Certified Nurse Aide #1 was seen walking past the resident, said something to Resident #1 and then stood in the doorway of the room next to Resident #1's room, at least 5 feet from where Resident #1 was laying. Licensed Practical Nurse #4 was viewed coming down the hall to do vital signs for Resident #1. Certified Nurse Aide #1 left the footage area when Licensed Practical Nurse #1 stated attending to Resident #1, and did not return at any time for the rest of the video footage provided. After another minute, Assistant Director of Nursing #1 was viewed coming down the hall. Assistant Director of Nursing #1 was observed to be talking to Resident #1 on the floor. There was visual evidence that a limited range of motion assessment was performed on the resident's arms. Assistant Director of Nursing #1 was observed to have Resident #1's head on their lap while talking to Licensed Practical Nurse #1 and Resident #1. Assistant Director of Nursing #1 took a phone call while kneeling on the floor and holding Resident #1's head. After Assistant Director of Nursing #1 put the phone back in their pocket, Assistant Director of Nursing #1 had Resident #1 bend their knees and with the help of Licensed Practical Nurse #1, they manually lifted Resident #1 from the floor by the resident's arms and placed them in the wheelchair. There was no documented evidence that any other range of motion was tested on Resident #1's legs. Resident #1 was left on the floor, unattended for a minimum of four (4) minutes, between 10:49 AM and 10:53 AMDuring an interview on 8/26/2025 at 12:03 PM, Registered Nurse #1 stated that they expected that staff would treat residents with respect and dignity. As the unit manager, Registered Nurse #1 stated that they did gentle reminders about resident safety and handling them. Registered Nurse #1 stated that they had regular staff, therefore abuse wasn't an issue on their unit. If residents were acting up, the staff would check for the resident for a urinary tract infection because the unit was pretty calm and everyone got along. Registered Nurse #1 stated that there should never be physical redirection with residents. Registered Nurse #1 stated they would remove a Certified Nurse Aide and enact the chain of command if they ever saw something that looked like abuse.During an interview on 8/27/2025 at 11:27 AM, Assistant Director of Nursing #1 stated that they were called to the unit because Resident #1 was on the floor. Assistant Director of Nursing #1 described where Resident #1 was laying at the time and stated they were alert and able to answer questions. Resident #1 indicated they had stood up on their own and fallen trying to sit down in their wheelchair (missed the chair when sitting). Registered Nurse #1 stated they asked about pain and did an assessment for range of motion. Resident #1 stated they had some gas type pain and because it was slightly after breakfast, that was what Assistant Director of Nursing #1 believed. Assistant Director of Nursing #1 stated that if at any point Resident #1 had given any indication that they had an issue with Certified Nurse Aide #1, they would have treated the situation differently. When asked how, Assistant Director of Nursing #1 stated they would have interviewed the staff member privately, maybe changed their assignment, or called the Director of Nursing to have Certified Nurse Aide #1 removed from care if they suspected abuse had taken place. When asked what the (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	expectation was for any Certified Nurse Aide who had lowered a resident to the floor, Assistant Director of Nursing #1 stated that the Certified Nurse Aide should get help. The staff member could call code blue, could take 3-6 steps into the room and pull the call bell, or yell for help. Assistant Director of Nursing #1 stated that maybe the staff member could go and get help physically but the preference would be to use the call bell system and stay with the resident to assure their safety while waiting for help. Assistant Director of Nursing #1 stated it would not be appropriate to leave a resident unattended on the floor for multiple minutes. When asked to quantify the number on minutes, Assistant Director of Nursing #1 stated maybe less than two minutes would be appropriate. The staff member should get a nurse and a vital sign machine and get back to the resident. During an interview on 8/28/2025 at 2:20 PM, Director of Nursing #1 stated that the actions of Certified Nurse Aide #1 were not acceptable. It was not the expectation that staff would be unkind or treat residents in an undignified way. It was not acceptable for Certified Nurse Aide #1 to leave Resident #1 on the floor the way that they did. New York Codes, Rules, and Regulations Title 10 S415.5(a)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews conducted during an abbreviated survey (Case #2591142), the facility did not prevent willful infliction of abuse, neglect, or mistreatment for two (2) (Resident # 1, and 3) of four (4) residents reviewed for abuse, neglect, or mistreatment. Specifically, the facility did not fully investigate an incident that occurred on 08/02/2025 when Certified Nurse Aide #1 lowered Resident #1 to the floor. Video footage captured on 08/02/2025 was viewed by facility staff on 08/14/2025 and showed abusive handling of Resident #1 that resulted in the resident falling to the floor and remaining unattended for four (4) minutes.This is evidenced by: The Facility's Abuse & Neglect Policy, updated on 04/03/2025, documented residents had the right to be free from neglect, verbal, sexual, physical or mental abuse, corporal punishment, exploitation and involuntary seclusion. Record review of the facility's abuse investigation dated 08/15/2025 through 09/03/2025 revealed Certified Nurse Aide #1 was suspended after it was discovered that they were possibly responsible for multiple injuries found on more than one resident in their care assignments. On 07/19/2025, a bruise and an abrasion was noted on Resident #2's forehead which was attributed to rough handling during bed mobility. Additionally, on 08/01/2025, bruising was noted to the right side of Resident #3's face and around their eye and nose that was attributed to Certified Nurse Aide #3 rolling Resident #3 into the wall next to their bed, and ill-fitting glasses. On 08/15/2025, bruising was noted to Resident #4's neck, appeared to be multiple days old, and was attributed to Resident #4 being resistive to care. Resident #3 Resident #3 was admitted to the facility with the diagnoses of unspecified dementia, unspecified severity with other behavioral disturbances (memory loss and reduced thinking ability without aggressive or disruptive