STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335280	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Center for Rehabilitation and Nursing	49 Marvin Avenue 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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews conducted during a survey, the facility failed to ensure residents were afforded the right to formulate advanced directives including having a physician order related to their code status (level of medical interventions a person wishes to have started if their breathing stopped such as cardiopulmonary resuscitation or do not resuscitate), and establishing mechanisms for documentation and communicating the residents' choices to staff responsible for their care for one (1) (Resident #1) of three (3) residents reviewed. Specifically, when the resident no longer wanted cardiopulmonary resuscitation on [DATE], there was no physician order for the change in code status and advance directive until [DATE]. Findings include: Resident #1: Resident #1 was admitted to the facility with diagnoses of end stage renal disease (kidneys no longer work to meet the body's needs) with dependence on renal dialysis (a treatment that filters waste and excess fluid from the blood when the kidneys are failing), diabetes (body cannot use insulin correctly and sugar builds up in the blood) with diabetic chronic kidney disease, and chronic peripheral venous insufficiency (occurs when leg veins become damaged and do not allow blood flow back to your heart). The Minimum Data Set (an assessment tool) dated [DATE], documented the resident was cognitively intact. The resident was able to make themselves understood and understood others. The Policy and Procedure titled, Advance Directives and State Specific Medical Orders for Life-Sustaining Treatment - NY, revised [DATE], documented residents had the right to formulate an advance directive and to modify or revoke their advance directives and/or MOLST (Medical Orders for Life-Sustaining Treatment) at any time and the modifications and/or revocation would be acknowledged and honored by the facility. The facility would follow Federal and State requirements in the acknowledgement of existing and execution of new or revised advance directives and MOLSTs when delivering care to residents. Policy implementation documented the resident could initiate an advance directive, and/or change determinations on their advance directive at any time. The Social Worker or designee would review the resident's advance directive, provide education to the resident regarding the advance directive, and ensure the resident's advance directive was reflected in the clinical record. Medical orders would be documented in the electronic health record to reflect the resident's code status and any restrictions to intubation and hospitalization, based on the resident's MOLST. Care Plan for Advance Directive - Health Care Proxy, created/initiated [DATE], documented the resident had Medical Orders for Life-Sustaining Treatment. Goal documented the resident's advance directive and Medical Orders for Life-Sustaining Treatment would be regarded and respected. Interventions documented review and revise advance directive/Medical Orders for Life-Sustaining Treatment quarterly and as needed. Encounter Note dated [DATE] at 1:00 AM, signed [DATE] at 8:02 AM by Physician #1, documented initial History and Physical. Advance Care Planning documented consent: do not resuscitate. Advance directives were voluntarily discussed with the resident. The resident was alert and oriented and competent to make the decision for themselves. When the resident was admitted to the facility they indicated they wanted to be fully resuscitated but now indicated they changed their mind and did not want to be resuscitated in case of cardiorespiratory arrest even if there was a chance for recovery. (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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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident understood the consequences of the decision. There was no documented evidence that the resident's code status was changed until [DATE]: Order Recap Report for order date [DATE] to [DATE], documented: CPR (cardiopulmonary resuscitation) order: attempt cardiopulmonary resuscitation. Order date was [DATE] and end date was [DATE]. Review of Pre Dialysis Notes dated [DATE], [DATE] and [DATE], documented the resident's code status was cardiopulmonary resuscitation order: attempt cardiopulmonary resuscitation. Please see Medical Orders for Life-Sustaining Treatment. Review of Order Recap Report for order date [DATE] to [DATE], documented: Do not resuscitate order: do not attempt resuscitation (allow natural death). Order date was [DATE] and end date was [DATE]. Medical Orders for Life-Sustaining Treatment form signed on [DATE] by the resident and Physician #1, documented do not resuscitate order: do not attempt resuscitation (allow natural death). During an interview on [DATE] at 12:51 PM, Registered Nurse #1 reviewed the progress notes and stated a change in the resident's code status for do not resuscitate was documented in Physician #1's note dated [DATE]. They did not recall an order for the change in code status. Typically, when Physician #1 wanted an order entered into the electronic medical record, they would communicate with the nurses by writing the order in a nurse book. Physician #1 would either hand the book to Registered Nurse #1, Licensed Practical Nurse #6, Director of Nursing #1, or Medical Records Staff #1 who worked in the same office as Physician #1. They reviewed physician orders and stated the order for cardiopulmonary resuscitation was discontinued on [DATE]. The staff person notified of the change in code was responsible for entering the order into the electronic medical record. If a code status changed it would be entered immediately at the time of the change. There should never be a delay of seven days for a code status change. During an interview on [DATE] at 2:36 PM, Medical Director #1 stated medical staff had a process in place for writing physician orders, placing them in a book and then handing them to nursing staff. This enabled the physician to physically show the order to the nurse and then nurse had the ability to ask questions about the order. They stated that aside from the written order, a verbal order was valid for a code status change since it needed to be entered at the time of the change. Some nursing homes were under the misconception that code status was not official until the Medical Orders for Life-Sustaining Treatment was completed and signed by the physician and stated that was not true. The facility should not have waited to enter the code status order because Physician #1 was only at facility two (2) days per week. 10 New York Code of Rules and Regulations 415.3(e)(1)(ii)

