STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335311	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tolstoy Foundation Rehabilitation and Nrsg Center	100 Lake Road Valley Cottage, NY 10989

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews during an abbreviated survey (NY00364233/724313), the facility did not ensure the resident right to be free from abuse for 1 of 3 residents (Resident #4) reviewed for abuse. Specifically, on 12/10/2024 Resident #4 reported that their roommate Resident #5 hit them during a verbal altercation. Resident #4 stated Resident #5 propelled their wheelchair over to their side of the room and struck them two times on their left chest/neck area.The findings are:The facility Abuse Prohibition Protocol policy last reviewed January 2024 documented all residents have the right to be free from physical and mental abuse. The facilities undated Assaultive Resident (Resident to Resident Altercation) policy documented the residents of the long-term care facility are protected from any physical and mental mistreatment from other residents. Resident to resident altercations is reported immediately to the charge nurse and supervisor. An individualized plan for monitoring resident behavior is developed. Psychiatric services are consulted, and a determination is made whether a resident is a danger to their self or others. Resident #4 was admitted with diagnoses including but not limited to Atrial Fibrillation, Hypotension and Cardiomegaly.A Quarterly Minimum Data Set, dated [DATE] documented Resident #4 was cognitively intact. The resident exhibited other behavioral symptoms not directed towards others and used a wheelchair or a walker for locomotion. The resident required set up assistance with eating and bed mobility, maximal assistance with toileting and moderate assistance with transferring.Review of a physical abuse care plan last revised 9/26/2024 documented Resident #4 had a potential for physical abuse. Interventions listed included to assess and anticipate the residents' needs and monitor/document/report as needed any signs and symptoms of abuse such as mood changes or behaviors.2) Resident #5 was admitted with diagnoses including but not limited to Acute Kidney Failure, Hypotension and Hyperlipidemia. A Significant Change Minimum Data Set, dated [DATE] documented Resident #5 had moderate cognitive impairment and did not exhibit any physical behaviors towards others. The resident required a walker or a wheelchair for locomotion. The resident required set up assistance with meals, supervision with toileting and transfers and independent with bed mobility.Review of an impaired cognitive function care plan last reviewed 10/18/2024 documented Resident #5 had impaired thought processes related to metabolic encephalopathy. Interventions listed included ask yes/no questions to determine the residents' needs and cue, reorient and supervise as needed. Review of an abuse care plan initiated 9/20/2024 documented Resident #5 had potential for abuse. Interventions listed included analyze the time of day, places, circumstances, triggers and what de-escalates behavior and document, assess and anticipate the resident's needs. Review of an accident/incident report dated 12/10/2024 documented Resident #4 alleged that Resident #5 was upset because they were making too much noise with their audio novels on their tape player. Resident #4 stated Resident #5 cursed at them and wheeled over to them in their wheelchair and struck Resident #4 two times on their left chest/neck area. Review of the Director of Social Services progress note dated 12/10/2024 at 7:08 PM documented they spoke with Resident #5 who was alleged to have hit Resident #4 their roommate. Resident #5 admitted to going on the other side of the room and they stated they grabbed Resident #4 by the wrist. Resident #5 was relocated for safety and the resident's representative was informed of the situation.During a telephone interview on 7/29/2025 at 10:36 AM, the Director of Nursing #2 stated. The Director of Nursing #2 stated they do not recall the exact incident with Resident #4 and Resident #5, but they remember the residents did not get along. The Director of Nursing #2 stated Resident #4 and Resident #5 were separated and placed on different wings of the facility. The Director of Nursing #2 stated the staff received education following the incident on resident-to-resident abuse. 10NYCRR 415.4(b)(1)(i)

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews during an abbreviated survey (NY00347972) the facility did not ensure that the resident is free from physical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms for 1 out of 3 residents (Resident #3) reviewed for restraints. Specifically, on 7/10/2024 Resident #3 who was moderately cognitively impaired and needed moderate assistance for bed mobility was found in bed with their floor mats propped up against their bed and held in place with two wooden night tables preventing the resident moving out the bed. The investigation revealed Certified Nurse Aide #1 was responsible and that Certified Nurse Aide #1 believed that placing the mats that way will prevent Resident #3 from rolling out of bed. There was no documented physician need/order for restraints.The findings are:The facility