STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335316	A. Building B. Wing	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Roscoe Regional Rehab & Residential H C F	420 Rockland Road Roscoe, NY 12776

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Based on observations, interviews, and record reviews during the recertification and abbreviated surveys (NY00371177/803531, NY00331127/803522) from 08/21/2025 to 08/25/2025, the facility did not ensure that the facility had sufficient nursing staff to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial wellbeing of each resident. Specifically, the staffing of certified nurse aides from 07/26/2025 to 08/28/2025 during the night shift were at minimal levels on 24 of 34 shifts. The staffing of certified nurse aides on the evening shift, during the same period, fell below the minimum for a portion of the shift on 24 of the 34 shifts. The staffing of nurses on the night shift during the same period were at minimal levels for 26 of 34 shifts. Additionally, residents, family members, and staff expressed concerns about low staffing, long wait times in response to call bells, and delays in receiving care. The findings are:The Facility Assessment last reviewed 11/29/2024 documented the maximum capacity as 85 residents and two respite with an average census of 75 residents. The minimum staffing for nurses is one (1) registered nurse or licensed practical nurse on each unit for the day and night shifts. The minimum staffing for direct care staff/certified nurse aides was outlined as follows; six (6) certified nurse aides on day and evening shifts which is a 1:13.5 ratio and two (2) certified nurse aides on night shift with a 1:40 ratio. The Assistant Director of Nursing / Registered Unit Manager provided a list of all incontinent residents in the facility. The North Unit had a 43 bed capacity with three (3) empty beds, 20 of the 40 residents were documented as incontinent. The South Unit had a 44 bed capacity with seven (7) empty beds, 22 of 37 residents were documented as incontinent. A total of 42 of 77 residents were documented as incontinent.The Administrator provided a list of all resident that wandered in the facility. There were eight (8) documented residents that wandered. The Administrator provided a list of all residents that required assistance of two (2) people and a mechanical lift for transfers. There were two (2) residents documented as requiring two-person assistance with transfers, and 17 residents were documented as requiring a mechanical lift for transfers. A review of the staffing sheets from 07/26/2025 to 08/28/2025 documented that only the minimum staffing of two (2) certified nurse aides was met for night shift on 24 of the 34 dates reviewed. On 26 of the 34 dates reviewed documented that only the minimum of two (2) nurses was met on the night shift making one (1) medication nurse the supervisor/charge nurse as well. The evening shift staffing of certified nurse aides had fallen below the minimum levels for part of the shift on 24 of 34 dates for the same period. A review of the 11-7 Get Ups (residents gotten out of bed by night shift) document posted on the North Unit documented a daily shower for one (1) resident on the night shift when there was only one (1) certified nurse aide working.During an interview on 08/26/2025 at 8:53 AM, Resident #9 stated that they rang their call bell at midnight and three (3) other times during the night shift last night. They were not changed until 6:50 AM that morning. They stated they were very uncomfortable lying in bed with feces in their brief from midnight until 6:50 AM. They stated delays in care had happened before during the night shift. They had informed the former Director of Nursing after it had happened at least 4 times. They stated on the overnight shift, they sometimes had two (2) certified nurse aides and sometimes only one (1) certified nurse aide on the unit. During an observation on 08/26/2025 at 9:10 AM there was a strong smell of urine in Resident #37's room. A urine stain covering half of their bed was observed. During an interview on 08/26/2025 at 9:42 AM, the Staffing Coordinator stated staffing could be challenging but a lot of staff did volunteer to do split shifts, and they filled any shortages however they could. They did not use agency and the evening shift was the most difficult shift to staff. During the Resident Council Meeting on 08/26/2025 at 11:28 AM, Resident #13 stated that the response to call bells was not timely at night. It had been brought up at every single resident council meeting and they still did not have enough staff. Resident #13 stated they used the call bell to get changed on the 11PM to 7AM shift. They stated they could call at 12 AM and wait until 3AM to be helped. The call bell stays on until answered. During a follow up interview on 08/26/2025 at 1:51 PM, the Staffing Coordinator stated they covered call outs or shortages however they could. Sometimes staff would stay for part of the next shift or until their assignment was completed and leave before the shift was over. During an interview on 08/26/2025 at 2:51 PM, the Director of Nursing stated assumed the role of the Director of Nursing on 08/18/2025 but had worked at the facility since 2022. They just started to get involved with staffing and thought the minimums were adequate. The staff was able to get their tasks completed. The night shift certified nurse aides did get some residents out of bed in the morning, but they did not have to assist residents with showers. There were times when they had more than the two (2) certified nurse aides on night