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F 0600 Level of Harm - 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 record review and interviews conducted during survey, the facility failed to ensure the resident's right to be free from neglect for one (1) (Resident #1) of three (3) residents reviewed. Specifically, Resident #1 had a pressure ulcer on the heel of their right foot known to the facility on [DATE]. There was no documented evidence the facility completed wound assessments or management from a qualified wound care provider after 09/19/2025. The designated in-house wound care provider completed rounds on days when the resident was scheduled to be out of the facility for dialysis and no alternate arrangements were made. On 10/06/2025, Resident #1 reported increased right foot pain and was transferred to the hospital from the dialysis center on 10/10/2025. The resident was diagnosed with sepsis (life-threatening reaction to an infection), a right pathological calcaneal fracture with acute osteomyelitis (heel fracture that often arises from a bone infection), and bacteremia (bacteria in the blood). Treatment included a right below-knee amputation on 10/17/2025. This resulted in actual harm and psychosocial harm to Resident #1 that was not Immediate Jeopardy. Findings include: Cross-referenced to F686: Treatment/Services to Prevent/Heal Pressure Ulcers Cross-referenced to F659: Qualified Persons Cross-referenced to F710: Resident's Care Supervised by a Physician Cross-referenced to F711: Physician Visits - Review Care/Notes/Order Facility policy and procedure titled, Abuse, revised 07/18/2025, documented the facility prohibited neglect of residents by anyone including but not limited to staff, family, friends and residents of the facility. Neglect was defined as the failure of the facility, its employees or service providers to provide goods and services necessary to avoid physical harm, pain, mental anguish, or distress. Facility policy and procedure titled, Wound Identification and Wound Rounds, revised 11/06/2023, documented the facility would identify, assess, and manage residents with wounds in accordance with current standards of practice. Any wound identified as worsening, defined by increase in pain, drainage, necrotic tissue, or odor would be assessed by the Registered Nurse, with physician and family notification of treatment changes as indicated. Resident #1 was admitted to the facility with diagnoses including end stage renal disease (kidneys no longer work to meet the body's needs) with dependence on renal dialysis (a treatment that filters waste and excess fluid from the blood when the kidneys are failing), diabetes (body cannot use insulin correctly and sugar builds up in the blood) with diabetic chronic kidney disease, and chronic peripheral venous insufficiency (occurs when leg veins become damaged and do not allow blood flow back to your heart). The Minimum Data Set (a resident assessment tool) dated 09/25/2025, documented the resident was cognitively intact, could make themselves understood and understood others. Record review of Admission/readmission Evaluation Part One (1) dated 09/18/2025 by Registered Nurse #2 documented an unstageable (depth of wound is unknown because devitalized tissue obscures the extent of tissue damage) pressure ulcer on the right heel of the foot that measured 2.5 centimeters long by 2.2 centimeters wide and had no depth. Registered Nurse #2 documented they were unable to visualize the wound bed, that there was 100 percent black/brown eschar (necrotic tissue-black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin), and that a treatment was in place. There is no documented evidence the wound treatments were completed as ordered 09/22/2025, 09/23/2025, 09/25/2025, and 09/29/2025. Team Meeting Note dated 09/19/2025 at 9:41 AM by Licensed Practical Nurse #1, documented the Interdisciplinary Team met on 09/19/2025 for the following reasons: High Risk Meeting. Meeting summary included Resident #1 was being referred to the in-house wound provider for a pressure ulcer on their right heel. There was no documented evidence that Resident #1's pressure ulcer on the right heel was discussed by the Interdisciplinary Team after 09/19/2025. There was no documented evidence of an assessment of the pressure ulcer on the right heel by a qualified person after the Interdisciplinary Team meeting on 09/19/2025 through (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	10/09/2025. Care Plan for Needs Hemodialysis, created/initiated on 09/19/2025, documented the resident was scheduled for hemodialysis (outside of the facility) related to end stage renal disease four (4) times a week on Monday, Tuesday, Thursday, and Friday, at 8:50 AM. Wound Documentation Note dated 10/02/2025 at 4:40 PM by Licensed Practical Nurse #1 documented the resident was not seen by the wound care provider due to dialysis schedule conflict. A total of three (3) wounds were assessed, including the unstageable pressure ulcer on the right heel. Notifications were made to the primary care physician and the resident's representative. Progress notes dated 10/02/2025 and 10/06/2025 documented Resident #1 was at hemodialysis when wound care provider made rounds.Nursing Progress Note dated 10/03/2025 at 8:18 AM by Registered Nurse #1 documented Resident #1 had a newly identified skin alteration according [SY3] [HM4] to POC [sic] documentation see Certified Nurse Aide for more details. Resident is out of facility at dialysis, will address when they return. There was no documented evidence in Nursing Progress Notes from 10/03/2025 at 8:18 AM to 10/06/2025 at 7:58 AM in which the newly identified skin alteration was assessed by a registered nurse. Progress Note dated 10/09/2025 at 8:47 AM by Wound Care Provider #1 documented they did not see Resident #1 as scheduled because Resident #1 was at dialysis. Nursing Progress Note dated 10/06/2025 at 7:58 AM by Registered Nurse #1, documented that on 10/06/2026 at 7:55 AM, Resident #1 reported increased right foot pain. Registered Nurse #1 documented there was an open sore on the heel. The resident was informed they would refer them to the physiatrist (physical medicine) and podiatry to look and assess them. Registered Nurse #1 documented Discussed wound doctor, yet dialysis schedule conflicts. Will also have NP see her There was no documented evidence that the facility made alternate arrangements to assess and manage the pressure ulcer by a qualified person. Podiatry Consult Note dated 10/08/2025 at 9:36 PM documented Resident #1's right heel had an intact dressing. There was no documented evidence of assessment, management or treatment for Resident #1's pressure ulcer by the Podiatrist that saw the resident on 10/08/2025. Nursing Progress Note dated 10/10/2025 at 12:00 PM by Registered Nurse #1 documented that the dialysis nurse called on 10/10/2025 at 12:00 PM to report the resident was being sent to the hospital for hypotension (low blood pressure) and lethargy (severe exhaustion, lack of energy, or mental alertness). Hospital Infectious Disease Consultation Note dated 10/11/2025 documented they were consulted for antibiotic management of a non-operative heel wound. The resident came to the hospital from the dialysis center on 10/10/2025. The resident presented with no fever and had a white blood count of 13.7 thousand (normal is 4 to 11 thousand). Blood cultures were obtained, and the resident was started on intravenous antibiotics. Magnetic resonance imaging of the right foot on 10/11/2025 had findings that were consistent with osteomyelitis of the calcaneus (heel fracture that often arises from a bone infection), and a fracture (bone break)/disruption of the infected fragment at the site of the Achilles attachment (tendon that connects the heel bone to the calf). The dressing to the right foot was taken down (removed). The wound was extensive with a large dark area of necrosis (cell injury which results in premature death of the cells) on the wound bed, and they could see and feel bones exposed by their heel. The wound had a strong odor and was draining thick brown pus material. Physical exam documented right heel with an extensive wound that probed about 1/2 (one half) inch deep. There was a large area of eschar on the wound bed, and the heel bone was exposed. Blood cultures showed mixed bacteria. Assessment was bacteremia. Hospitalist Discharge summary dated [DATE] documented the resident presented on 10/10/2025 with right foot heel pain and a draining foot ulcer. Initial assessment was consistent with a right pathological calcaneal fracture with acute osteomyelitis. A below knee amputation was completed on 10/17/2025. During an interview on 03/23/2026 at 11:55 AM, Family Member #1 stated