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

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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	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 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 (continued on next page)

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

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 shift, but only three (3) regular certified nurse aides for night shift were currently employed at the facility and they did not use agency staff. They expected incontinence care and repositioning to be completed every 2 hours. They stated the 1:40 ratios were acceptable for the certified nurse aides on night shift. During an interview on 08/26/2025 at 3:32 PM, the Administrator stated they believed the minimum staffing numbers were adequate. The staff provided quality care even when staffing was at a minimum. They would like more staff on night shift but were struggling to get the staff. They made every effort to fill the vacancies and meet the minimums. Many staff were cross trained, and filled in at times. They were actively recruiting, offering competitive salaries, consistent units, incentives, sign on bonuses, and referral bonuses. The Administrator stated residents did not complain to them directly. They stated there were some call bell issues, which was reflected in the Resident Council minutes, but that had improved. During an observation and interview on 08/26/2025 at 4:35 PM, Resident #58 was observed down the end of the hall on the North Unit walking with their pants down on their lower legs with their brief exposed. The brief appeared large and low. Staff was informed by this surveyor and tended to the resident. The Assistant Director of Nursing stated that Resident #58 did walk around the units all day long. During an interview on 08/28/2025 at 5:30 AM, Licensed Practical Nurse #4 stated there was usually only one (1) certified nurse aide on each unit on night shift. They stated that some nights, call bells rang more often when there was only one (1) certified nurse aide working on the unit. They stated they helped with toileting residents and changing briefs when they could. During an interview on 08/28/2025 at 5:37 AM, Certified Nurse Aide #5 stated they were a regular certified nurse aide on night shift and usually the only certified nurse aide on the North Unit on the night shift. They stated a new aide was hire recently so now they had a third certified nurse aide split between the two (2) units on nights. They stated it is rough for one certified nurse aide to work alone on the night shift. They stated call bells rang all night, and it was crazy busy. They stated they were assigned to wash and dress three (3) to four (4) residents every morning, and to assist Resident #79 to shower every morning (documented on an assignment list posted at the nurse's station). They stated nurses helped if they could but had medications and treatments and other tasks to complete. They stated that residents might wait for hours for assistance. They further stated that Residents #13, #24, and #59 had loose stools routinely on night shift and required more time to be cleaned. During an interview on 08/28/2025 at 5:48 AM, Registered Nurse Supervisor #6 stated they worked fulltime. They stated usually one night per week, in addition to performing their role as the Nursing Supervisor, they had to be the medication nurse on the unit. They stated the other nights there was a Licensed Practical (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Nurse on each unit. They also stated they were responsible for administering treatments every night and they helped as they were able with toileting, 2-person transfers, and answering call lights.10NYCRR 415.13(a)(1)(i-iii)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations, interviews, and record review during the recertification survey from 08/25/2025 to 08/29/2025, the facility did not ensure each resident was treated in a manner and in an environment that maintained or enhanced each resident's dignity and respect for four (4) residents (Resident #11, Resident #20, Resident #64, Resident #74) observed during dining. Specifically, during dining observations for lunch in the main dining room on 08/25/2025 and 08/26/2026, staff did not serve all residents sitting at tables together, and residents were observed waiting while other residents at the same table were eating and finishing their meals. The findings are:The facility Dining Room Service Policy last reviewed 11/2019 had no documented evidence of serving instructions by table in the dining room. During an observation in the main dining room on 08/25/2025 at 12:42 PM, Resident #11, Resident #9, and Resident #38 were sitting together at the same table. Resident #38 was finishing their lunch, Resident #9 was not eating but had been served their food, and Resident #11 was waiting to be served. Resident #11 was served as Resident #38 was finishing. During observations of lunch in the main dining room on 08/26/2025 starting at 12:07 PM, Resident #64 was sitting at a table with Resident #27 and Resident #35. Resident #27 and Resident #35 had received their food. Resident #64 had not received their food and was calling out hello, I need some food multiple times over a time span of approximately ten minutes. At another table, Resident #42 was sitting with Resident #20. Resident #42 was almost done with their meal and Resident #20 had not been served yet. They received their food when Resident #42 was done with their meal. At a third table, Resident #76 and Resident #74 were sitting together. Resident #76 already had their food, but Resident #74 was waiting to be served for at least ten minutes or more.During an interview on 08/27/2025 at 12:41 PM, the Director of Dietary stated that food should have been served by table so that residents sitting together ate at the same time. Staff involved with the tray distribution should have been looking at that when they served residents. During an interview on 08/27/2025 at 4:11 PM, the Assistant Director of Nursing stated that residents sitting at the same table should have been served at the same time. They tried to organize the meal tickets, but it was not always followed.10NYCRR 415.5(a)

