STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335285	A. Building B. Wing	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Valley Center for Rehabilitation and Nursing	661 N Main St Spring Valley, NY 10977

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview the facility did not ensure that food was stored in accordance with professional standards for food service safety. Specifically, twenty-five (25) food items were not properly identified and dated in the kitchen refrigerators, freezers, and food storage areas.Findings include:The facility policy titled Food Storage last revised May 2025, documented all containers must be legible and accurately labeled and dated. Food must be dated as it is placed on the shelves and left over food is stored in covered containers or wrapped carefully and securely. Each item is clearly labeled and dated before it is refrigerated. All foods should be covered, labeled and dated. All foods will be checked to assure that foods (including leftovers) will be consumed by their safe use by dates. On 12/15/2025 at 9:40 AM, the initial inspection of the kitchen was conducted with the Food Service Director, and the following were observed:In the Meat Refrigerator: a five (5) lb. container of peeled garlic with no opened date, one (1) tray of cabbage-open to air in a container with no date prepared and no identification label, one (1) tray of chicken legs with no identification label. In the Meat Freezer: one (1) tray of ground chicken with no date prepared and no identification label and one (1) tray of cabbage open to air in a container with no date prepared and no identification label.In the Two Door Cooler: nine (9) cups of salad with no date prepared and no identification label, two (2) trays of juices with no identification label, two (2) opened bags of bread with no opened date, one (1) opened bag of Corn Flakes with no opened date and no identification label and one (1) pound block of butter opened with no opened date. In the Dairy Freezer: one (1) bag of carrots with no opened date, three (3) sandwiches with no identification label and one (1) container of apple sauce with no identification label.During an interview on 12/15/2025 at 10:01 AM, the Food Service Director stated they knew all items needed to be marked with dates opened and an identification of what the item was. They stated all food items that were not labeled correctly were opened or prepared during the weekend.During a follow-up interview on 12/22/2025 at 9:02 AM, the Food Service Director stated when food arrived at the facility, the food was to be properly labeled and dated. If food was removed from the original container, then the food item needed to be properly labeled and dated. They stated If a food item was opened, then the container must be labeled with an open date.10NYCRR 415.14(h)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 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. Based on observation, record review, and interview the facility did not ensure each resident received care, consistent with professional standards of practice, to prevent and/or treat pressure ulcers for three (3) of eight (8) residents (Residents #59, #91 and #100) reviewed for Pressure Ulcers. Specifically, 1) heel offloading was not implemented as per physician order for Resident #59 who was assessed at risk for pressure ulcers 2) heel offloading was not implemented as per comprehensive care plan and physician order for Resident #91 who was assessed at risk for pressure ulcers and 3) heel offloading was not implemented as per physician order for Resident #100 who was assessed at risk for pressure ulcers.The findings include:A policy titled Pressure Ulcer Prevention and Intervention Program, updated 06/2025, documented residents of this facility will have a pressure sore prevention and intervention program to identify risk factors, prevent pressure sore and ulcer formation when avoidable and promote skin integrity, as well as interventions to heal existing pressure sores and ulcers and prevent new sores from developing.1) Resident #59's diagnoses included hypertensive heart disease, unspecified sequelae of cerebral infarction, and spastic hemiplegia affecting the right non -dominant side. The physician order dated 10/01/2022 documented heels offloaded The current care plan titled At Risk for Impairment of Skin Integrity did not include an intervention to address offloading the heels. A quarterly Minimum Data Set (a resident assessment tool) dated 10/21/2025 documented Resident #59 had severe cognitive impairment, did not reject cares, had impairments on both upper and lower extremities, was dependent for all cares and was at risk for