Restraint-Free Environment policy last reviewed June 2021 documented the purpose is to ensure that Residents live in an environment which is restraint-free as possible. It is the policy of the facility to ensure that restraints shall only be used for the safety and well-being of the resident(s) and only after all alternatives have been tried unsuccessfully. Restraints shall only be used to treat the Resident's medical symptom(s) and never for discipline or staff convenience, or for the prevention of falls.Resident #3 admitted to the facility 2/15/2024 with diagnoses including but not limited to Metabolic Encephalopathy, Depression and Muscle Weakness.A Quarterly Minimum Data Set, dated [DATE] documented Resident #3 had moderate cognitive impairment. The resident exhibited physical/verbal behaviors directed towards others and refused evaluation and cares. The resident used a wheelchair for locomotion and required moderate assistance with eating and bed mobility and was dependent for toileting and transfers. The resident did not have side rails or restraints in use.Review of an impaired cognition care plan initiated 2/23/2024 documented Resident #3 had impaired thought process related to disease. Interventions listed included cue, reorient and supervise as needed and keep the resident's routine consistent, try to provide consistent caregivers as much as possible to decrease confusion. Review of the facility undated accident/incident investigation documented on 7/10/2024 at approximately 12:16 PM Resident #3 was found with mats propped up against their bed. This incident raised concerns regarding safety and proper care procedures. The investigation revealed Certified Nurse Aide #1 was responsible and believed that placing the mats in this manner would prevent the resident from rolling out of bed, thereby ensuring their safety. The facility investigation documented the facility was unable to substantiate a breach in the quality of care provided to Resident #3 as Certified Nurse Aide #1 believed their actions were keeping the resident safe. Although no physical harm came to Resident #3 the use of mats propped up is a physical restraint.Review of Certified Nurse Aide #1's statement dated 7/15/2024 documented on 7/10/2024 when they came to work in the morning, Resident #3's floor mat was already up. After Resident #3 ate breakfast, they became agitated, so they left the mat up to prevent the resident from falling and getting injured. The statement documented Certified Nurse Aide #1 wrote they never imagined a floor mat standing upright would be considered an issue or a form of restraint. During an interview on 6/3/2025 at 11:25 AM Licensed Practical Nurse #1 stated they have been working in the facility since 2012. Licensed Practical Nurse #1 stated Resident #3's floor mats were placed against the bed by the night shift for protection. Resident #3 was aggressive and was difficult. Licensed Practical Nurse #1 stated they do not recall if the floor mats were up when they saw the resident. The certified nurse aides are responsible for placing the floor mat. Licensed Practical Nurse #1 stated as a nurse if they saw the floor mats up, they would have removed the floor mats and the certified nurse aides would be educated. The floor mats should not be standing up; they should be on the floor. Licensed Practical Nurse #1 stated it would be considered a restraint, having the floor mats up. Attempts to interview Certified Nurse Aide #1 was unsuccessful.During an interview on 6/9/2025 at 2:47 PM the Assistant Director of Nursing #2 stated the incident that occurred on 7/10/2024 occurred during a federal survey. The Assistant Director of Nursing #2 stated the Federal surveyors asked them to enter Resident #3's room and when they entered the room the resident was lying on their back in the bed. The Assistant Director of Nursing #2 there was a floor mat on the left and the right sides of the bed, up against the side rails with two nightstands holding them in place. The Assistant Director #2 stated they spoke with Certified Nurse Aide #1 and Licensed Practical Nurse #1, both assigned to the resident and Licensed Practical Nurse #1 told the federal surveyors that Resident#3 placed the mats there. The Assistant Director of Nursing #2 stated Resident #3 could not move so they could not have placed the floor mats in that position. The Assistant

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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 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. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview during an abbreviated survey (NY00347972/724229, NY00364233/724313), the facility did not ensure an allegation involving abuse was reported immediately, but no later than two hours after the allegation is made if the events that cause the allegation involve abuse and to report the results of all investigations to the New York State Department of Health within 5 working days of the incident for 2 out of 3 residents (Resident #3, Resident #4) reviewed for abuse. Specifically, (1) on 7/10/2024 Resident #3 was found in bed with their floor mats propped up against their bed and held in place with two wooden night tables preventing the resident from exiting. The investigation revealed Certified Nurse Aide #1 who was responsible. The facility did not report the incident to the New York State Department of Health until 7/11/2024 and the 5-day investigative conclusion was not submitted to the New York State Department of Health until 7/17/2025; (2) on 12/10/2024 Resident #4 reported that their roommate Resident #5 had hit them after they were involved in a verbal disagreement. Resident #4 stated Resident #5 rolled over to them in their wheelchair and struck them two times on their left chest/neck area. The 5-day investigative conclusion was not submitted to the New York State Department of Health until 12/16/2024.The findings are:The Facility Abuse Prohibition Protocol policy last reviewed January 2024 documented the initial telephone report must be made as soon as a reasonable suspicion of abuse is found. The date and name of the person to whom the report was given is documented. The facility then has five (5) business days to complete an investigation. 1) Resident #3 had diagnoses including but not limited to Metabolic Encephalopathy, Depression and Muscle Weakness.Review of the facilities undated accident/incident investigation documented on 7/10/2024 at approximately 12:16 PM Resident #3 was found with mats propped up against their bed. This incident raised concerns regarding safety and proper care procedures. The investigation revealed Certified Nurse Aide #1 who was responsible and believed that placing the mats in this manner would prevent the resident from rolling out of bed, thereby ensuring their safety. The facility investigation documented the facility was unable to substantiate a breach in the quality of care provided to Resident #3 as Certified Nurse Aide #1 believed their actions were keeping the resident safe. Although no physical harm came to Resident #3 the use of mats propped up is a physical restraint.The facility did not report the incident to the New York State Department of Health until 7/11/2024. The 5-day investigative conclusion was not submitted to the New York State Department of Health until 7/17/2025.2) Resident #4 was admitted with diagnoses including but not limited to Atrial Fibrillation, Hypotension and Cardiomegaly.A Quarterly Minimum Data Set, dated [DATE] documented Resident #4 was cognitively intact. The resident exhibited other behavioral symptoms not directed towards others and used a wheelchair or a walker for locomotion. The resident required set up assistance with eating and bed mobility, maximal assistance with toileting and moderate assistance with transferring.3) Resident #5 was admitted with diagnoses including but not limited to Acute Kidney Failure, Hypotension and Hyperlipidemia. A Significant Change Minimum Data Set, dated [DATE] documented Resident #5 had moderate cognitive impairment and did not exhibit any physical behaviors towards others. The resident required a walker or a wheelchair for locomotion. The resident required set up assistance with meals, supervision with toileting and transfers and independent with bed mobility.The facility Investigative Summary dated 12/16/2024 documented on 12/10/2024 at approximately 6:00 PM, Resident #4 reported that their roommate Resident #5 hit them after they had a verbal disagreement about the volume of the television. The incident was unwitnessed. The Investigative summary documented the type of incident as a verbal altercation that escalated into physical contact. Resident #4 and Resident #5 were involved in a verbal altercation, during which Resident #5 struck Resident #4. No injuries were reported or observed following the incident. A full body and skin assessment was performed on Resident #4 by the Registered Nurse Supervisor and no signs of physical injury were identified.The 5-day investigative conclusion was not submitted to the New York State Department of Health until 12/16/2024.During a telephone interview on 7/29/2025 at 10:36 AM, the Director of Nursing #2 stated they do not recall the actual dates they submitted the documentation to the New York State Department of Health whether it was submitted late or not. The Director of Nursing #2 stated they no longer work in the facility and no longer have access to the documentation. 10NYCRR 415.4(b)(1)(ii)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews during an abbreviated survey (NY00374955/724315), the facility did not ensure a thorough investigation was completed for 1 out of 3 residents (Resident #1) reviewed for falls. Specifically, on 3/5/2025 Resident #1 had a fall while attempting to transfer themself from the bed to a chair. The accident/incident report submitted by the facility was incomplete with no investigative summary and no staff statements were obtained. The findings are:The facility Accident/Incident Reports and Investigations policy last revised January 2024 documented an accident/incident report shall be initiated for any outward event at the time of that event. An investigation will be initiated to analyze the event in order to prevent reoccurrence. An outward event is considered any unusual circumstance that occurs involving the safety and well-being of a Resident, such as falls. Registered Nurses assess the situation and initiate the accident/incident form and investigation. An investigation includes interview of staff working on the