behavior), hypothyroidism (a condition when the thyroid does not produce enough thyroid hormones to meet the bodies needs), and major depressive disorder (a mood disorder that causes persistent feelings of sadness and loss of interest). The Minimum Data Set, dated [DATE], documented the resident was usually able to understand others, was usually understood, and was severely cognitively impaired. A facility Incident and Accident Report, dated 08/01/2025 at 2:00 PM, documented that a blue/gray bruise was noted on Resident # 3's nose. The contributing factors were documented as poor safety awareness, dementia, ill-fitting glasses, wall not padded, and resting their head on the table at times when fatigued. Measures to prevent recurrence were to place mat on wall, check glasses for appropriate fit, and to place staff on supervised care for follow up and education. Statements documented in the Incident and Accident Report documented the following: 1. Registered Nurse #2, dated 08/01/2025, spoke with Resident #3's family member who had visited on 07/30/2025 did not observe any bruising when visiting.2. Assistant Director of Nursing #1, dated 08/01/2025, documented that they had spoken with Certified Nurse Aide #1 who verbalized that Resident #3 was difficult while providing care, had swung their hands while attempting to provide personal care, and had hit their head on the wall while rolling over. Certified Nurse Aide #1 had not seen an injury at that time. Assistant Director of Nursing #1 documented they discussed how to approach and reapproach when resident's behaviors escalated. 3. Certified Nurse Aide #1, dated 08/19/2025, documented on 08/01/2025, they started to wash Resident #3 and they became combative with Certified Nurse Aide #1, they stopped to dry Resident #3 and put their clothes on.The Comprehensive Care Plan titled, Activities of Daily Living, dated 10/08/2021, documented that Resident #3 was a one person assist for bed mobility and activities of daily living. The Comprehensive Care Plan titled, Behavior Symptoms: Physical or Verbal Abuse/Resists Care, dated 10/08/2021, documented that Resident #3 had a history of hitting and screaming at staff at times during care, and refusing care. Interventions included allowing Resident #3 time to de-escalate, reapproach the resident if they were refusing care, and place soft object in Resident #3's hands while providing care if combative.Resident #1Resident #1 was admitted to the (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility with diagnoses of Parkinson's Disease with Dyskinesia and Fluctuations (a condition that causes muscle tremors and rigidity along with involuntary writhing movements), and Unspecified Dementia without Behavioral Disturbance (memory loss and reduced thinking ability without aggressive or disruptive behavior), Psychotic Disturbance (episodes of hallucinations or false beliefs), Mood Disturbance (a degenerative neurological disease causing memory loss and cognitive decline with psychological issues like agitation), and Anxiety (excessive worry or fear that interferes with daily life). Minimum Data Set (an assessment tool) dated 08/08/2025, documented Resident #1 could be understood, could understand others, and had intact cognition for decisions of daily living. A facility-provided incident and accident report dated 08/02/2025 documented that Certified Nurse Aide #1 observed Resident #1 standing in their room, assisted the resident to their wheelchair, and began to exit the resident's room with the resident in the wheelchair. While exiting, Resident #1 grabbed the wall handrail and lifted themselves up from the wheelchair, prompting Certified Nurse Aide #1 to lower the resident to the floor to prevent a fall. The report documented Certified Nurse Aide #1's accounting was while attempting to reseat the resident. and that the Resident #1's self-propelled standing was attributed to gastric distress.The facility's abuse investigation dated 08/26/2025 through 09/03/2025 included video footage dated 08/02/2024 at 10:48 AM. Video footage (with no audio) showed:- Resident #1 stood unsupervised in their room. Certified Nurse Aide #1 entered Resident #1's room without knocking, placed hands on Resident #1's arms and pulled the resident into the wheelchair. - Resident #1 resisted but was eventually positioned in the wheelchair. - Certified Nurse Aide #1 repeated the maneuver, and on a second (2nd) attempt the resident nearly missed the wheelchair and almost fell.- While the wheelchair was being moved backward toward the hallway by Certified Nurse Aide #1, Resident #1 attempted to block the front wheel with their foot. - While the wheelchair moved, Resident #1 stood up, and fell onto the floor on their side. - Certified Nurse Aide #1 gestured toward the resident, with the staff member lifting the shoulders and placing their hands down at their sides while walking away from the resident, who remained on the floor. - Resident #1 remained on the floor alone for two (2) minutes before Certified Nurse Aide #1 returned with a mechanical hoyer lift. Certified Nurse Aide #1 stood approximately five (5) feet away, spoke briefly and then left the area. - Approximately two (2) minutes later, Licensed Practical Nurse #4 entered the hallway to obtain vital signs for Resident #1. Certified Nurse Aide #1 did not re-enter the viewing area outside of Resident #1's room for the remainder of the recording. During an interview on 8/27/2025 at 4:24 PM, Certified Nurse Aide #1 stated they were putting a machine away and noticed Resident #1 standing up in their room. Certified Nurse Aide #1 stated they assisted Resident #1 into their wheelchair, who sat willingly. Certified Nurse Aide #1 stated they intended to push Resident #1 to the nursing station so they could be watched. As Certified Nurse Aide #1 was going out of the room, Resident #1 grabbed a handrail bar and pulled themselves to a standing position. Certified Nurse Aide #1 stated they assisted the resident to sit back down but Resident #1 did not sit in the chair completely, so Certified Nurse Aide #1 helped lower them to the floor and went to tell the nurse what happened. When asked about the willingness of Resident #1 to be moved in the wheelchair, Certified Nurse Aide #1 stated that Resident #1 willingly sat down but then resisted being taken out of their room by putting their foot in front of the wheels of the wheelchair. Certified Nurse Aide #1 turned the wheelchair around and pulled the resident's wheelchair backwards out of the doorway. When asked if Certified Nurse Aide #1 put their hands on Resident #1, they stated that in the hallway, as the resident grabbed the handrail and stood up, they lost their balance and that was