pressure ulcers.During observations on 12/15/2025 at 3:38 PM, 12/16/2026 at 10:15 AM, 12/16/2025 at 12:50 PM, 12/17/2025 at 9:29 AM, 12/17/2025 at 12:53 PM, 12/18/2025 at 9:05 AM and 12/19/2025 at 9:56 AM Resident #59 was in bed lying on their back. Resident #59's heels were not offloaded and were resting on the mattress. No pillows were in place to assist with offloading heels. During an interview on 12/18/2025 at 9:20, Certified Nurse Aide #7 stated Resident #59 was dependent with activities of daily living. They stated they were not aware that Resident #59's bilateral heels should be offloaded. They stated Resident 59's heels did not have wounds, therefore did not need to be offloaded. During an interview on 12/18/2025 at 9:45 AM, Registered Nurse Unit Manager #6 stated Resident #59 did not have heel wounds. After checking the electronic medical record, they stated there was a physician order to offload the resident's heels. Registered Nurse Unit Manager #6 stated it was difficult to offload the heels because Resident #59 moved their feet frequently. They stated certified nurse aides and nurses were responsible for ensuring heels were offloaded. They stated they completed spot checks on unit residents to ensure heels were offloaded if ordered by physician. They stated they were not sure if they checked Resident #59 during this week.2) Resident #91's diagnoses included unspecified sequelae of cerebral infarction, anxiety disorder, and unspecified dementia with other behavioral disorder.An annual comprehensive Minimum Data Set (a resident assessment tool) dated 11/24/2025 documented Resident #91 had severe cognitive impairment, no rejection of cares, was dependent for activities of daily living and at risk for pressure ulcers. A resident care plan titled Impaired Activities of Daily Living documented turn and position and encourage to elevate heels in bed. A physician order dated 02/10/2025 documented turn and reposition and heels offloaded.During observations on 12/15/2025 at 10:27 AM, 12/16/2025 at 9:58 AM, and 12/17/2025 at 9:45 AM, Resident #91 was in bed with their bilateral heels resting on the mattress. The heels were not offloaded. During an interview on 12/18/2025 at 11:00 AM, Licensed Practical Nurse #9 stated Resident #91's bilateral heels should be offloaded while in bed during the day. They stated certified nurse aides or nurses were responsible for offloading heels and ensuring they were not resting on the mattress. During an interview on 12/18/2025 at 11:32 AM, Registered Nurse Supervisor #4 stated all residents who have an order for heels to be offloaded, should be offloaded. They stated unit nurses/unit manager/supervisor should be supervising certified nurse aides to ensure resident's heels were offloaded. 3) Resident # 100's diagnoses included hemiplegia and hemiparesis, heart (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	failure, and atrial fibrillation. A physician order dated 01/02/2025 documented turn and reposition, heels offloaded, and air mattressThe quarterly Minimum Data Set (a resident assessment tool) dated 10/09/2025 documented Resident #100 had severe cognitive impairment, required substantial/maximal assistance for bed mobility, was dependent for transfers and was at risk for pressure ulcersA resident care plan titled At Risk for Skin Impairment dated 10/23/2025 documented turn and reposition every two (2) hours, weekly skin checks, and protective skin care every shift and as needed. There was no care plan intervention to offload heels as per physician order. During observations on 12/16/2025 at 9:30 AM, 12/16/2025 at 12:37 PM Resident #100 was observed in bed lying on their back. The bilateral bare feet were resting on the mattress and were not offloaded. During an interview on 12/18/2025 at 11:10 AM. Licensed Practical Nurse #9 stated Resident 100's bilateral heels should be offloaded when in bed. During an interview on 12/22/2025 at 3:18 PM, the Director of Nursing stated Resident heels should be offloaded when there was a physician order or care plan intervention. 10NYCRR 415.12(c)(1)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility did not ensure residents with limited range of motion received appropriate treatment and services to increase range of motion and/or prevent further decrease in range of motion for four (4) of six (6) residents (Residents #50, #34, #59, and #91) reviewed for Positioning and Mobility. Specifically, 1) the use of carrot splints was not implemented as per physician order and care plan for Resident #50 with contractures (fingers bent into the palms) of both hands, 2) the use of a left- hand roll brace was not implemented as per physician order for Resident #34, and 3) the use of a right resting hand splint was not implemented as per physician order for Resident #59. Additionally, the use of a left-hand carrot was not implemented as per physician order for Resident #91. The findings include: The policy and procedure titled Contracture Management revised 09/21/2025 documented prevent the decrease in range of motion, maintain skin and joint integrity, and optimize functional abilities. Minimize all potential contractures when possible and minimize further loss of range of motion in existing contractures with the use of splints and /or orthotics and/or positioning devices to supports as tolerated. 