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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. Based on interview, observation and record review during the recertification survey from 08/25/2025 to 08/29/2025, the facility did not ensure residents received care consistent with professional standards of practice, to prevent pressure ulcers and to prevent worsening of pressure ulcers for two (2) of three (3) residents (Residents #7 and #76) reviewed for pressure ulcers. Specifically 1) for Resident #7, treatments recommended by the wound care physician were not ordered and there was no documented evidence that the treatments were administered, and 2) for Resident #76, the physician's order to offload their heels was not implemented as evidenced by observation.The facility policy titled Documentation of Pressure Ulcer and Chronic Wounds last revised June 2023 documented that the Assistant Director of Nursing (or skin nurse as designated by the Director of Nursing) will be the official baseline and subsequent reference point for all skin wound assessments and the provider will be updated the new skin issues and or change in condition. The facility policy titled Medication / Treatment Administration Documentation last revised June 2024 documented that all medications and treatments are charted as administered by signature of initials in the electronic medication or treatment administration record. The facility policy titled Physician Orders last revised July 2025 documented that all medication/ treatment orders are written on the physician order form or telephone order form and/ or entered into the electronic health record. The facility policy titled Consultants last revised February 2023 documented that consultants provide the facility with written, dated, and signed reports of each consultation visit. Such reports contain the consultant's recommendations, plans for implementation of his/ her recommendations, findings, and plans for continued service as appropriate. 1) During an interview on 08/25/2025 at 1:14 PM, Resident #7 stated they had wounds on their buttocks which were healing. The 07/17/2025 consultant wound note included documentation of a Stage 2 pressure wound right arm. It measured 2.0 x 2.4 centimeters, was a fluid filled blister with a duration of one day. The healing potential was fair, with estimated time to heal 1-2 months. The plan was offloading and treatment with Skin Prep. There was no documented evidence of a physician's order for a treatment to the Stage 2 pressure wound/fluid filled blister to the resident's right arm. The July 2025 Treatment Administration Record did not document evidence that a treatment was administered to the resident's Stage 2 pressure wound/fluid filled blister to the resident's right arm. The 07/18/2025 Quarterly Minimum Data Set documented one (1) Stage 2 pressure ulcer, not present on admission, and one (1) Stage 4 present on admission. The 08/21/2025 consultant wound note included documentation of a left buttock deep tissue injury of two (2) days duration, which measured 5.6 centimeters x 5.5 centimeters x 0.1 centimeter. Treatment was xeroform gauze. There was no documented evidence of a physician's order for a treatment to the deep tissue injury to (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the resident's left buttock. The August 2025 Treatment Administration Record did not include documented evidence that the recommended treatment was administered to the resident's left buttock deep tissue injury prior to 08/27/2025. During interviews on 08/27/2025 at 10:43 AM and 08/29/2025 at 12:33 PM, Registered Nurse Unit Manager #1 stated there was no documented evidence of a treatment order for the Stage 2 pressure wound to the right arm, and therefore a treatment was not documented as having been administered. They further stated there was no documented evidence of a treatment order for the left buttock deep tissue injury, and therefore a treatment was not documented as having been administered. They stated the treatment orders should have been placed by them or any other nurse on duty. They stated the Assistant Director of Nursing and the Nurse Managers were responsible for entering treatment orders. During an interview on 08/28/2025 at 12:54 PM, the Director of Nursing stated the Registered Nurse Manager was responsible to enter new treatment orders as recommended during wound rounds. 2) Resident #76's diagnoses included congestive heart failure, type 2 diabetes mellitus with mild non proliferative diabetic retinopathy and lymphedema. The 04/13/2025 physician's order documented to off load bilateral heels every shift. The 08/01/2025 Quarterly Minimum Data Set (resident assessment) documented Resident #76 had moderate cognitive impairment, bilateral lower extremity impairment, was dependent for bed mobility, was at risk for pressure ulcers/injuries and required pressure reducing device for chair and bed. The 08/05/2025 resident care plan titled Skin Integrity documented Resident #76 was at risk for skin integrity related to disease process. Interventions included: float heels in bed. During an observation on 08/25/2025 at 12:25 PM, Resident #76 was observed in bed with left heel boot in place, and right foot on mattress, not offloaded. During an observation on 08/28/2025 at 8:54 AM, Resident #76 was observed in bed with left heel boot in place, right foot on mattress, not offloaded. During an observation and interview on 08/28/2025 at 10:32 AM with Licensed Practical Nurse #11, Resident #76 was in bed, left heel boot in place and right heel offloaded on towel. Licensed Practical Nurse #11 stated Resident #76's physician orders were for a left heel boot while in bed and stated there was no physician order for right heel to be offloaded. They stated certified nurse aide staff usually applied the bootie and offloaded