when Certified Nurse Aide #1 grabbed them to lower the resident to the floor. After Certified Nurse Aide #1 lowered the resident to the floor, they went to get the nurse. Certified Nurse Aide #1 stated they went back to Resident #1 and stayed with them until help arrived. Certified Nurse Aide #1 stated that they could not identify the nurses that came to help and believed they were agency nurses. Certified Nurse Aide #1 stated they were standing right there until the resident was off the floor. Certified Nurse Aide #1 stated no statement was taken from them after the incident. Certified Nurse Aide #1 stated they were told to put their (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	statement in the computer but was unable to do so because they couldn't figure out how to do the documentation on the computer. Certified Nurse Aide #1 stated they gave a verbal statement the day Resident #1 fell. Certified Nurse Aide #1 stated that they did not handle residents roughly.Review of video footage revealed Certified Nurse Aide #1 neglected Resident #1 when the resident fell to the floor in the hallway and Certified Nurse Aide #1 walked away. During an interview on 08/27/2025 at 11:10 AM, Licensed Practical Nurse #4 stated Certified Nurse Aide #1 informed the individual that Resident #1 was ambulating around their room when was not supposed to be. Licensed Practical Nurse #4 asked Certified Nurse Aide #1 to place the resident into a chair. Certified Nurse Aide #1 left and returned to state Resident #1 was on the floor. Licensed Practical Nurse #4 stated that when they approached Resident #1 with the vital signs machine, Resident #1 was mumbling something about Certified Nurse Aide #1, but they could not understand. Licensed Practical Nurse #4 did not suspect that the explanation given by Certified Nurse Aide #1 was inaccurate.During an interview on 08/27/2025 at 11:27 AM, Assistant Director of Nursing #1 stated that a couple of days to a week before this incident, Certified Nurse Aide #1 had provided personal care to, and turned Resident #3 in a way that caused them to hit their face on the wall causing an injury. Assistant Director of Nursing #1 spoke to Certified Nurse Aide #1 and Director of Nursing #1 and thought that perhaps Certified Nurse Aide #1 needed a little more education regarding bed mobility training. They stated Certified Nurse Aide #1 was agreeable to more education. Assistant Director of Nursing #1 stated they had no concerns that Certified Nurse Aide #1 was abusing the residents in any way, just needed more teaching. Assistant Director of Nursing #1 stated that no one felt like Resident #1 had been abused at the time of the incident. Assistant Director of Nursing #1 stated that it was a culmination of events that led Director of Nursing #1 to view the video. Assistant Director of Nursing #1 stated that if at any point Resident #1 had given any indication that they had an issue with Certified Nurse Aide #1, they would have treated the situation differently. When asked how, Assistant Director of Nursing #1 stated they would have interviewed the staff member privately, maybe changed their assignment, or called Director of Nursing #1 to have Certified Nurse Aide #1 removed from care if they suspected abuse had taken place. When asked what the expectation was for any Certified Nurse Aide who had lowered a resident to the floor, Assistant Director of Nursing #1 stated that a Certified Nurse Aide should get help. The staff member could call Code Blue, could take three (3) to six (6) steps into the room and pull the call bell, or yell for help. Assistant Director of Nursing #1 stated that perhaps the staff member could go and get help physically but the preference would be to use the call bell system and stay with the resident to assure their safety while waiting for help. Assistant Director of Nursing #1 stated it would not be appropriate to leave a resident unattended on the floor for multiple minutes. When asked to quantify the number on minutes, Assistant Director of Nursing #1 stated maybe less than two minutes would be appropriate. They stated the staff member should alert a nurse and return the resident. During an interview on 08/28/2025 at 2:20 PM, Director of Nursing #1 stated that the actions of Certified Nurse Aide #1 were not acceptable. They stated that it was not the expectation that staff would be unkind or treat residents in an undignified way. It was not acceptable for Certified Nurse Aide #1 to leave Resident #1 on the floor the way that they did. During an interview on 08/26/2025 at 12:03 PM, Registered Nurse #1 stated that staff would treat residents with respect and dignity, that gentle reminders about resident safety was provided, and that physical redirection was never appropriate. Registered Nurse #1 stated they would remove the alleged staff member and enact the chain of command if they ever saw something that looked like abuse.During an interview on 08/26/2025 at 2:55 PM, Director of Nursing #1 stated that video footage was reviewed only as part of investigations involving reportable incidents or an increase in bruising reports. They stated no staff raised concerns about Certified Nurse Aide #1 until Director of Nursing #1 began questioning employees. During an interview on 08/26/2025 at 3:26 PM, Administrator #1 stated they of the incident when there were suspicions of multiple cases of abuse related to Certified Nurse Aide #1. Administrator #1 stated incidents that would lead to looking at video footage included falls with (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	injuries and resident-to-resident issues. Administrator #1 stated they trusted Director of Nursing #1 and Assistant Director of Nursing #1 in their role to keep track of events. Administrator #1 stated there was a ?see something, say something' culture in the facility amongst the staff. 