1). Resident # 50 was admitted with diagnoses including Alzheimer's, dementia, and depression. The quarterly Minimum Data Set (an assessment tool) dated 09/24/2025 documented Resident #50 had severe cognitive impairment. The 06/20/2025 Activities of Daily Living/Mobility care plan documented range of motion to both upper extremities with morning and evening care, and application of splints. The 06/20/2025 occupational therapy evaluation documented Resident #50 had contractures of both hands and recommended bilateral carrot splints to be always worn except during hygiene, skin checks, bathing, and range of motion exercises. The 6/22/2025 physician order documented carrot splints for both hands remove for hygiene, skin checks, bathing, and range of motion exercises. During an observation on 12/15/2025 at 11:17 AM, Resident #50 was sitting in a Geri-chair with contractures to both hands. The carrot splints were resting on the resident's chest and not on their hands. During an observation on 12/16/2025 at 8:06 AM, Resident #50 was sleeping in bed with the left carrot splint off. The carrot splint was resting on the sheets in the resident's bed. During an observation on 12/17/2025 at 8:46 AM, Resident #50 was in bed while Certified Nurse Aide #17 fed them breakfast. Resident 50's hands were contracted. The carrot splints were resting on top of the resident's bedside chest. During an observation on 12/17/2025 at 11:11 AM, Resident #50 was sitting in a Geri-chair with the left-hand clenched and without the use of the carrot splint. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation/interview on 12/17/2025 at 1:04 PM, Resident #50 was sitting in a Geri-chair and Certified Nurse Aide #18 assisted them with their lunch. Resident #50 did not have carrot splints in use. During an interview on 12/17/2025 at 1:10 PM, Registered Nurse Manager #6 stated there were no physician orders for the use of carrot splints in the medication and/or treatment administration records and there was no care plan in place for the use of splints. Registered Nurse Manager #6 stated certified nurse aides or nurses were responsible for placing the splints on the residents. During a follow-up observation/interview on 12/17/2025 at 1:17 PM, Certified Nurse Aide #18 logged on to the kiosk, and stated there was documentation that carrot splints were placed on Resident #50 hands. Certified Nurse Aide #18 stated the resident was not wearing the splints, they found them in the resident's Geri-chair. During an interview on 12/17/2025 at 3:51 PM, the Director of Rehabilitation stated that the splints were to be used for severe contractures. The Director of Rehabilitation stated the carrot splints helped to keep the fingers from further flexing and prevented the nails from digging into the resident's palm. 2) Resident # 34's had diagnoses including contracture of the left wrist and spastic hemiplegia. A physician order dated 11/06/2024 documented left-hand roll. Remove for hygiene/skin checks/range of motion. A care plan titled Impaired Activities of Daily Living dated 02/12/2025 documented splint/brace, refer to physician order for details and equipment/devices when out of bed. The Quarterly Minimum Data Set, dated [DATE] documented Resident #34 was cognitively intact, had a left sided contracture, no rejection of cares, and received supervision for activities of daily living. During an observation and interview with Resident #34 on 12/15/2025 at 3:31 PM. Resident # 23 had a left-hand contracture and was without the use of a left-hand roll brace. Resident #34 stated the hand roll brace was present in their drawer. Resident #34 stated they were not aware why staff was not placing the hand roll brace daily. They stated they did not ask staff to apply the hand roll brace when it was not applied. Resident #34 stated they could not apply or remove the hand roll brace independently. During an observation on 12/16/2025 at 9:07 AM, 12/16/2025 at 12:51 PM, 12/17/2025 at 9:30 AM and 12/17/2025 at 12:59 PM Resident #34 was sitting in a wheelchair. A left-hand roll