resident was to be seen by the wound care doctor at the facility. They were told by nursing staff that the wound doctor was there on Thursday when the resident was out for dialysis treatment and could not be seen. Staff told them they could not evaluate the wound; they could only have a nurse look at it. The Infectious Disease doctor at the hospital told Resident #1 there was a hole in their heel that was (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	infected in the bone. They told Resident #1 they needed to amputate, or they would lose their life. Resident #1 asked if they could amputate just the foot and was told it would be a below knee amputation with the possibility of an above knee amputation. They stated Resident #1 was traumatized. Resident #1 asked Family Member #1 if they should even have it amputated because if they had it amputated, It's going to affect my life so much, especially with it being the right leg and not being able to drive again. During an interview on 03/24/2026 at 2:39 PM, Licensed Practical Nurse #1 stated they helped with wounds. The wound care provider was supposed to see Resident #1, but their dialysis treatment conflicted, and they were not in the building when the wound care doctor was present. The wound care provider came one (1) day a week that they believed was Thursday. The resident's first wound evaluation would have been a week from admission, on 09/25/2025 and the wound care provider did not see the resident. When Licensed Practical Nurse #1 accompanied the wound care provider during wound rounds, they would evaluate the wound and put a note in the electronic medical record that they were seen by the wound care provider. If the wound care provider or Registered Nurse #1 was not available, they would conduct wound rounds by themselves. The initial evaluation was always done by a registered nurse. When Licensed Practical Nurse #1 documented a wound, they would write about what they saw during the evaluation. On 09/25/2025, a registered nurse was not with them when they did weekly wounds for Resident #1. They did not refer the resident to the wound care provider on 09/25/2025 because there was no change in the wound. Even if they did refer to the wound care provider on 09/25/2025, the resident would not have been seen because they were at the dialysis center. Nurse Practitioner #1 was notified on 09/25/2025 and should have seen and assessed the resident. On 10/02/2025, Licensed Practical Nurse #1 evaluated the wound and then Registered Nurse #1 went into the room and looked at the resident's wound bed that had started to separate, was still covered with eschar, was pulling away from the edges, had serosanguineous (thin and watery, with light red or pink hue caused by the presence of red blood cells) drainage that was not purulent. Registered Nurse #1 called Nurse Practitioner #1. The resident was not seen by the wound care provider on 10/02/2025 because they were at the dialysis center. During an interview on 03/25/2026 at 9:36 AM, Registered Nurse #1 stated there was a conflict between Resident #1's dialysis schedule on Thursday, and the wound care provider's schedule and the resident was unable to be seen by them. A solution to the conflict would have been to change the resident's dialysis time because it needed to align better with the wound care provider's schedule. No changes were made. They would have assessed the resident's wound in absence of the wound care provider and stated they did not do a thorough job documenting the assessments. They were with Licensed Practical Nurse #1 during wound rounds on 10/02/2025, and stated the wound started to open and the current treatment was not effective. They notified the provider and received an order for a new treatment. They reviewed a note they had written on 10/02/2025 and stated the note did not include the change in the wound and the measurements. If the medical provider saw the resident on 10/02/2025, they would have written a note. They assessed the resident's foot on 10/06/2025, when the resident reported increased pain in their right foot. They did not recall removing the dressing and assessing the status of the wound at that time. They notified the medical provider and reached out to the physiatrist who was responsible for pain management. If the medical provider saw the resident on 10/06/2025, they would have written a note. During an interview on 03/25/2026 at 11:58 AM, Director of Nursing #1 stated they were not aware of the conflict between dialysis and wound care for Resident #1. If they were made aware, they would have made sure the physician or nurse practitioner was made aware and would have looked at the wound themselves. They stated that on 09/18/2025, the resident's wound was assessed by a registered nurse, on 09/25/2025 by a licensed practical nurse, and on 10/02/2025 by a registered nurse. They did not see an assessment for 10/9/2025. They were not sure if they were aware the wound care provider had signed off on the resident on 10/09/2025. The wound care provider was coming in on Thursday when Resident #1 was not in the facility. They stated licensed practical nurses could measure but could not assess a wound and were (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	supposed to write what they observed in a nursing progress note. They stated Physician #1's admission evaluation note for the resident did not include documentation of the pressure ulcer. During an interview on 04/01/2026 at 10:05 AM, Administrator #1 stated they were not working at the facility when Resident #1 was admitted , and that the facility conducted high-risk meetings for residents with wounds, and Resident #1 should have had weekly meetings. Director of Nursing #1 was responsible for providing oversight to all nursing staff and the Corporate Nurse Consultant provided oversight to the Director of Nursing. Administrator #1 was responsible for ensuring meetings were held to discuss the residents' needs. They stated the physician/nurse practitioner was responsible for a resident's overall care. They stated they attended Quality Assurance and Performance Improvement meetings and after reviewing the notes stated, wounds and pressure ulcers were discussed/reviewed at the meetings. During an interview on 03/26/2026 at 1:53 PM, Nurse Practitioner #1 stated they never got to see Resident #1 because they (Nurse Practitioner #1) were only in the facility on Tuesday and Friday and the resident was always at dialysis on those days. Physician #1 was in the facility on Monday and Wednesday. They did not recall being called for anything specific regarding Resident #1 and said if they were called, they would have given a verbal order and would have asked staff to ensure Physician #1 saw the resident when they came into the facility. Physician #1 did the resident's admission evaluation and there was no documentation in the note about the resident's pressure ulcer. They stated ultimately, there was a medical director that could have been notified of any concerns. They did not realize Licensed Practical Nurse #1, who was doing weekly wound assessments, was not a registered nurse. During an interview on 03/31/2026 at 2:17 PM, Wound Care Provider #1 stated they used to go into facility for weekly wound rounds on Thursdays. They had no flexibility in their schedule and could not be in the facility more than one (1) day a week. They stated if the resident was not available for them to assess due to dialysis, the resident should have been seen at a wound care center. Their wound care notes were available to all staff. They stated it was not normal and unacceptable for there to be no weekly assessment by a registered nurse when the wound care provider was not able to see the resident. They stated if the registered nurse had assessed the wound and identified that it had gotten worse; they could have sent the resident out to a wound care center at that time. During an interview on 03/27/2026 at 1:14 PM, Medical Director #1 stated they were told about what happened to Resident #1 and there was no reason why the in-house wound care provider could not see the resident virtually, when there was a conflict with the resident's dialysis schedule. They stated they wished they had known about the situation with Resident #1 because they could have called the wound care provider or the dialysis center to come up with a plan. They stated there was a reason why skin checks were done, and wound services came into the facility. They relied on weekly wound assessments and treatments done by staff. They stated during interval medical visits, the wound care notes needed to be reviewed. They stated the resident not being seen by medical or wound care because they were going to dialysis four (4) days a week was not an excuse for not having an assessment by a qualified person. 