10 New York Codes, Rules, and Regulations 415.4(b)(1)(i)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on record review and interviews conducted during an abbreviated survey, the facility did not provide needed care and services that were resident centered and in accordance with professional standards of practice to meet each resident's physical, mental, and psychosocial needs for one (1) (Resident #1) of four (4) residents reviewed. Specifically, Resident #1 was not assessed for full range of motion before being manually lifted from the floor and placed in their wheelchair after suffering a fall to the floor. This is evidenced by:The facility's policy and procedure titled, Post Fall Routine, revised 5/2024, documented the purpose of the Post Fall Routine was to assess the resident for injury, to identify and treat any underlying causes and predisposing risk factors, to provide the resident physical comfort and reassurance, and to insure the resident's safety by preventing re-occurrence. The procedures documented were 1. Registered Nurse would assess the resident for any injury related to the fall and provide emergency treatment, as necessary; 2. All resident would be assisted off the floor with a Hoyer lift. The Nursing Supervisor may use discretion for residents who are noncompliant; 3. Determine any causative factors that may have contributed to the fall, i.e. change in mobility, toileting needs and correct immediately; 4. Complete the Resident Incident/Accident in electronic health record. Notify Provider and family. Document in electronic health record; 5. Document on the Care Plan and in the Certified Nurse Aide Instructions new interventions put in place. Nurse to document in progress note notifications and interventions; 6. Monitor resident for 48 hours post-fall; 7. The Resident Incident/Accident Report would be reviewed at the next Interdisciplinary Team Meeting. Document team intervention and update the resident's care plan and Certified Nurse Aide Instructions. Resident #1 was admitted to the facility with diagnoses of Parkinson's Disease with Dyskinesia, with Fluctuations (a condition that causes muscle tremors and rigidity along with involuntary writhing movements) and Unspecified Dementia, Unspecified Severity, without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance (a degenerative neurological disease-causing memory loss and cognitive decline with psychological issues like agitation), and Anxiety. Minimum Data Set (MDS, an assessment tool) dated 8/08/2025, documented Resident #1 could be understood, could understand others and had intact cognition for decisions of daily living. Resident #1's Comprehensive Care Plan titled, Vision, dated 11/04/2024,documented encourage resident to ask for assistance as needed, and orient resident to changing surroundings. Resident #1's Comprehensive Care Plan titled, Activity Participation, dated 11/15/2024, documented to respect resident's right to refuse participation or attendance in recreational activities, initiate conversation with resident as frequently as possible, maintain preferred independent leisure activity, and provide escort or transportation as needed. Resident #1's Comprehensive Care Plan titled, Falls, dated 11/04/2024, documented to investigate cause of fall immediately, provide reality orientation, attempt to maintain a high-profile area as often as possible, and report any unsafe behavior to nursing. A facility provided incident and accident report dated 8/02/2025 documented that Certified Nurse Aide #1 noticed Resident #1 standing in their room, Certified Nurse Aide #1 assisted the resident to their wheelchair and when they were exiting the resident's room together, Resident #1 grabbed the wall handrail and pulled themselves from the wheelchair. The report documented Certified Nurse Aide #1's accounting was while attempting to reseat the resident, Resident #1 needed to be lowered to the floor to prevent them from falling to the floor. Resident #1's self-propelled standing out of the wheelchair was attributed to gastric distress. The facility's abuse investigation dated 8/26/2025 through 9/03/2025 (TBD), included video footage dated 8/02/2024 starting at 10:48 AM. Per the video footage, Resident #1 was standing unsupervised in their room. Certified Nurse Aide #1 was viewed entering Resident #1's room without knocking, placing their hands on Resident #1's arms and pulling the resident into their wheelchair. Resident #1 appeared to resist Certified Nurse Aide #1 but was eventually maneuvered into their wheelchair. Resident #1 stood again in their room and Certified Nurse Aide #1 again pulled the resident into their wheelchair. While pulling Resident #1 into their wheelchair a (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	second time, Resident #1 appeared to almost miss the wheelchair and nearly fall. As the video footage continued, Resident #1 was observed being pushed in their wheelchair by Certified Nurse Aide #1 but attempted to block the front wheel with their foot. Certified Nurse Aide #1 was observed turning the wheelchair around so that the resident and the chair could be moved backwards out into the hallway. Certified Nurse Aide #1 continued to pull the wheelchair backwards, and while the wheelchair was moving, Resident #1 stood up, resulting in Resident #1 falling to the floor, and onto their side. There was no video footage of Resident #1 grabbing onto a chair rail and pulling themselves from their wheelchair. Certified Nurse Aide #1 appeared to throw their hands down at their sides and then walk away leaving the resident lying on the floor. As the video footage continued, Resident #1 was observed to have laid on the floor alone for 2 minutes before Certified Nurse #1 comes back into the viewing area, pushing a mechanical Hoyer lift towards where the resident was laying. Certified Nurse Aide #1 was seen walking past the resident, said something to Resident #1 and then stood in the doorway of the room next to Resident #1's room, at least 5 feet from where Resident #1 was laying. Licensed Practical Nurse #4 was viewed coming down the hall to do vital signs for Resident #1. Certified Nurse Aide #1 left the footage area when Licensed Practical Nurse #1 stated attending to Resident #1, and did not return at any time for the rest of the video footage provided. After another minute, Assistant Director of Nursing #1 was viewed coming down the hall. Assistant Director of Nursing #1 was observed to be talking to Resident #1 on the floor. There was visual evidence that a limited range of motion assessment was performed on the resident's arms. Assistant Director of Nursing #1 was observed to have Resident #1's head on their lap while talking to Licensed Practical Nurse #1 and Resident #1. Assistant Director of Nursing #1 took a phone call while kneeling on the floor and holding Resident #1's head. After Assistant Director of Nursing #1 put the phone back in their pocket, Assistant Director of Nursing #1 had Resident #1 bend their knees and with the help of Licensed Practical Nurse #1, they manually lifted Resident #1 from the floor by the resident's arms and placed them in the wheelchair. There was no documented evidence that any other range of motion was tested on Resident #1's legs. During an interview on 8/26/2025 at 3:26 PM, Administrator #1 stated that they were not aware of the incident until there were suspicions of multiple cases of abuse related to Certified Nurse Aide #1. When asked if camera footage was a standard part of investigating incidents, Administrator #1 stated that