brace was not in place. During an interview with Certified Nurse Aide #7 they stated Resident #34 had a left-hand contracture, but they were not aware if Resident #34 wore a brace. Certified Nurse Aide #7 stated they did not recently place a brace on Resident #34 and did not discuss brace use with the unit nursing staff. During an interview on 12/18/2025 at 9:53 AM, Registered Nurse Unit Manager #6 stated Resident #34 had a physician order for a hand roll device on the left hand and they believed Resident #34 wore the brace all week. Registered Nurse Unit Manager #6 stated they provided spot checks on the unit to ensure residents wore the ordered devices. They stated they were not sure if they provided a spot (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	check for Resident #34. During an interview on 12/22/2025 at 9:12 AM, the Director of Rehabilitation stated Resident #34 had a physician order for a left-hand roll brace to be worn during waking hours and nursing staff was responsible for applying the device daily. The Director of Rehabilitation stated they were not aware why the brace was not in place. They stated if there were concerns regarding a resident not wanting to wear a brace or if a brace was missing, nursing should enter a rehabilitation referral for evaluation. 3) Resident # 59 had diagnoses including unspecified sequelae of cerebral infarction and spastic hemiplegia affecting the right non- dominant side. A physician order dated 10/28/2022 documented right resting hand splint. Remove for sleep, hygiene and range of motion. Check skin every four (4) hours. 8:00 AM on and 8:00 PM off. A care plan titled Contractures updated 2/12/2024 documented refer to physician orders for detail. A quarterly Minimum Data Set (a resident assessment tool) dated 10/21/2025 documented Resident #59 had severe cognitive impairment, did not reject cares, had impairments on both sides upper and lower, and was dependent for all cares and movement. During an observation on 12/15/2025 at 3:38 PM, Resident #59's right-hand was contracted and without the use of a resting hand splint. During an observation on 12/16/2025 at 10:11 AM, 12/16/2025 at 12:48 PM, 12/17/2025 at 9:29 AM, and 12/17/2025 at 12:53 PM Resident #59 was in bed, without the use of a right resting hand splint. During an interview on 12/18/2025 at 9:20 AM, Certified Nurse Aide #7 stated Resident #59 did not have a brace/splint. They stated they did not place a brace on Resident #59 while providing cares. Certified Nurse Aide #7 stated they did not check the electronic medical record to confirm if Resident #59 required a right-hand splint/brace due to not being good with computers. They stated they did not discuss a right-hand splint/brace with unit nursing staff. During an interview and observation on 12/18/2025 at 9:36 AM, Licensed Practical Nurse #5 stated Resident #59 had a right-hand contracture. They stated they were not aware if Resident #59 wore a splint. During an interview on 12/18/2025 at 9:45 AM Registered Nurse Unit Manager #6 stated Resident #59 had a right-hand contracture and wore a splint daily from 8:00 AM to 8:00 PM. They stated they applied the right-hand splint this morning but did not apply the splint earlier in the week. They stated they were not aware if Resident #59 had the right-hand splint on earlier in the week. They stated they were not sure if they completed spot checks on Resident #59 to confirm if the splint was in place. They stated nursing staff were responsible for applying the right-hand splint each morning. During an interview on 12/22/2025 at 9:12 AM, the Director of Rehabilitation stated Resident #59 should have a right-hand splint on during waking hours daily. They stated they did not receive communication from unit staff regarding resident #59 not wearing the brace. 10NYCRR 415.12 (e)(2)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident?s assessment is updated at least once every 3 months. Based on interviews and record review the facility did not ensure the residents' Minimum Data Set assessments were completed not less frequently than once every three (3) months for one (1) of two (2) residents (Resident #44) reviewed for Resident Assessment. Specifically, a quarterly Minimum Data Set assessment was not completed three (3) months after the completion of the 06/28/2025 annual Minimum Data Set for Resident #44.The findings includeAn undated facility policy titled Comprehensive Assessment documented the Assessment Coordinator is responsible for ensuring that the Interdisciplinary Assessment Team conduct timely resident assessments at least quarterly.Resident #44's diagnoses included obstructive uropathy, unstageable pressure ulcer of sacral