10 New York Code of 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 a Survey, the facility failed to report the results of all investigations to his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within five (5) working days of the incident, and if the alleged violation is verified appropriate corrective action was taken for one (1) of one (1) residents reviewed. Specifically on 10/14/2025, Resident #3 threw objects including a chair that resulted in the chair hitting Resident #5's right foot. Resident #3 also climbed on top of Resident #4's bed while Resident #4 was laying in their bed. There was no documented evidence this incident involving Resident #3 was reported to the State Survey Agency as required. Findings include: Facility policy titled, Abuse Policy, reviewed 07/18/2025, documented the facility prohibited the mistreatment, neglect, and abuse of residents/patients and misappropriation of resident/patient property by anyone, including staff, family, friends, or other residents. The Administrator and Director of Nursing would be responsible for investigating and reporting to the appropriate State Agency(s) immediately (no later than two (2) hours after allegation/identification of allegation) after identifying the alleged/suspected incident. The policy further defines abuse as the willful infliction of injury or intimidation resulting in physical harm, pain, or mental anguish. Resident #3 was admitted to the facility with diagnoses of vascular dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life caused by decreased blood flow to the brain), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest) and anxiety (a feeling of fear, dread, and uneasiness that acts as a natural reaction to stress). The Minimum Data Set (an assessment tool) dated 01/12/2026, documented the resident could be understood, could understand others, and had moderate cognitive impairment. Facility Investigation Summary documented the date and time of incident as 10/14/2025 at 8:30 PM. During this time, Resident #3 had escalated behaviors and a psychotic episode. Resident #3 threw soda cans and an object at a nurse in their room while the nurse administered medication to the roommate (Resident #4). Resident #3 was escorted back to bed. Resident #3 began swinging their walker at staff. Staff attempted to redirect the resident without success, and the resident was at significant risk of harm to others. Staff placed Resident #3 on a one to one (1:1) (when a dedicated caregiver was assigned exclusively to one resident to provide personalized attention). Resident #3 stood up from the bed they were in and got into the bed where Resident #4 was laying. Resident #3 was removed from this bed and placed in another bed. Resident #4 was also assisted out of the bed and brought to another room. Resident #3 continued to be aggressive and went across the hall into Resident #5's room. Resident #3 pushed a tray table out of their way and Resident #5 tried to push it back. While doing this, Resident #5 hit their elbow. Resident #3 picked up a chair and threw the chair down. The chair hit Resident #5's right foot. There were two (2) Certified Nurse Aides in the room at this time and they escorted Resident #3 out of the room. Medical Director #1 was notified and orders were given to send Resident #3 to the hospital. A Registered Nurse skin assessment was completed for both Resident #4 and Resident #5. It further documented that there was no evidence of abuse, neglect, exploitation, mistreatment, or intentional misconduct by staff. The event was determined to be the result of an episode of an acute psychosis event of Resident #3, where they became belligerent, aggressive, violent and exhibited physical behavior. Resident #3 was at very high risk of harm to others. There was no alternative but to attempt to pharmacologically intervene and transfer to the hospital for further evaluation. There was no documented evidence that the facility submitted a report of the resident-to-resident abuse to the New York State Department of Health. During an interview on 03/26/2026 at 2:08 PM, Director of Nursing #1 stated they were not in the facility at the time of this incident, but they received a phone call from Registered Nurse #1 regarding the incident. Director of Nursing #1 stated they did not believe this incident was reportable to the State Agency (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	because Resident #3 did not hurt anyone. Director of Nursing #1 stated they completed the facility investigations and Administrator #1 was the person to report incidents to the State Agency. During an interview on 03/26/2026 at 2:22 PM, Administrator #1 stated they had been working in the facility for about three (3) months and heard about the incident that occurred on 10/14/2025. Administrator #1 stated if any incident occurred, a facility investigation would be started and completed by Director of Nursing #1. 10 New York Codes, Rules, and Regulations 415.4(b)(2)

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Troy Center for Rehabilitation and Nursing	49 Marvin Avenue Troy, NY 12180

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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 record review and interviews conducted during a survey, the facility failed to ensure comprehensive care plans were developed and implemented for residents according to professional standards for one (1) (Resident #6) of three (3) residents reviewed. Specifically, Resident #6's comprehensive care plan did not contain measurable goals and interventions for the care and treatment of the stage three (3) pressure ulcer on the sacrum (triangular bone at the base of the spine). Findings include: Cross-referenced to F686: Treatment/Services to Prevent/Heal Pressure Ulcers Resident #6: Resident #6 was admitted to the facility with diagnoses of orthopedic surgery of right tibia/fibula (bones in lower leg) aftercare, diabetes, and chronic kidney disease stage 3A (where kidney function is between 45-59 percent). The Minimum Data Set (an assessment tool) dated 02/28/2026, documented the resident was cognitively intact. The resident was able to make themselves understood and understood others. The Policy and Procedure titled, Care - Plans Comprehensive, revised 10/2019, documented a comprehensive, person-centered care plan that included measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs was developed and implemented for each resident. The Interdisciplinary Team, in conjunction with the resident and representative, developed and implemented a comprehensive, person-centered care plan for each resident. The care plan would describe services that were furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Areas of concern that were identified during the resident assessment