incidents that would lead to looking at video footage included falls with injuries and resident to resident issues. Administrator #1 stated that they trusted Director of Nursing #1 and Assistant Director of Nursing #1 to keep track of things. Administrator #1 stated the last Quality Assurance Process Improvement meeting was on 8/21/2025. When asked if this investigation or incident was discussed during the meeting, Administrator #1 stated that they got called away during the meeting, but it was not discussed while they were in the room. Administrator #1 stated that the facility may have had delayed reporting what had happened, but there was a see something, say something attitude in the facility amongst the staff. During an interview on 8/27/2025 at 11:27 AM, Assistant Director of Nursing #1 stated that they were called to the unit because Resident #1 was on the floor. Assistant Director of Nursing #1 described where Resident #1 was laying at the time and stated they were alert and able to answer questions. Resident #1 indicated they had stood up on their own and fallen trying to sit down in their wheelchair (missed the chair when sitting). Registered Nurse #1 stated they asked about pain and did an assessment for range of motion. Resident #1 stated they had some gas type pain and because it was slightly after breakfast, that was what Assistant Director of Nursing #1 believed. When asked what the expectation was for any Certified Nurse Aide who had lowered a resident to the floor, Assistant Director of Nursing #1 stated that the Certified Nurse Aide should get help. The staff member could call code blue, could take 3-6 steps into the room and pull the call bell, or yell for help. Assistant Director of Nursing #1 stated that maybe the staff member could go and get help physically but the preference would be to use the call bell system and stay with the resident to assure their safety while waiting for help. Assistant Director of Nursing #1 stated it would not be appropriate to leave a resident unattended on the floor for (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	multiple minutes. When asked to quantify the number on minutes, Assistant Director of Nursing #1 stated maybe less than two minutes would be appropriate. The staff member should get a nurse and a vital sign machine and get back to the resident. During an interview on 8/28/2025 at 2:20 PM, Director of Nursing #1 stated that after a resident has a fall, the Registered Nurse on duty must do an assessment. The assessment would include neurological checks, skin integrity checks, range of motion checks, and assessment for pain. If the staff member suspected an injury, the staff member would not move them. If there was a concern for any particular body system, for example a full respiratory assessment would be done if the resident was short of breath, the staff would be expected to do a focused assessment. While reviewing the video footage, Director of Nursing #1 stated they did not know who Assistant Director of Nursing #1 was talking to on the phone and did not feel like they had done a full assessment on Resident #1 before picking them up off the floor. During an interview on 8/28/2025 at 3:58 PM. Assistant Director of Nursing #1 stated they checked Resident #1 for range of motion, cognitive changes, neurological checks, pain and discomfort, facial grimacing, and asked Resident #1 questions. Assistant Director of Nursing #1 stated they were the house supervisor the day the incident occurred. They stated that they believed the telephone call they took was regarding an admission coming to the facility. After reviewing the video footage of the assessment done by Assistant Director of Nursing #1, they stated that they believed they had done a full body range of motion assessment, indicating that having Resident #1 bend their knees prior to pulling them to their feet was a satisfactory assessment. When for the policy of how facility staff would pick up a resident off the floor after a fall, Assistant Director of Nursing #1 stated that if the resident was a mechanical lift, that would need to be used, and that it depended on the resident's body mechanics allowed for it. When asked if staff were allowed to manually life a resident like Assistant Director of Nursing #1 had, they stated that it was considered sufficient practical to life someone off the floor the way they did. 10 New York Codes, Rules, and Regulations 415.12

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews conducted during the abbreviated surveys (Case #2591142), the facility did not ensure a quality assessment and assurance committee developed and implemented appropriate plans of action to correct identified quality deficiencies. Additionally, the facility did not implement written policies and procedures for feedback, data collection systems, and monitoring, including adverse event monitoring. Specifically, the facility did not follow the policies established to provide performance improvement plans, staff correction, and resident safety. This is evidenced by: Cross reference: F600, F684The facility policy titled, Quality Assurance Performance Improvement with effective date 08/15/2025, and last updated 06/06/2025, documented the Quality Assurance Performance Improvement program would aim for safety and high quality with all clinical intervention and service delivery while emphasizing autonomy, choice, and quality of daily life for residents and family by ensure their data collection tools and monitoring systems were in place and were consistent for proactive analysis, system failure analysis, and corrective action. The scope of the Quality Assurance Performance Improvement program encompasses all types and segments of care and services that impact clinical care, quality of life, resident choice, and care transitions. These include, but were not limited to, customer service, care management, patient safety, credentialing, provider relations, human resources, finance, and information technology. Aspects of service and care were measured against established performance goals and key measures were monitored and trended on a quarterly and/or annual basis. The monitoring process documented that the system to monitor care and services will continuously draw data from multiple sources. These feedback systems would actively incorporate input from staff, residents, families, and others, as appropriate. Performance indicators would be used to monitor a wide range of processes and outcomes and would include a review of findings against benchmarks and/or targets that had been established to identify potential opportunities for improvement and corrective action. The system also maintained a system that would track