unit on the day and shift of the event with corresponding statements from each.Resident #1was admitted with diagnoses including but not limited to Diabetes Mellitus, End Stage Renal Disease and Benign Neoplasm of the Duodenum.An admission Minimum Data Set, dated [DATE] documented Resident #1 was cognitively intact. Resident #1 required a wheelchair or a walker for locomotion and had impairment to their upper extremities on both sides. The resident was independent with eating and required maximal assistance with toileting, bed mobility and transfers. Review of an accident/incident report dated 03/05/2025 at 4:00 AM documented Resident #1 had a witnessed fall while attempting to transfer their self from bed to a chair despite prior teaching and instructions to remain in bed due to instability. Resident #1 had been informed that they need assistance with transfers. Transferring independently was unsafe. While attempting to transfer independently Resident #1 slid down to the floor. Further review of the accident/incident report revealed it was incomplete and there was no documentation of Resident #1's representative being made aware of the fall. On 5/30/2025 at 4:10 PM the Assistant Director of Nursing provided a copy of the accident/incident report dated 3/5/2025, and stated only the top portion of the report was completed and they are unsure why Registered Nurse #1 did not complete the report.During a telephone interview on 06/03/2025 at 2:52 PM, Registered Nurse #1 stated they could not complete a statement for the incident that occurred on 03/05/2025 because they were short staffed, and they were working as the floor nurse and also supervising the facility. Registered Nurse #1 stated they documented in a progress note Registered Nurse #1 stated although they witnessed Resident #1's fall the proper process is to have the Certified Nurse Aides write a statement as they were called for assistance. Registered Nurse #1 stated they wrote everything in their progress note, but they did not complete the incident report. 10 NYCRR 483.12(c)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews during an abbreviated survey (NY00374955/724315, NY00364233/724313), the facility did not ensure that a comprehensive person-centered care plan was developed and implemented to ensure services were provided to maintain the residents' highest practicable physical, mental, and psychosocial well-being for 3 of 3 residents (Resident #1, Resident #4, Resident #5) reviewed for care planning. Specifically, (1) Resident #1 was identified as a high risk for fall on admission and there was no documented evidence of a fall risk care plan being initiated. Resident #1 sustained a fall on 3/5/2025 when they attempted to self-transfer from the bed to a chair and slid down to the floor; (2) on 12/10/2024 Resident #4 reported that their roommate Resident #5 had hit them after they engaged in a verbal disagreement. Resident #4 stated Resident #5 rolled over to them in their wheelchair and struck them two times on their left chest/neck area. Resident #5's room was subsequently changed on 12/10/2024 to another wing in the facility to ensure safety. There was no documented evidence of Resident #4, #5's abuse care plans being updated post incident.The findings are:The facility Development and Implementation of Resident Care Plans policy dated January 10, 2024, documented the purpose is to establish guidelines for development, implementation, and review of individualized care plans for Residents to ensure high quality, person-centered care. The facility is committed too creating and maintaining comprehensive, individualized care plans for each resident that address their unique needs, preferences, and goals, and promote their overall health and well-being. Upon admission, a comprehensive assessment of the Resident's physical, mental, emotional and social needs will be conducted by licensed nursing staff within forty-eight hours. Based on the assessment, an initial care plan will be developed within seven days of admission.1)Resident #1 was admitted with diagnoses including but not limited to Diabetes Mellitus, End Stage Renal Disease and Benign Neoplasm of the Duodenum.An admission Minimum Data Set, dated [DATE] documented Resident #1 was cognitively intact. Resident #1 required a wheelchair or a walker for locomotion and had impairment to their upper extremities on both sides. The resident was independent with eating and required maximal assistance with toileting, bed mobility and transfers. Resident #1 was at risk for pressure ulcers and had a pressure relieving device for their wheelchair and bedReview of a fall risk evaluation dated 2/26/2025 documented Resident #1 had a fall risk score of 14. The fall risk evaluation documented a score of 10 or higher indicated the resident was at high risk for fall.There was no documented evidence of a fall risk care plan initiated for Resident #1.During an interview on 5/30/2025 at 2:59 PM, Registered Nurse #2 stated the Assistant Director of Nursing, or the day shift supervisor is responsible for initiating the care plans for areas triggered on the admission assessment. Registered Nurse #2 stated the admission assessments are reviewed within a day of admission by the nursing supervisor or director of nursing, and if a care