would be evaluated before interventions were added to the care plan. The Policy and Procedure titled, Wound Identification and Wound Rounds, revised 11/06/2023, documented the Registered Nurse/Interdisciplinary Team would develop a care plan for the new skin impairment. The Registered Nurse would initiate a care plan including prevention interventions as necessary. Document titled LN: Admission/readmission Evaluation Part 1 dated 02/24/2026 by Registered Nurse #1 documented a stage three (3) pressure ulcer (serious skin injury that involves full-thickness skin loss and exposure of the fatty tissue) on the sacrum that measured two (2) centimeters long by two (2) centimeters wide by 0.1 centimeters deep. Care Plan for Nutritional Problem or Potential Nutritional Problem, created/initiated 02/27/2026, documented the resident had a pressure injury on the sacrum. The comprehensive care plan did not have evidence of measurable goals and interventions for the care/treatment of the stage three (3) pressure ulcer on the sacrum, to promote healing and prevent infection. During an interview on 03/25/2026 at 11:58 AM, Director of Nursing #1 stated care plans were initiated by a registered nurse and updated/revised as things changed. The care plan was updated when a wound was identified. During an interview on 03/26/2026 at 3:09 PM, Registered Nurse #1 stated care plans were initiated by the Interdisciplinary Team and updated/revised when the resident's status changed. 10 New York Code of Rules and Regulations 415.11(c)(1)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review and interviews conducted during a survey, the facility failed to ensure that comprehensive care plans were revised and updated according to professional standards for one (1) (Resident # 1) of three (3) residents reviewed. Specifically, for Resident #1, the comprehensive care plan was not updated (a.) to reflect weekly wound assessments were not done by the wound care provider when the resident was out for dialysis treatment on 09/25/2025, 10/02/2025, and 10/09/2025, and (b.) when there was a significant change in the pressure ulcer on 10/02/2025 and had deteriorated. Findings include: Cross-referenced to F686: Treatment/Services to Prevent/Heal Pressure UlcersResident #1: Resident #1 was admitted to the facility with diagnoses of end stage renal disease (kidneys no longer work to meet the body's needs) with dependence on renal dialysis (a treatment that filters waste and excess fluid from the blood when the kidneys are failing), diabetes (body cannot use insulin correctly and sugar builds up in the blood) with diabetic chronic kidney disease, and chronic peripheral venous insufficiency (occurs when leg veins become damaged and do not allow blood flow back to your heart). The Minimum Data Set (an assessment tool) dated 09/25/2025, documented the resident was cognitively intact. The resident was able to make themselves understood and understood others. The Policy and Procedure titled, Care - Plans Comprehensive, revised 10/2019, documented assessments were ongoing, and care plans were revised as information about the residents' condition changed. The Interdisciplinary Team reviewed and updated the care plan when there was a significant change in the resident's condition, when the desired outcome was not met, when the resident had been readmitted to the facility from a hospital stay, and at least quarterly with scheduled quarterly Minimum Data Set. The Policy and Procedure titled, Wound Identification and Wound Rounds, revised 11/06/2023, documented the Registered Nurse/Interdisciplinary Team would develop a care plan for the new skin impairment. The Registered Nurse would initiate a care plan including prevention interventions as necessary. Care Plan for Alteration in Skin Integrity, created on 09/19/2025 and initiated on 09/30/2025, documented the resident had an actual pressure injury site to their right heel of the foot with eschar tissue (a thick, dry, black or brown layer of dead tissue). Interventions included apply treatment per order, refer to Physical Therapy/Occupational Therapy as needed for position evaluation, and refer to wound care specialist as needed. Wound Evaluation (Weekly) dated 10/02/2025 at 4:40 PM by Licensed Practical Nurse #1, documented an unstageable pressure ulcer on the right heel that measured four (4) centimeters long by four (4) centimeters wide and depth was unable to determine. There was 100% black/brown eschar, with a scant amount of serous (clear to yellow fluid that leaks out of a wound), and no odor. Treatment was in place. Response to treatment documented deteriorated. Interventions/action plan: treatment re-evaluated or changed. Additional comments: wound care provider unable to see due to dialysis schedule conflict. The comprehensive care plan did not have evidence of an update/revision when the resident was not seen by the wound care provider for weekly wound assessment of the pressure ulcer on 09/25/2025, 10/02/2025, and 10/09/2025, when the resident was out of the facility for scheduled dialysis treatment. The comprehensive care plan did not have evidence of an update/revision when there was a significant change in the pressure ulcer on 10/02/2025 and had deteriorated. During an interview on 03/25/2026 at 11:58 AM, Director of Nursing #1 stated care plans were initiated by a registered nurse and updated/revised as things changed. The care plan was updated when a wound was identified. During an interview on 03/26/2026 at 3:09 PM, Registered Nurse Manager #1 stated care plans were initiated by the Interdisciplinary Team and updated/revised when the resident's status changed. 10 New York Code of Rules and Regulations 415.11(c)(2)(i-iii)

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care by qualified persons according to each resident's written plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews conducted during a survey, the facility failed to ensure services provided or arranged by the facility as outlined by the comprehensive care plan were provided by qualified persons in accordance with each resident's written plan of care for one (1) (Resident #1) of three (3) residents reviewed. Specifically, Resident #1's unstageable pressure ulcer on the right heel was assessed on 9/25/2025 by a Licensed Practical Nurse who was not qualified to do so within their scope of practice. Findings include: Resident #1: Resident #1 was admitted to the facility with diagnoses of end stage renal disease (kidneys no longer work to meet the body's needs) with dependence on renal dialysis (a treatment that filters waste and excess fluid from the blood when the kidneys are failing), diabetes (body cannot use insulin correctly and sugar builds up in the blood) with diabetic chronic kidney disease, and chronic peripheral venous insufficiency (occurs when leg veins become damaged and do not allow blood flow back to your heart). The Minimum Data Set (an assessment tool) dated 9/25/2025, documented the resident was cognitively intact. The resident was able to make themselves understood and understood others. Policy and Procedure titled, Wound Identification and Wound Rounds, revised 11/6/2023, documented the facility would identify, assess, and manage residents with pressure injuries, skin alterations, impairments, or wounds in accordance with current standards of practice. The Wound Nurse/Designee, Wound Care Provider and Registered Dietician were notified of pressure ulcer or skin impairment, and the resident was scheduled for weekly wound rounds. For weekly wound rounds, the Designated Wound Nurse or Licensed Nurse would complete weekly wound rounds with the wound provider and other members of the Interdisciplinary Team (as necessary). Care Plan for Alteration in Skin Integrity, created on 9/19/2025 and initiated on 9/30/2025, documented