and monitor adverse events that would be investigated every time they occurred. Action plans would be implemented to prevent reoccurrence. The Overall Performance Improvement Projects would be a concentrated effort on a particular problem in one area of nursing center or on a facility-wide basis. They would involve gathering information systemically to clarify issues or problems and intervening for improvements. Van Rensselaer Manor would conduct Performance Improvement Projects to examine and improve care or services in areas that the nursing center identified as needing attention, with continued follow up and evaluation for improvement. Areas for improvement were identified by routinely and systematically assessing quality of care and service, and included high risk, high volume, and problem prone areas. When a performance improvement opportunity was identified as a priority, the Quality Assurance Committee would initiate the process to charter a Performance Improvement Project team. This charter would describe the scope and objective of the improvement project so the team working on it had a clear understanding of what they were being asked to accomplish. Team members would be identified from internal and external sources by the Quality Assurance Committee or designated project manager, and with relationship to their skills, service provision, job function, and/or area of expertise to address the performance improvement topic. A facility policy titled Supervised Work and Supervised Care, dated , documented that any employee who had failed to follow the facility policy for resident care, medications or treatment, or those who's care was under review would be placed on Supervised Care. The listed actions for Supervised Work included in part: 3. A supervisor must document what their job responsibilities were each time they worked and signed off that they were supervised (see Supervised Work Form); 4. For Nursing, the Charge Nurse was responsible person to supervise the employee. The Supervised Work Tracking Tool stayed with the Supervisor until the employee was cleared; 6. The Department Head (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was responsible to read the results and notify/discuss it with the Administrator if there was a problem. Additionally documented under Supervised Care, 1. If it was suspected that there was a violation of policy and procedure or a care complaint involving a staff member, they would be put on Supervised Care; 2. Supervised Care Staff Notification Form would be completed and signed by Supervisor and staff member being placed on Supervised Care; 3. Supervised Work form would be initiated and would be ongoing until it had been deemed they could perform their job correctly and safely; 4. One form was completed, it was filed in their personnel file.Resident #3Resident #3 was admitted to the facility with the diagnoses of unspecified dementia, unspecified severity with other behavioral disturbances (memory loss and reduced thinking ability without aggressive or disruptive behavior), hypothyroidism (a condition when the thyroid does not produce enough thyroid hormones to meet the body's needs), and major depressive disorder (a mood disorder that causes persistent feelings of sadness and loss of interest). The Minimum Data Set, dated [DATE], documented the resident was usually able to understand others, was usually understood, and was severely cognitively impaired. A facility Incident and Accident Report, dated 08/01/2025 at 2:00 PM, documented that a blue/gray bruise was noted on Resident # 3's nose. The contributing factors were documented as poor safety awareness, dementia, ill-fitting glasses, wall not padded, and resting their head on the table at times when fatigued. Measures to prevent recurrence were to place mat on wall, check glasses for appropriate fit, and to place staff on supervised care for follow up and education. Statements documented in the Incident and Accident Report documented the following: 1. Registered Nurse #2, dated 08/01/2025, spoke with Resident #3's family member who had visited on 07/30/2025 did not observe any bruising when visiting. 2. Assistant Director of Nursing #1, dated 08/01/2025, documented that they had spoken with Certified Nurse Aide #1 who verbalized that Resident #3 was difficult while providing care, had swung their hands while attempting to provide personal care, and had hit their head on the wall while rolling over. Certified Nurse Aide #1 had not seen an injury at that time. Assistant Director of Nursing #1 documented they discussed how to approach and reapproach when resident's behaviors escalated. 3. Certified Nurse Aide #1, dated 08/19/2025, documented on 08/01/2025, they started to wash Resident #3, and they became combative with Certified Nurse Aide #1, they stopped to dry Resident #3 and put their clothes on. Resident #1 Resident #1 was admitted to the facility with diagnoses of Parkinson's Disease with Dyskinesia, with Fluctuations (a condition that causes muscle tremors and rigidity along with involuntary writhing movements) and Unspecified Dementia, Unspecified Severity, without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance (a degenerative neurological disease-causing memory loss and cognitive decline with psychological issues like agitation), and Anxiety. Minimum Data Set (MDS, an assessment tool) dated 08/08/2025, documented Resident #1 could be understood, could understand others and had intact cognition for decisions of daily living. A facility provided incident and accident report dated 08/02/2025 documented that Certified Nurse Aide #1 noticed Resident #1 standing in their room, Certified Nurse Aide #1 assisted the resident to their wheelchair and when they were exiting the resident's room together, Resident #1 grabbed the wall handrail and pulled themselves from the wheelchair. The report documented Certified Nurse Aide #1's accounting was while attempting to reseat the resident, Resident #1 needed to be lowered to the floor to prevent them from falling to the floor. Resident #1's self-propelled standing out of the wheelchair was attributed to gastric distress.The facility's abuse investigation dated 08/26/2025 through 09/03/2025, included video footage dated 08/02/2024 starting at 10:48 AM. Per the video footage, Resident #1 was standing unsupervised in their room. Certified Nurse Aide #1 was viewed entering Resident #1's room without knocking, placing their hands on Resident #1's arms and pulling the resident into their wheelchair. Resident #1 appeared to resist Certified Nurse Aide #1 but was eventually maneuvered into their wheelchair. Resident #1 stood again in their room and Certified Nurse Aide #1 again pulled the resident