region and adult failure to thrive. An annual Minimum Data Set (a resident assessment tool) dated 06/28/2025 documented Resident #44 had severe cognitive impairment, was dependent for activities of daily living, and had one pressure ulcer. There was no documented evidence of a September/October 2025 quarterly Minimum Data Set.During an interview on 12/19/2025 at 11:14 AM Minimum Data Set Coordinator #3 stated Resident #44 had an annual comprehensive Minimum Data Set completed on 06/28/2025 and a quarterly Minimum Data Set should have been completed in September or October 2025. NY CRR 415.11(a)(4)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on record review and interview conducted during the recertification survey from 12/15/2025 to 12/22/2024, the facility did not ensure that Minimum Data Set 3.0 Assessments accurately reflected the residents' status for one (1) of seven (7) residents reviewed for Accidents. Specifically, the Minimum Data Set 3.0 annual comprehensive assessment did not identify Resident #9 as an active smoker.The findings included:An undated facility policy titled Comprehensive Assessment documented information derived from the comprehensive assessment helps the staff to plan care that allows the resident to reach his/her highest practicable level of functioning. Resident #9's diagnoses included nicotine dependence, unspecified paraplegia and bipolar disorder. The Resident Smoking Contract was signed and dated on 12/05/2024.The care plan updated 08/24/2025 documented monitor compliance with smoking contract, resident would be directed to designated smoking area and smoking screen to determine safety.The Annual Comprehensive Minimum Data Set (a resident assessment tool) dated 10/22/2025 documented Resident #9 was cognitively intact. The Minimum Data Set was not coded to indicate Resident #9 was an active smoker at the time of assessment.During an interview on 12/15/2025 at 12:10 PM Resident #9 stated they were an active smoker and had signed a smoking contract with the facilityDuring an interview and observation on 12/19/2025 at 11:06 AM, Minimum Data Set Coordinator #3 stated they completed the annual comprehensive Minimum Data Set assessment on 10/22/2025. They stated Resident #9 was coded as a non-smoker. They stated this was an oversight and Resident #9 should have been coded as a smoker. They stated they would modify the assessment.10NYCRR 415.11(c)(1)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, Interview, and record review the facility did not ensure they developed and/or implemented a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's needs for one (1) of five (5) residents (Resident #13) reviewed for Environment. Specifically, a care plan was not developed and/or implemented to address Resident #13's known hoarding behavior.The findings include:Resident #13 had diagnoses of chronic kidney disease and malignant neoplasm of the cervix.The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #13 was cognitively intact and did not display any inappropriate behavior.The Comprehensive Care Plan related to behavior initiated 10/15/2025 documented Resident #13 had episodes of refusing to go for dialysis treatment.There was no documented evidence a behavior care plan was developed to address Resident #13's hoarding behavior.On 12/16/2025 at 11:57 AM and 12/18/2025 at 3:45 PM, Resident #13's room was observed with six large clear plastic bags containing an assortment of clothing. The plastic bags were arranged on the periphery of Resident #13's rooms and were piled on top of each other on chairs blocking access to the sink, bathroom, and windows in the resident's room. There were several large plastic storage bins on two wire shelves against the wall on the far side of room from the doorway. Resident #13 was interviewed during the observation and stated they were unable to put their clothing away and organize their belongings. Resident #13 stated staff used to help them to go through their belongings. They stated they did not trust staff to put it away for them. On 12/19/2025 at 11:27 AM, the Case Manager was interviewed and stated Resident #13 had hoarding tendencies and did not allow anyone to touch the clothing in their room. Staff have attempted to clean out Resident #13's room. The former Director of Nursing had a set schedule and would regularly work with Resident #13 to remove extraneous items to prevent overcrowding in the room. They stated no other staff member has been assigned since the Director of Nursing left and there was no set schedule to help Resident #13 clean out their room. The Case Manager reviewed Resident #13's medical record and stated there was no care plan to address Resident #13's hoarding behavior and there was no system in place to prevent Resident #13's hoarding behaviors from increasing. On 12/22/2025 at 1:38 PM, the Director of Nursing was interviewed and stated it was tricky to address Resident #13's hoarding behavior and try to organize or discard extraneous items in their room. They stated Resident #13 did have a noncompliance care plan in place. If there was anything unsafe, the Director of Nursing stated staff would remove it from Resident #13's room. 10 NYCRR 415.12