the resident had an actual pressure injury site to their right heel with eschar (necrotic tissue-black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin). Interventions documented apply treatment per order, refer to Physical Therapy/Occupational Therapy as needed for position evaluation, and refer to wound care specialist as needed. Document titled LN: Admission/readmission Evaluation Part 1 dated 9/18/2025 by Registered Nurse #2 documented an unstageable pressure ulcer (depth of wound is unknown because devitalized tissue obscures the extent of tissue damage) on the right heel that measured 2.5 centimeters long by 2.2 centimeters wide and had no depth. Unable to visualize the wound bed. There was 100% black/brown eschar. It documented a treatment was in place. Team Meeting Note dated 9/19/2025 at 9:41 AM by Licensed Practical Nurse #1, documented the Interdisciplinary Team met on 9/19/2025 regarding Resident #1 for the following reason: High Risk Meeting. Meeting attendees included Nursing, Social Services, Rehab/Therapy, Dietary, Administration, and Nurse Practitioner #1. The resident was invited but declined to attend. Meeting summary documented Resident #1 had a pressure ulcer on the right heel and would be referred to the in-house wound provider. Document titled LN: Wound Evaluation (Weekly) dated 09/25/2025 at 11:50 AM by Licensed Practical Nurse #1, documented an unstageable pressure ulcer on the right heel that measured 2.5 centimeters long by 2.2 centimeters wide and the depth was UTD (unable to determine). There was 100% black/brown eschar, with no exudate (drainage) and no odor. Treatment was in place and response to treatment was improved. Additional comments: refer to wound care provider. There was no documented evidence that the in-house wound care provider or a qualified person assessed the resident's pressure ulcer on the right heel on 09/25/2025. An email dated 04/10/2026 at 9:43 AM from the New York State Education Department, Nursing Board Office, documented general information about the scope of practice of New York State licensed professionals. It was not within the scope of practice of a Licensed Professional Nurse to (a) practice nursing independently or provide nursing care that they are not competent to perform and (b) perform nursing assessments, determine nursing diagnoses, or develop or change nursing care plans. A competent, trained Licensed (continued on next page)

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Practical Nurse may measure, document and report their findings to a Registered Nurse once an assessment of each patient and the wound is performed prior to and after as indicated, any wound care or measurements a patient may require. A Licensed Practical Nurse was accountable to make observations and report their findings to the directing Registered Nurse, who performed the assessment and formulated a care plan. The Registered Nurse was responsible for reassessing the patient and formulating a plan of care, evaluating and amending that plan based on the assessments. Licensed Practical Nurses may collect clinical data (wound size, color, drainage, etc.) and report it to a Registered Nurse. The Registered Nurse was responsible for determining/interpreting that clinical data. The Registered Nurse makes a determination of effectiveness of the nursing and/or medical regimen and makes a decision regarding the plan of care. During an interview on 03/24/2026 at 2:39 PM, Licensed Practical Nurse #1 stated they were a travel resource nurse and worked at the facility in September and October 2025, as the Assistant Director of Nursing duties, while the position was vacant. They helped with wounds, infection control, education, and other assignments. The wound care provider was supposed to see the resident, but their dialysis treatment conflicted, and they were not in the building when the wound care doctor was present. The wound care provider came one day a week that they believed was Thursday. The resident's first wound evaluation would have been a week from admission, on 09/25/2025 and the wound care provider did not see the resident. They stated the resident was not at high risk. When Licensed Practical Nurse #1 accompanied the wound care provider during wound rounds, they would evaluate the wound and put a note in the electronic medical record that they were seen by the wound care provider. If the wound care provider or Registered Nurse Manager #1 was available, they would conduct wound rounds by themselves. The initial evaluation was always done by a registered nurse. When Licensed Practical Nurse #1 documented a wound, they would write about what they saw during the evaluation. On 09/25/2025, a registered nurse was not with them when they did weekly wounds for Resident #1. There was 100% eschar on the wound bed and there was no way to see the depth of the wound. There was no worsening or significant change and would have let the registered nurse know. They did not refer the resident to the wound care provider on 09/25/2025 because there was no change in the wound. Even if they did refer to the wound care provider on 09/25/2025, the resident would not have been seen because they were at the dialysis center. Nurse Practitioner #1 was notified on 09/25/2025 and should have seen and assessed the resident. During an interview on 03/25/2026 at 9:36 AM, Registered Nurse #1 stated Resident #1 had a pressure ulcer on their right heel upon admission on [DATE] and was assessed by the registered nurse supervisor. They did not know if they attended the high-risk meeting on 09/19/2025. The weekly wound assessment scheduled for 09/25/2025 was done by Licensed Practical Nurse #1 who was the corporate regional clinical nurse manager and was the facility's acting Assistant Director of Nursing. Registered Nurse #1 usually accompanied Licensed Practical Nurse #1 and the wound care provider on weekly wound rounds and stated on 09/25/2025 they were most likely assigned to a medication cart and passed medications or just did not document the assessment. If they were assigned to a medication cart and had to pass medications, they would not have attended wound rounds. During an interview on 03/25/2026 at 11:58 AM, Director of Nursing #1 stated they believed they were the director in September and October 2025. When Resident #1 was admitted on [DATE], there was an unstageable pressure ulcer with eschar on the wound bed and was documented on the assessment. They were not aware of conflict between dialysis and wound care. If they were made aware they would have made sure the physician or Nurse Practitioner was made aware and would have looked at the wound themselves. They stated that on 09/18/2025, the resident's wound was assessed by a registered nurse, and on 09/25/2025 by a licensed practical nurse. Licensed Practical Nurse #1 was a corporate resource nurse who went to each facility when they needed help. They stated licensed practical nurses could measure but could not assess a wound and were supposed to write what they observed in a nursing progress note. During an interview on 03/26/2026 at 1:53 PM, Nurse Practitioner #1 stated they did not realize Licensed Practical Nurse #1 (continued on next page)