into their wheelchair. While pulling Resident #1 into their wheelchair a second time, Resident #1 appeared to almost miss the wheelchair and nearly fall. As the video footage continued, Resident (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#1 was observed being pushed in their wheelchair by Certified Nurse Aide #1 but attempted to block the front wheel with their foot. Certified Nurse Aide #1 was observed turning the wheelchair around so that the resident and the chair could be moved backwards out into the hallway. Certified Nurse Aide #1 continued to pull the wheelchair backwards, and while the wheelchair was moving, Resident #1 stood up, resulting in Resident #1 falling to the floor, and onto their side. Certified Nurse Aide #1 appeared to throw their hands down at their sides and then walk away leaving the resident lying on the floor. As the video footage continued, Resident #1 was observed to have laid on the floor alone for 2 minutes before Certified Nurse #1 comes back into the viewing area, pushing a mechanical Hoyer lift towards where the resident was laying. Certified Nurse Aide #1 was seen walking past the resident, appeared to say something to Resident #1 and then stood in the doorway of the room next to Resident #1's room, at least 5 feet from where Resident #1 was laying. Licensed Practical Nurse #4 was viewed coming down the hall to do vital signs for Resident #1. Certified Nurse Aide #1 left the footage area when Licensed Practical Nurse #1 started attending to Resident #1, and did not return at any time for the rest of the video footage provided. A facility form titled Supervised Care, to Certified Nurse Aide #1, from Assistant Director of Nursing #1, dated 08/01/2025, documented it was an official notification they were on Supervised Care. They had been placed on Supervised Care because they had violated a policy or procedure; or there was a resident complaint regarding their care; or there was an actual or suspected case of abuse. The problem area identified was ?care concerns. At the bottom the signature lines contained a misspelled version of Certified Nurse Aide #1's signature, which was noted to not match any other document signed by Certified Nurse Aide #1, and Assistant Director of Nursing #1's signature. Both signatures were dated 08/02/2025. The Supervised Care audit form provided with the signed document had one line filled out, dated 08/01/2025, filled out by Assistant Director of Nursing #1, reason listed consistent care concerns, and that Administration was aware. There was no documented evidence that any auditing of care by Certified Nurse Aide #1 was completed. During an interview on 08/26/2025 at 12:33 PM, Director of Nursing #1 stated that they started looking at video footage of Unit A1, where Certified Nurse Aide #1 worked, because there had been a notable increase in incident reports of bruising, injuries, and residents falling on the unit, during Certified Nurse Aide #1's shift, and to residents in their assigned areas. When reviewing the incident reports, Director of Nursing #1 noted that the version of events provided by Certified Nurse Aide #1 did not match what other staff members reported, or the injuries noted on residents. Director of Nursing #1 stated that per paperwork they were provided by Assistant Director of Nursing #1, it was their understanding that Certified Nurse Aide #1 on ?supervised care' after Resident #3 had sustained an injury during personal care on 08/01/2025.During an interview on 08/26/2025 at 2:55 PM, Director of Nursing #1 stated that they did not randomly view video footage, but looked at them as part of investigations when there were reportable incidents or when there was an increase in reports of bruising. Director of Nursing #1 stated that no other staff said anything about Certified Nurse Aide #1 being a problem until after the Director of Nursing #1 started asking the staff questions. During an interview on 08/26/2025 at 3:26 PM, Administrator #1 stated that they were not aware of the incident until there were suspicions of multiple cases of abuse related to Certified Nurse Aide #1. When asked if camera footage was a standard part of investigating incidents, Administrator #1 stated that incidents that would lead to looking at video footage included falls with injuries and resident to resident issues. When asked if the Administrator was aware of the care concerns surrounding Certified Nurse Aide #1, Administrator #1 stated that there were over 400 employees at the facility and Administrator #1 couldn't possibly keep track of all of them. Administrator #1 stated that they trusted Director of Nursing #1 and Assistant Director of Nursing #1 to keep track of things. Administrator #1 stated the last Quality Assurance Process Improvement meeting was on 08/21/2025. When asked if this investigation or incident was discussed during the meeting, Administrator #1 stated that they got called away during the meeting, but it was not discussed while they were in the room. Administrator #1 stated that the facility may have had delayed reporting what (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had happened, but there was a see something, say something attitude in the facility amongst the staff. During an interview on 08/27/2025 at 11:10 AM, Licensed Practical Nurse #4 stated Certified Nurse Aide #1 came to them and stated Resident #1 was ambulating around their room and was not supposed to be. Licensed Practical Nurse #4 told Certified Nurse Aide #1 to go and get them into a chair. Certified Nurse Aide #1 came back and said that Resident #1 was on the floor, so Licensed Practical Nurse #4 got the vital machine and went to take vitals. Resident #1 was mumbling something about the aide, but Licensed Practical Nurse #4 stated they couldn't understand Resident #1. It was the first time Licensed Practical Nurse #4 and Certified Nurse Aide #1 had worked together. Licensed Practical Nurse #4 stated that Assistant Director of Nursing #1 told them to keep an eye on Certified Nurse Aide #1 because there were some concerns about their care, like they suspected Certified Nurse Aide #1 of something. During an interview on 08/27/2025 at 11:27 AM, Assistant Director of Nursing #1 stated that a couple of days to a week before this incident, there was a resident (believed Resident #3 but couldn't be sure) that Certified Nurse Aide #1 had provided personal care to, and turned Resident #3 in a way that caused them to hit their face on the wall causing an injury. Assistant Director of Nursing #1 spoke to the Certified Nurse Aide #1 and thought that perhaps Certified Nurse Aide #1 needed a little more education regarding bed mobility training. Assistant Director of Nursing #1 stated