STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335275	A. Building B. Wing	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sapphire Nursing at Wappingers	37 Mesier Avenue Wappingers Falls, NY 12590

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 - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(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 - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews during an abbreviated survey (NY00373412, NY00374723), the facility did not ensure residents were free from abuse for 3 out of 3 residents (Resident #1, Resident # 2, Resident # 6) reviewed for abuse. Specifically, 1) On 2/26/2025 Resident #1 who had a known history of wandering, wandered into Resident # 2's room and Resident # 2 became agitated and put their hands on Resident # 1. Resident # 1 fell to the floor and kicked Resident # 2 in the leg. Resident #1 had no behavior care plan initiated before the incident. 2) On 3/11/2025 Resident # 1 was observed by staff in the doorway of their room holding their roommate(Resident # 6) by the collar. There was no documented behavior care plan was not initiated for Resident # 1 who had a known previous history of resident to resident altercation.The findings are:A review of the facility's Abuse investigation protocol/ Resident to Resident abuse policy last reviewed 5/2/2024 documented it is the policy of the facility to conduct a thorough investigation of all accusations/or reports of resident abuse to determine if a crime has been committed. Nursing Administration / Nurse administrator on call is responsible for reviewing information provided and advises if any further interventions are needed to ensure the safety of the resident. Considers room or floor change to prevent reoccurrence. Care plans for both residents must be updated to reflect risk for victimization, behaviors, aggressive behaviors, etc.Resident # 1 was admitted to the facility on [DATE] with a diagnosis that include but not limited to dementia with mood disturbances, Pre-glaucoma, and depression.A Minimum Data Set, dated [DATE] documented the Resident had a Brief Interview Mental Status score of 01/15 indicating the resident is not cognitively intact with no documented behaviors. No impairments to upper or lower extremities. Resident uses a wheelchair and walker for locomotion. Independent with eating and supervision with bed mobility and transfers. Resident is occasionally incontinent of urine and always continent of bowel. Review of an elopement/wander risk assessment dated [DATE] documented Resident #1 score was a 20 indicating the resident was a high risk for elopement/wandering.A review of all Resident # 1's care plans revealed no behavior care plan was in place.A review of Resident # 1's skin assessment dated [DATE] documented scratches to the right arm. Resident # 2 was admitted to the facility on [DATE] with diagnosis that include but not limited to Diabetes type 2, Muscle weakness, and End Stage Renal Disease.A Minimum Data Set, dated [DATE] that documented the resident had a brief interview of mental status score a 14/15 indicating the resident is cognitively intact with no behaviors present. Resident # 2 uses a wheelchair and walker for locomotion. Resident has an impairment on one side of the upper extremity. Requires set up with eating, independent with bed mobility, and supervision with transfers. Resident is occasionally incontinent of urine and always continent of bowel.A review of the facility's internal investigation conclusions / findings dated 2/26/2025 documented that on 2/26/2025 at 4:15pm, Resident # 2 grabbed Resident # 1's arm, pulled Resident # 1 out of their room and onto the ground. Resident # 1 landed on their buttocks. Resident # 1 kicked Resident # 2 in the leg in attempt to get Resident # 2 to let go of their arm. Staff intervened immediately. 911 was called immediately after assessing the resident's safety. Resident # 1 was assisted off the floor and into a wheelchair. Resident # 1 was assisted back to bed, body assessment completed by a Registered Nurse, then the resident was seen by the in-house Nurse Practitioner. Ambulance arrived with a police escort. Resident # 2 was discharged to Mid-[NAME] Regional Hospital for psychological evaluation. Resident # 2 has not returned to the facility.A review of the police case report 2025-0394 dated 02/26/2025 documented caller from the facility reports a psychiatric emergency with a patient who had been physical with another patient, and they would like to have them removed. Patient was willingly transported to Mid-[NAME] Regional for evaluation by Empress.During an interview on 5/9/2025 at 12:30pm, Certified Nursing Aide # 1 stated they worked in the facility for a while but cannot remember the date. They are usually assigned to the south side, but it depends on the needs. They are familiar with Resident # 1. Resident # 1 needs supervision and has dementia. Resident # 1 will wander into other resident's room, and they will redirect them. The resident can get agitated. Resident # 1 will become physically aggressive if you don't back off of them, but if you back off and give them space, they will calm down. Certified Nursing Assistant # 1 had not seen them initiate physical aggression toward other residents, but Resident #1 will protect themself. Certified Nursing Assistant # 1 can recall an incident between Resident # 1 and Resident # 6 where they were sitting at the table together and Resident #6 became aggressive toward Resident #1. They were separated from each other. Resident # 2 was in the facility and was on dialysis, but they are no longer in the