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility did not ensure the resident plan of care was reviewed and revised for one (1) of three (3) residents (Resident #13) reviewed for Rehabilitation Services. Specifically, Resident #13 had a care plan intervention for bilateral siderail enablers and was observed without enablers in place. Resident #13 had diagnoses of chronic kidney disease and malignant neoplasm of the cervix.The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #13 was cognitively intact and was independent in rolling to the left and right in bed.The Comprehensive Care Plan related to activities of daily living performance and physical mobility dated 08/28/2025 and last reviewed 09/10/2025 documented Resident #13 used top bilateral bed rails for rolling to the left and right in bed, bed mobility, and transfers from bed. The Comprehensive Care Plan related to impaired mobility dated 08/28/2025 documented Resident #13 was provided with bilateral 1/2 siderails to promote and assist with bed mobility. Nursing Bed Rail/Grab Bar assessment dated [DATE] documented Resident #13 needed a bedrail to increase independence with bed mobility and transfers in and out of bed.The Physician Order an order for Resident #13 to have siderails was initiated 08/27/2025 and discontinued on 12/10/2025.On 12/16/2025 at 11:57 AM, Resident #13 was interviewed and stated they used to have siderails on their bed to move more easily in bed. Resident #13 stated their siderails were removed and they did not know the reason.On 12/19/2025 at 12:50 PM, the Director of Rehabilitation was interviewed and stated the latest rehabilitation evaluation determined Resident #13 should have bilateral bedrail enablers in bed for mobility. The Director of Rehabilitation stated nursing was also responsible for conducting a safety assessment of Resident #13 to determine whether bedrails were appropriate. The Director of Rehabilitation checked the medical record and stated the last nursing assessment for bedrails was in 09/2025 and documented Resident #13 should have siderails. The Director of Rehabilitation stated they did not know why Resident #13's bedrails were removed and would need to communicate with the Nursing Department.On 12/22/2025 at 11:09 AM, Licensed Practical Nurse #11 was interviewed and stated they were responsible for updating resident care plans and Resident #13's care plan intervention for bedrails may not have been updated to reflect the resident's most recent bed mobility status.On 12/22/2025 at 1:38 PM, the Director of Nursing was interviewed and stated Resident #13 previously used bedrails for bed mobility but no longer was safe using them and the order for bedrails was discontinued. 10 NYCRR 415.11(c)(2)(i-iii)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335285	A. Building B. Wing	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Valley Center for Rehabilitation and Nursing	661 N Main St Spring Valley, NY 10977

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interview the facility did not ensure drugs and biologicals were maintained in accordance with currently accepted professional standards for storage. Specifically, the Three East High Side medication cart was found unattended in the unit corridor near the nursing station unlocked with one (1) drawer left open.The findings are:The policy titled Medication Storage dated May 2025, documented nursing staff shall be responsible for maintaining medication storage, and compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts and boxes) containing drugs and biologicals shall be locked when not in use.During an observation on 12/18/2025 at 4:00 PM, the Three East High Side medication cart was found unattended in the unit corridor near the nursing station unlocked with one (1) drawer left open. The medication carts assigned nurse, Licensed Practical Nurse #20 was not near the cart, not within eyesight of the cart and was in the unit's medication room behind a closed door. During an interview on 12/18/2025 at 4:09 PM, Licensed Practical Nurse #20 stated they knew the cart was supposed to be locked to prevent any resident or other nurse from having access to the medications.10 NYCRR 415.18