they had no concerns that Certified Nurse Aide #1 was abusing the residents in any way, just maybe needed more teaching. Certified Nurse Aide #1 was young, was relatively new and working on the memory care unit required a special type of person. After Resident #1 was reportedly lowered to the floor by Certified Nurse Aide #1, Assistant Director of Nursing #1 stated that they spoke with Certified Nurse Aide #1 again, and they both agreed that Certified Nurse Aide #1 would benefit from some extra education. Assistant Director of Nursing #1 stated that supervised care did not necessarily mean that they had a one-on-one working with them. There wasn't an abuse concern. The Supervised Care was related to education. It was set up a day or two (07/31/2025 was the date provided) before the event with Resident #1. It was meant to be more of a follow up tool. In general, depending on the directed action from the Supervision of Care, one to one supervision might be a part of it, but it could also be managed with education. It could also mean that a person needs to be removed from care. It depended on the situation and what the goal of the supervised care was. In this specific instance it was about more education and not needed to have eyes on while providing care. During an interview on 08/27/2025 at 4:24 PM, Certified Nurse Aide #1 stated that they were never put on Supervised Care, were not supervised at any time when they were working, and that the Supervised Care form that was supposedly signed by Certified Nurse Aide #1 was forged and offered as proof that the name that was signed was both not their signature, and that their name was spelled incorrectly. Certified Nurse Aide #1 stated they were handed the Supervised Care Form for the first time on 08/19/2025. Certified Nurse Aide #1 stated that had they known that they were on Supervised Care, they would not have been able to provide care to the residents without someone monitoring them.During an interview on 08/28/2025 at 1:26 PM Medical Director #1 stated that they assessed Resident #1 after they had heard what happened. At the time, Resident #1 was very pleasant. Resident #1 denied being injured by anyone, denied having anyone put hands on them, and had no issues with staff. Medical Director #1 stated that they attended Quality Assurance meetings and abuse, and abuse reporting was discussed. During a follow up interview on 08/28/2025 at 2:20 PM, Director of Nursing #1 was asked to explain the process of Supervised Care. Resident A said a staff member was a rough care giver that they have care concerns with the staff member. The Supervised Care Form would be filled out and signed while the staff member was told why it was happening. The staff member would be assigned to someone who would audit the staff member. Once the audits were completed, the staff member would be taken off Supervised Care. The auditing of care lasted about 3 shifts worth usually, unless staff reported that it needed to be extended. The Supervised Form had 3 sections related to the concern raised. It was expected that the supervisor placing the staff member on Supervised Care would fill out the staff notification section which should (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have had details regarding why the staff member was being placed on Supervised Care. Once the form was filled out, both the supervisor and the staff member would sign the form in front of each other. When looking at Certified Nurse Aide #1's Supervised Care Form, it was noted that the date at the top of the form was 08/01/2025 and the date of the signature lines was 08/02/2025. The only thing written on the reason for supervised care was ?care concerns'. Director of Nursing #1 stated all the questions should have been filled out and that the form should have said more than ?care concerns'. There should have been bruising and rough care mentioned on the sheet if it was filled out at the time. Director of Nursing #1 stated that Assistant Director of Nursing #1 gave Director of Nursing #1 until the investigation had commenced and Director of Nursing #1 had asked Assistant Director of Nursing #1 for all the related information. Director of Nursing #1 stated that Supervised Care meant that the staff member should not have been alone. Education could be a piece of Supervised Care, but it would be in conjunction with hands-on instruction too. Director of Nursing #1 stated that they did not believe that Certified Nurse Aide #1 was really put on Supervised Care and that the form provided to them by Assistant Director of Nursing #1 was either not appropriately documented and implemented, or Certified Nurse Aide #1 wasn't put on Supervised Care at all and the form retroactively documented. Director of Nursing #1 stated there was no documented evidence that any care auditing of Certified Nurse Aide #1 was done, nor was there any education beyond what Assistant Director of Nursing #1 wrote on the Supervised Care Form. During an interview on 08/28/2025 at 3:58 PM, Assistant Director of Nursing #1 stated that they had spoken with Certified Nurse Aide #1 on 8/02/2025 but had filled out the form on 8/01/2025 in preparation for the discussion on 8/02/2025. Because Assistant Director of Nursing #1 was concerned that perhaps Certified Nurse Aide #1 needed a little more education, and was not suspicious of abuse, they wrote care concerns. Assistant Director of Nursing #1 stated the incident with Resident #3 triggered the need for Supervised Care to be implemented, which was why it was dated 08/01/2025. Assistant Director of Nursing #1 was able to sit down with Certified Nurse Aide #1 on 08/02/2025 after Resident #1's fall, and they signed it together on 8/02/2025. When asked what kind of education was provided to Certified Nurse Aide #1, or what the follow up was to the conversation had with Certified Nurse Aide #1, Assistant Director of Nursing #1 stated that they didn't know if any other supervisors did education with Certified Nurse Aide #1 between 08/02/2025 and 08/14/2025. The education that Assistant Director of Nursing #1 did was the review of the Supervised Care plan, time management and maybe to do some audits in the future. During an interview on 09/03/2025 at 10:00 AM, Administrator #1 and Director of Nursing #1 stated that as a Quality Assurance Improvement Process plan, they needed to regroup as a team to look at Supervised Care, the policy, and following up with supervisors to look at and track the issues that needed to be tracked. Administrator #1 stated that they reported to the County Director of Social Services. Annual reports were sent to them, and they came to the building twice a month. 10 New York Codes, Rules and Regulations 415.27(a-c)