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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	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview during the abbreviated survey, (NY00340966), the facility did not ensure all allegations were thoroughly investigated for 1 of 4 residents. Specifically, Resident # 3 complained of pain in the shoulder and had x ray done on 4/26/2024 that showed a displaced right scapular fracture and osteopenia and was transferred to the hospital on 4/26/2024. The hospital history and physical report documented the resident reported that while in the facility when they were being repositioned, they heard a pop in their right shoulder. The facility did not provide any incident and accident report of the incident when requested by surveyors.The findings are: Resident #3 was re-admitted on [DATE] with diagnosis that include but not limited to Parkinson's Disease, Functional Quadriplegia, and Acute Kidney Failure.A quarterly Minimum Data Set, dated [DATE] documented a Brief Interview of Mental Status Score a 15; indicating the resident was cognitively intact with no behaviors. Resident had upper and lower extremity impairment on one side and uses a wheelchair for locomotion. Resident required supervision with eating and was dependent with bed mobility and transfers. Always incontinent of urine and frequently incontinent of bowel.The facility did not provide anu incident/accident report when requested.Review of the Radiology Report dated 4/26/2024 documented there was an x ray of the right shoulder. The Impression documented a Displaced scapular fracture and Osteopenia.A review of the Hospital Transfer Sheet dated 4/26/2024 documented under clinical information that the x ray showed a fracture of the right shoulder. Resident complained of right shoulder pain and received Tylenol around the clock.Review of the Hospital History and Physical Report dated 4/26/2024 documented under chief complaint that Resident #3 stated nurses were helping her reposition in bed yesterday and they heard a pop in their right shoulder. In house x-ray showed scapular fracture.On 6/09/2025 surveyor requested all incident reports on file for the Resident from 3/2024 to 4/2024. The Administrator informed surveyor that there were no incident reports for the resident from 3/2024 through 4/2024.A review of a nursing progress note written by Registered Nurse Supervisor dated 4/26/2024 documented Resident #3's x ray report of the right shoulder showed a Displaced scapular fracture and osteopenia. Xray results reported Assistant Director of Nursing, Family and Nurse Practitioner. Resident #3 to be sent to [NAME] for further evaluation. During an interview 6/11/2025 at 9:24am with Administrator stated that they know they spoke with the resident regarding the allegation that nurses pulled on them when repositioning them. They did not think it was a fracture. The old director of nursing may have a soft file where they started an investigation, but they need to find the file to see if they can locate the file. They did not think there was an official investigation completed for the incident because the facility questioned the aides, and they reported they were not rough with the resident. They completed the first X ray in house that looked like a fracture. However, the resident was at their baseline and had their regular range of motion, and did not seem to be in any more pain than usual. Out of an abundance of precaution they sent the resident to the hospital for follow- up where the hospital did the full trauma workup. They requested for the hospital to complete the trauma workup on the resident. Eventually the hospital completed the workup on the resident, and it revealed that the resident did not have a fracture.During an interview on 6/11/2025 at 10:17am with Resident #3's family representative they stated Resident # 3 had multiple incidents in the facility that were centered around care. For example, there was an incident where they fell, and it was not clear what happened. Resident # 3's family representative stated that while in the facility the staff was trying to help them out of bed, but they slipped and fell. This incident that occurred on 4/26/2025 when they were hospitalized it was reported that they were pulled on during cares. Resident # 3's Family Representative heard this and reported it to the Director of Nursing in the facility. They were told by the Director of Nursing that they would complete an internal investigation. Resident #3's family Representative reported they never filed a formal complaint with any one about the incident, but they did report it to the Director of Nursing.