area is triggered then a care plan is initiated. During an interview on 6/2/2025 at 2:08 PM, the Director of Nursing #1 stated all residents should have a fall risk care plan implemented if they are identified as a risk for fall during the admission assessment.2) Resident #4 was admitted with diagnoses including but not limited to Atrial Fibrillation, Hypotension and Cardiomegaly.A Quarterly Minimum Data Set, dated [DATE] documented Resident #4 was cognitively intact. The resident exhibited other behavioral symptoms not directed towards others and used a wheelchair or a walker for locomotion. The resident required set up assistance with eating and bed mobility, maximal assistance with toileting and moderate assistance with transferring.Review of a physical abuse care plan last revised 9/26/2024 documented Resident #4 had a potential for physical abuse. Interventions listed included assess and anticipate the residents needs and monitor/document/report as needed any signs and symptoms of abuse such as mood changes such as behaviors.Review of an accident/incident report dated 12/10/2024 documented Resident #4 reported Resident #5 was upset that they were making too much noise with their novels on their tape player. Resident #4 stated Resident #5 cursed at them and wheeled over to them in their wheelchair and struck Resident #4 two times on their left chest/neck area.There was no documented evidence of Resident #4's abuse care plans being updated with the incident that occurred on 12/10/2024 or new interventions implemented. 3) Resident #5 was admitted to the facility on [DATE] with diagnoses including but not limited to Acute Kidney Failure, Hypotension and Hyperlipidemia. A Significant Change Minimum Data Set, dated [DATE] documented Resident #5 had moderate cognitive impairment and did not exhibit any physical behaviors towards others. The resident required a walker or a wheelchair for locomotion. The resident required set up assistance with meals

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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. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview during an abbreviated survey (NY00370834/724309) the facility did not ensure the comprehensive care plan was reviewed, updated, and revised for 1 out of 3 residents reviewed (Resident #2) for care planning. Specifically, Resident #2 had a Stage 2 pressure ulcer to their sacrum and bilateral buttocks. The pressure ulcer worsened to a Stage 4 pressure ulcer. The actual skin impairment care plan had no documentation of the sacral pressure ulcer, measurements, treatments ordered and there were no updates of wound progression and physician findings when physician finding reports were submitted to the facility.The findings are:The facility Development and Implementation of Resident Care Plans policy last reviewed January 10, 2024 documented the purpose is to establish guidelines for the development, implementation, and review of individualized care plans for the residents to ensure high quality, person-centered care. The facility is committed to creating and maintaining comprehensive, individualized care plans for each resident that address their unique needs, preferences, and goals and promote their overall health and well-being. Residents' progress will b monitored continuously, and assessments will be updated as needed to reflect any changes in condition or preferences. The care pan will be formally reviewed and updated at least quarterly, or more frequently if significant changes occur. Resident #2 was admitted to the facility on [DATE] with diagnoses including but not limited to Type 2 Diabetes Mellitus, Osteomyelitis and Hypertension.Review of Quarterly Minimum Data Set, dated [DATE] documented Resident #2 had severe cognitive impairment. Resident #2 had impairment on one side to the upper and lower extremity. The resident required a walker for locomotion. Resident #2 was dependent for all cares. Resident #2 was always incontinent of bladder and bowel. Resident #2 was at risk for pressure ulcers and had unhealed ulcers present. Resident #2 had a Stage 2 pressure ulcer which developed in the facility and a Stage 4 pressure ulcer that was present on admission. Review of an actual skin impairment care plan last reviewed 2/13/2024 documented Resident #2 had a Stage 4 pressure ulcer to their left heel. Interventions listed included clean left Heel wound with normal saline pat dry then apply calcium Alginate sheet daily one time a day for wound management, monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, maceration etc. to the Physician and pressure relieving/reducing mattress, pillows, to protect the skin and elevate heels while in bed.The actual skin impairment care plan had no documentation of the presence of Resident #2's sacrum/bilateral buttocks pressure ulcer. There was no documented evidence of measurements, treatments ordered and/or updates of wound progression and physician findings when physician finding reports were submitted to the facility. Review of the Assistant Director of Nursing #3's health status note dated 1/23/2025 at 11:04 AM documented Resident #2 was seen by the wound team on 1/22/2025. Resident #2's left heel wound is resolved. Resident #2's Stage 4 sacrum/bilateral buttocks pressure ulcer