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	who was doing weekly wound assessments was not a registered nurse. During an interview on 03/31/2026 at 2:17 PM, Wound Care Provider #1 stated it was not normal and unacceptable for there to be no weekly assessment by a registered nurse when the wound care provider was not able to see the resident. 10 New York Code of Rules and Regulations 415.11(c)(3)(ii)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews during a survey, the facility failed to ensure a resident with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing and prevent infection for three (3) (Resident #s 1, 6, and 7) of three (3) residents reviewed. Specifically, the facility failed to provide daily care/treatment of a pressure ulcer in accordance with professional standards of practice and care planned interventions for (a.) Resident #1's unstageable pressure ulcer on the right heel, (b.) Resident #6's stage 3 pressure ulcer on the sacrum, and (c.) Resident #7's stage 3 pressure ulcer on the sacrum, that were present upon admission. Findings include:Cross-referenced to F600: Free from Abuse and Neglect Cross-referenced to F656: Develop/Implement Comprehensive Care Plan Cross-referenced to F657: Care Plan Timing and Revision Policy and Procedure titled, Wound Identification and Wound Rounds, revised 11/06/2023, documented the facility would identify, assess, and manage residents with pressure injuries, skin alterations, impairments, or wounds in accordance with current standards of practice. For new admissions and a newly discovered pressure ulcer, the Register Nurse would complete a skin assessment including documentation of size, depth, stage if applicable and appearance of the skin impairment. The licensed nurse would notify the health care provider and obtain a treatment order utilizing the facility's wound care guidelines.Resident #1: Resident #1 was admitted to the facility with diagnoses of end stage renal disease (kidneys no longer work to meet the body's needs) with dependence on renal dialysis (a treatment that filters waste and excess fluid from the blood when the kidneys are failing), diabetes (body cannot use insulin correctly and sugar builds up in the blood) with diabetic chronic kidney disease, and chronic peripheral venous insufficiency (occurs when leg veins become damaged and do not allow blood flow back to your heart). The Minimum Data Set (an assessment tool) dated 09/25/2025, documented the resident was cognitively intact. The resident was able to make themselves understood and understood others.Care Plan for Alteration in Skin Integrity, created on 09/19/2025 and initiated on 09/30/2025, documented the resident had an actual pressure injury site to their right heel with eschar tissue (necrotic tissue-black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin). Interventions included apply treatment per order. Document titled LN: Admission/readmission Evaluation Part 1 dated 09/18/2025 by Registered Nurse #2 documented an unstageable pressure ulcer (depth of wound is unknown because devitalized tissue obscures the extent of tissue damage) on the right heel that measured two and a half (2.5) centimeters long by two and two tenths (2.2) centimeters wide and had no depth. Unable to visualize the wound bed. There was 100 percent black/brown eschar (necrotic tissue-black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin). It documented a treatment was in place. Review of the Order Recap Report for order date 09/01/2025 to 10/31/2025 and the Treatment Administration Record dated September 2025, did not document a treatment order for the unstageable pressure ulcer on the right heel on 09/18/2025. There was no treatment order until 09/20/2025: Treatment Administration Record dated September 2025, documented TheraHoney Gel (wound dressings), apply to right heel topically every dayshift for wound care; cleanse with normal saline solution, apply gel to wound bed only and cover pressure area with optifoam (highly absorbent foam dressing). The start date was 09/20/2025. The treatment was not documented as being administered on 09/22/2025, 09/23/2025, 09/25/2025, and 09/29/2025. On 09/26/2025, 09/27/2025, 09/30/2025, 10/01/2025, and 10/02/2025, location of administration documented the treatment was administered to both heels. There was no documented evidence that the resident had a wound on their left heel. Order Recap Report dated 09/01/2025 to 10/31/2025, documented an order dated 10/02/2025 for Anasept Antimicrobial External Gel 0.057% (sodium hypochlorite, a broad-spectrum antimicrobial), apply to right heel every day shift for wound care, cleanse with wound cleanser, apply collagen (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	powder (specialized wound care product promotes wound healing and tissue regeneration) and anasept to wound bed, cover with island dressing (sterile, bordered gauze dressing for wounds with light to moderate drainage). Start date was 10/03/2025 at 7:00 AM and was discontinued on 10/10/2025. Treatment Administration Record documented that the treatment was not administered until 10/04/2025 and was not administered on 10/06/2025. On 10/04/2025, 10/05/2025, 10/07/2025, 10/08/2025, and 10/09/2025, location of administration documented not recorded. Resident #6: Resident #6 was admitted to the facility with diagnoses of orthopedic surgery of right tibia/fibula (bones in lower leg) aftercare, diabetes, and chronic kidney disease stage 3A (kidney function is between 45-59 %). The Minimum Data Set, dated [DATE], documented the resident was cognitively intact. The resident was able to make themselves understood and understood others. Care Plan for Nutritional Problem or Potential Nutritional Problem, created/initiated 02/27/2026, documented the resident had a pressure injury on the sacrum. Document titled LN: Admission/readmission Evaluation Part 1 dated 02/24/2026 by Registered Nurse #1 documented a stage three (3) pressure ulcer (serious skin injury that involves full-thickness skin loss and exposure of the fatty tissue) on the sacrum that measured two (2) centimeters long by two (2) centimeters wide by 0.1 centimeters deep. There was no treatment order for the stage three (3) pressure ulcer on the sacrum that was identified on 02/24/2026 until 02/27/2026. Order Summary Report for active orders as of 03/01/2026, documented an order dated 02/26/2026 for Calcium Alginate - Silver External Pad two (2) inch by two (2) inch, apply to sacrum topically every dayshift for wound care, cleanse with normal saline and pat dry, cut calcium alginate silver to size of wound bed and apply, cover with border gauze. Start date was 02/27/2026. Treatment Administration Record dated March 2026, documented Calcium Alginate - Silver External Pad two (2)-inch x two (2) inch, apply to sacrum topically every dayshift for wound care, cleanse with normal saline and pat dry, cut calcium alginate silver to size of wound bed and apply, cover with border gauze. Start date was 02/27/2026 at 7:00 AM. The treatment was scheduled to be done at 7:00 AM. The order was discontinued on 03/18/2026 at 10:58 AM. The treatment was not documented as being administered on 03/03/2026, 03/08/2026, and 03/18/2026. The record was blank. Resident #7: Resident #7 was admitted to the facility with diagnoses of cirrhosis of liver (late stage of liver disease characterized by scarring in the liver tissue), diabetes, and hypokalemia (low amount of potassium in the blood). The Minimum Data Set, dated [DATE], documented the resident had moderate cognitive impairment. The resident usually made themselves understood and understood others. Care Plan for Alteration in Skin Integrity, initiated 02/19/2026, documented the resident had a stage three (3) pressure ulcer on the sacrum. Interventions included apply treatment per order. Nursing admission Evaluation Note dated 02/18/2026 at 2:48 PM by Registered Nurse Manager #1, documented a stage three (3) pressure ulcer on the sacrum that measured two and a half (2.5) centimeters long by two and a half (2.5) centimeters wide, by two tenths (0.2) centimeters deep. Treatment Administration Record dated March 2026, documented Santyl External Ointment 250 unit/gram (collagenase), apply to sacrum topically every shift for wound care, cleanse with normal saline, apply nickel thick layer of Santyl to wound, cover with normal saline moistened gauze and island dressing. Start