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews during an abbreviated survey (NY00360874), the facility did not ensure 1 out of 3 (Resident # 7) residents were free from significant medication errors. Specifically, Resident # 7 did not receive their physician ordered medication Enoxaparin Sodium (a medication to prevent blood clots) from 11/6/2024-11/12/2024. There were omissions on the Medication Administration Record with no documented nursing notes as to why the medications were not administered. 2) Resident #7 did not receive their medication Diazepam (a central nervous system depressant) from 11/6/2024-11/12/2024 as ordered by the physician. There was no documentation that the physician was notified or reasons why the medications were not administered. Resident #7 was transferred to the hospital on [DATE] for change in mental status. The findings are:The facility Medication Administration Policy and Procedure dated 9/1/2024 documented it is the policy of the facility to ensure that Medication Administration and documentation occurs in a timely and accurate manner.Resident # 7 was admitted to the facility on [DATE] and had diagnoses that include but not limited to trauma subdural hematoma without loss of consciousness, alcohol abuse, and major depressive disorder.A discharge Minimum Data Set, dated [DATE] documented the resident had no behaviors present. Resident required set up with eating and moderate assistance with toileting, moderate assistance with bed mobility and maximum assistance with transfers. Resident occasionally incontinent of urine and always continent of bowel.Review of the physician order dated 11/6/2024, documented the physician prescribed Enoxaparin Sodium Subcutaneous solution 30 milligrams/0.3 milliliters, give 30 milligrams subcutaneously every 12 hours, at 9 am and 9 pm for a diagnosis of personal history of traumatic brain injury.Review of the Medication Administration Record revealed Resident # 7 did not receive their medication (Enoxaparin Sodium, to prevent clotting) on 11/07/2024-11/09/2024 at 9am and 9pm and 11/10/2024 at 9am as ordered. Nurse progress notes from 11/6/2024-11/12/2024 was reviewed. There were no documented reasons as to why the doses were not administered on 11/7/2024-11/09/2024 at 9am and 9pm and 11/10/2024 at 9am.The physician order dated 11/6/2024 documented a physician order to give Diazepam (a central nervous system depressant) oral tablet 10 milligrams 1 tablet by mouth three times a daily for 180 days at 9 am, 1pm, and 5pm for a diagnosis of Anxiety.Review of the Medication Administration Record revealed omissions on for Diazepam on 11/6/2024 at 9am, 1pm, and 5pm, on 11/7/2024 and 11/08/2024 at 9am, 1pm and 5pm. The reason documented not done.Nurse progress notes from 11/6/2024-11/12/2024 were reviewed. There was no documented evidence as to why the doses of Diazepam were not administered on 11/6/2024-11/08/2024 at 9am, 1pm, 5pm as ordered.A review of a nursing progress note dated 11/13/2024 documented the resident was admitted to the hospital with a diagnosis of Altered Mental Status.A review of a nursing progress note dated 11/12/2024 at 10:43 am documented resident family member met with writer with concerns of resident's medical condition. Writer reported to resident bedside to assess the resident. Resident noted to be laying in bed in fetal position facing the wall. Writer approached the resident and attempted to get the resident's attention. Resident failed to engage with writer. Resident's pupils noted to be dilated and resident staring straight forward. Resident unable to answer basic question when asked. Responses seemed mumbled. This is a noticeable change from residents' baseline upon admission. Resident noted to have emesis on several occasions in the past few days.During an interview with Nurse Practitioner on 6/17/2025 at 11:48 am they stated usually during an omission of medications the nurses will note why the medication was not administered in a nursing progress note. Nurse Practitioner reviewed the medication administration record for Resident # 7 and stated it was 9 months ago, so they do not remember what happened with this resident's medication. It was ordered and there is no documentation why it was not administered. The Nurse Practitioner stated the diazepam was ordered for anxiety and they would have held the medication if there was no indication of anxiety. If a medication is ordered and it is out of stock, the nurses will inform the physician. The Nurse Practitioner stated they could not remember if they were informed or not. They were made aware that the resident was vomiting, and the resident was assessed. The nurses need to inform the physicians that the resident is refusing their meds and that is the facility protocol. They were not notified in this instance and there are no notes to indicate why the resident did not receive the diazepam or lovenox. Residents have the right to refuse medication, but there should be a note if the resident refuses a medication. During an interview on 6/17/2025 at 12:12pm, the Director of Nursing stated Narcotics needed for specific med pass are placed in the medication carts after the nurses complete their narcotic count at the beginning