measures: 12 cm x 15 cm x 2.3 cm with 50% granulation, 50% slough/eschar in the center, heavy drainage noted. The treatment ordered is to cleanse site with normal saline solution, pat dry apply, Santyl, to the center of the pressure ulcer and pack loosely with sterile gauze, apply collagen and cover with super absorbent dressing daily. During a telephone interview on 7/30/2025 at 10:54 AM the Assistant Director of Nursing #2 stated the former wound care Physician visited the facility weekly and completed a weekly wound note, which was sent to the facility. The Assistant Director of Nursing #2 stated nursing is expected to document wound progression on the care plan if there was any improvement or decline and any changes to treatment orders. The Assistant Director of Nursing #2 stated the nurse is also responsible to document the wound care Physician's findings and update the residents care plan. The Assistant Director of Nursing #2 stated the Assistant Director of Nursing #3, or the unit nurses would update the residents care plans for the wound round notations. The Assistant Director of Nursing #2 stated they update the residents care plans occasionally as they used to be the Minimum Data Set coordinator. The unit managers should have updated the resident's care plans. During a telephone interview on 7/30/2025 at 12:38 PM the Assistant Director of Nursing #3 stated the nurse manager for the unit would be the one to update the resident's care plans after the wound care visits. The Assistant Director of Nursing #3 stated the unit managers also receive emails with changes, and they are responsible for updating the care plans and the orders in real time. 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
	335311	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tolstoy Foundation Rehabilitation and Nrsg Center	100 Lake Road Valley Cottage, NY 10989

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 an abbreviated survey (NY00374955), the facility did not ensure a resident with pressure ulcers received necessary treatment and services consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 1 out 3 residents (Resident #1) reviewed for pressure ulcers. Specifically, Resident #1 admitted to the facility on [DATE] was noted to have a Stage 2 pressure ulcer to their intergluteal medial cleft on their admission skin check. There was no documented evidence that the Physician was informed of Resident #1's Stage 2 pressure ulcer or of any treatments being ordered for the pressure ulcer. The findings are:The facility Prevention and Treatment of Pressure Ulcers policy last revised January 2024 documented it is the policy of the facility to prevent, care for, and provide treatment for decubiti. The Physician must be notified of any wounds or pressure ulcers at the time of assessment. Nursing Supervisors on all shifts should make daily rounds and personally supervise the preventative measures and treatment of Residents with ulcers and Residents prone to recurrent ulcers.Resident #1 was admitted with diagnoses including but not limited to Diabetes Mellitus, End Stage Renal Disease and Benign Neoplasm of the Duodenum.An admission Minimum Data Set, dated [DATE] documented Resident #1 was cognitively intact. Resident #1 required a wheelchair or a walker for locomotion and had impairment to their upper extremities on both sides. The resident was independent with eating and required maximal assistance with toileting, bed mobility and transfers. Resident #1 was at risk for pressure ulcers and had a pressure relieving device for their wheelchair and bed.Review of a potential for pressure ulcer care plan initiated 3/4/2025 documented Resident #1 was at risk related to low mobility. Interventions listed included educate as to causes of skin breakdown and follow facility policies/protocols for the prevention/treatment of skin breakdown.Review of Resident #1's skin check dated 2/26/2025 documented they had a Stage 2 pressure ulcer to their intergluteal medial cleft area present on admission with onset date unknown. The site did not have signs and symptoms of infection and Resident #1 denied pain to the area. The pressure ulcer measured 5 cm x 4 cm.Resident #1's Braden scale for predicting pressure ulcer risk evaluation dated 2/26/2025 documented the resident had a score of 18. Documented a total score of 12 or less indicated high risk for developing pressure ulcers.There was no documented evidence that the Physician was informed of Resident #1's pressure ulcer or of any treatments being ordered by the Physician on admission.During an interview on 5/30/2025 at 2:59 PM, Registered Nurse #2 stated they are not sure what happened with Resident #1's orders, as they usually get a treatment order from the Physician for pressure injuries. Registered Nurse #2 stated they did not get an order from the Physician for Resident #1's pressure injury and this was an oversight. During an interview on 6/2/2025 at 2:08 PM, the Director of Nursing #1 stated the nurses are supposed to inform the Physician if a resident has wounds on admission and to obtain treatment orders. The Director of Nursing stated there are standing orders for different stages of wounds, but the Physician needs to be made aware to determine which protocol to apply. 10 NYCRR 415.12(c)(1)