date was 03/06/2026 at 7:00 AM. The treatment was scheduled to be done at 7:00 AM. The order was discontinued on 03/12/2026 at 12:27 PM. The treatment was not documented as being administered on 03/08/2026 and 03/12/2026. The record was blank. During an interview on 03/25/2026 at 9:36 AM, Registered Nurse Manager #1 stated Resident #1 had a pressure ulcer on their right heel that was assessed on admission by the registered nurse supervisor on 09/18/2025. They recalled the treatment being skin prep or Medihoney. The registered nurse who completed the admission was to ensure treatment was in place when a wound was identified and would call physician for the order. They were not aware there was no order for Resident #1 until 09/20/2025. The medication cart nurse was responsible for doing the treatment during their assigned shift and should complete it by shift change. If there were blanks on the Treatment Administration Record, the treatment was not done. They were not aware treatments were not done and stated the protocol was (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to report any missed treatment to Registered Nurse Manager #1 and the physician. During an interview on 03/25/2026 at 11:58 AM, Director of Nursing #1 stated they believed they were the director in September and October 2025. When Resident #1 was admitted on [DATE], there was an unstageable pressure ulcer with eschar on the wound bed and was documented on the assessment. They reviewed the electronic medical record and did not see an order for treatment until 09/20/2025. They reviewed the Treatment Administration Record and saw missing treatments. Treatments were scheduled for all three (3) shifts, day, evening, night. The day nurse had the whole shift to do the treatments that were usually done in between medication passes. If unable to do a treatment, they were to notify the physician, Director of Nursing, and nurse manager, or ask other licensed staff for help. It should also be written on the 24-hour report, which was on paper back then. During an interview on 03/26/2026 at 11:15 AM, Licensed Practical Nurse #4 stated they completed assigned wound care during the 3:00 PM to 11:00 PM shift, towards the end of the shift. When the wound care was completed, it was documented on the Treatment Administration Record in the electronic medical record. If they could not complete the wound care, they would document in the computer system and on the 24-hour shift report and would tell the oncoming nurse. During an interview on 03/26/2026 at 11:23 AM, Licensed Practical Nurse #5 stated they usually worked the 7:00 AM to 3:00 PM shift and would complete assigned wound care in between medication passes throughout the shift. They document in the computer system when wound the care was complete. If they could not complete the wound care, they would write a nursing note in the computer system and on the 24-hour shift report. If a resident refused treatment, they would leave the resident and reapproach. They stated wound care was important and they would let Registered Nurse #1 know if they continued to refuse. During an interview on 03/26/2026 at 3:09 PM, Registered Nurse #1 stated a treatment was supposed to be in place when a wound was identified. There should never be a blank entry on the Treatment Administration Record, which indicated the treatment was not done. If treatment could not be done, there needed to be communication to Registered Nurse #1, and to the oncoming nurse. During an interview on 03/27/2026 at 1:14 PM, Medical Director #1 stated they relied on weekly wound assessments and treatments done by staff. 10 New York Code of Rules and Regulations 415.12(c)(1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335280	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Center for Rehabilitation and Nursing	49 Marvin Avenue 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 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. Based on record review and interviews conducted during a survey, the facility failed to ensure the physician reviewed the resident's total program of care, including medications and treatments at each visit for one (1) (Resident #1) of three (3) residents reviewed. Specifically, the Attending Physician saw Resident #1 on 09/24/2025 for admission evaluation and their progress note did not include a plan for care and treatment of an unstageable pressure ulcer on the right heel. Findings include: Cross-referenced to F600: Free from Abuse and NeglectResident #1: Resident #1 was admitted to the facility with diagnoses of end stage renal disease (when the kidneys no longer work to meet the body's needs) with dependence on renal dialysis (a treatment that filters waste and excess fluid from the blood when the kidneys are failing), diabetes (body cannot use insulin correctly and sugar builds up in the blood) with diabetic chronic kidney disease, and chronic peripheral venous insufficiency (occurs when leg veins become damaged and do not allow blood flow back to your heart). The Minimum Data Set (an assessment tool) dated 09/25/2025, documented the resident was cognitively intact, was able to make themselves understood and understood others. The Policy and Procedure titled, Physician Visits, revised 05/2019, documented the Attending Physician must perform relevant tasks at the time of each visit, including a review of the resident's total program of care and appropriate documentation. Document titled Admission/readmission Evaluation Part 1 dated 09/18/2025 by Registered Nurse #2 documented an unstageable pressure ulcer (depth of wound is unknown because devitalized tissue obscures the extent of tissue damage) on the right heel that measured 2.5 centimeters long by 2.2 centimeters wide and had no depth. Unable to visualize the wound bed. There was 100% black/brown eschar (necrotic tissue-black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin). It documented a treatment was in place. Team Meeting Note dated 09/19/2025 at 9:41 AM by Licensed Practical Nurse #1, documented the Interdisciplinary Team met on 09/19/2025 regarding Resident #1 for the following reason: High Risk Meeting. Meeting attendees included Nursing, Social Services, Rehab/Therapy, Dietary, Administration, and Nurse Practitioner #1. The resident was invited but declined to attend. Meeting summary documented Resident #1 had a pressure ulcer on the right heel and would be referred to the in-house wound provider. Encounter Note dated 09/24/2025 at 1:00 AM by Physician #1, documented initial History and Physical. Review of systems skin/breast documented no rashes or skin breakdown. Physical exam of the skin documented warm and dry. The note did not include documentation of the pressure ulcer on the right heel and there was no documented plan for treatment of the pressure ulcer. During an interview on 03/27/2026 at 1:14 PM, Medical Director #1 stated that when Resident #1 was in the facility, Physician #1 was getting ready to retire, was frustrated and did not always write notes about all the resident's concerns. Physician #1 has since retired and was out of the country. They stated it was difficult to find qualified persons to work in nursing homes, including physicians. They stated they did speak with Nurse Practitioner #1 and discussed opportunities to improve as a medical team. The medical team needed to be aware of a resident's wound status and needed to open/read the notes from the wound care provider. They stated during interval medical visits the wound care notes needed to be reviewed. During an interview on 04/1/2026 at 10:05 AM, Administrator #1 statedthe physician/nurse practitioner was responsible for a resident's overall care. Physician #1 retired. They stated Physician #1 was not resident centered. 10 New York Code of Rules and Regulations 415(b)(2)(iii)