heels after cares. During a review of the electronic medical record with Licensed Practical Nurse #11, they stated there was an order for bilateral heels to be offloaded in bed and they would remind certified nurse aide staff to offload bilateral heels while Resident #76 in bed. During an interview and observation on 08/28/2025 at 11:02 AM, Certified Nurse Aide #9 stated they had provided cares to Resident #76 earlier. They stated they applied the left heel boot and offloaded the right heel due to Resident #76 stating their feet were hurting. They were unaware if Resident #76 had a certified nurse aide task for bilateral heels to be offloaded. During a review of electronic (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medical record with Certified Nurse Aide #9, they stated that floating heels in bed was documented under the Skin Integrity task for Resident #76 and therefore bilateral heels should always be offloaded by all certified nurse aide staff. During an interview on 08/28/2025 at 3:32 PM, the Assistant Director of Nursing/Unit Manager stated that resident heels should be off loaded when there is a physician's order and a care plan intervention to offload/float heels. They stated certified nurse aide staff were made aware of tasks by checking the electronic medical record Kardex every day before shift for assigned residents and during huddle at shift change. The expectation was that residents who were at risk for pressure ulcers had their heels offloaded. 10 NYCRR 415.12(c)(1)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review conducted during the recertification survey from 08/25/2025 to 08/29/2025, the facility did not ensure each resident received adequate supervision to prevent accidents. This was evident for two (2) of four (4) residents (Resident #18 and #4) reviewed for accidents and hazards. Specifically, 1) there was no documented evidence Resident #18 received frequent rounding or that adequate interventions were implemented following a fall on 05/04/2025 and the resident fell again on 05/06/2025 resulting a right hip fracture, and 2) Resident #4 had unwitnessed falls on 08/23/2025 and 08/24/2025 and there was no documented evidence that care plan interventions were updated after the falls, neurological checks were not completed for 48 hours after the 08/24/2025 fall as per facility policy, and there was no documentation of a visual assessment by a registered nurse or physician after either fall. Findings include: The facility policy titled Accident/Incident Investigation and Prevention, revised 06/2023, documented: It is the responsibility of the licensed nursing professional to implement care plan changes to prevent repeat incidents. All residents who have an accident/injury will be assessed by a registered nurse/supervisor according to the resident triage needs based on the injury. All accidents / injuries will have a documented evaluation in the designated section on the Accident/Incident Report not to exceed two shifts. Physical Therapy will complete the Post Fall Review Evaluation following each change in plane incident. 1) Resident #18 had diagnoses of right hip fracture and dementia without behavioral disturbance. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #18 was cognitively intact, did not display any behavior, sometimes felt lonely or isolated, had a fall without injury since their prior assessment, was incontinent of bowel and bladder, was not on a toileting program or schedule, was totally dependent on caregivers for assistance with transfers and toileting hygiene, was unable to ambulate, and required maximal assistance with bed mobility. The Care Plan related to falls initiated 06/12/2021 documented Resident #18 was at risk for falls due to cognition, medication, mobility, and unsafe behavior. The care plan was revised to include the following interventions to prevent Resident #18's falls: keep in high traffic areas when out of bed as of 06/12/2021,reacher as of 11/03/2022, a non-skid slip mat on the resident's wheelchair seat as of 02/20/2025, and non-skid shoes/slippers as of 03/10/2025. The Care Plan related to bed mobility initiated 06/11/2021 documented Resident #18 required the maximal assistance of one person for bed mobility and transfers as of 04/25/2025. The Fall Risk Evaluation dated 04/17/2025 documented Resident #18 was ambulatory with a device or gait issues, used narcotics and psychotropics, and had a recent change in medications. The Nursing Note dated 04/21/2025 documented Resident #18 was noted with increased weakness and asked for assistance to get out of bed to be toileted. Resident #18 required the maximum assistance of two people to transfer. The Activities Note dated 04/22/2025 documented an interdisciplinary significant change meeting was held due to Resident #18's episodes of incontinence and decrease in activity of daily living (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	status. The Care Plan related to toileting initiated 04/25/2025 documented Resident #18 had self-performance deficits and required maximal assistance with toilet transfers and tasks. The Medical Doctor Order and Medication Administration Record documented Resident #18 received oxycodone-acetaminophen 5-325mg at bedtime from 04/15/2025 to 05/05/2025. The Nursing Note dated 04/29/2025 documented Resident #18 used a wheelchair for ambulation and had sporadic periods of bladder incontinence. The Certified Nurse Aide Instructions as of 05/01/2025 documented non-skid shoes/slippers were used with Resident #28 for safety and documented Resident #18 chose to wear one sneaker and one slipper for traction and comfort. Incontinent care was provided as needed upon Resident #18's request. The Quarterly/Interim Performance and Nursing Evaluation dated 05/02/2025 documented Resident #18 was wheelchair dependent, had no lower extremity impairment, was incontinent of bowel and bladder, and required maximal assistance with toileting hygiene and transfers. The Fall Risk Evaluation dated 05/02/2025 documented Resident #18 was at risk for falls because they forgot to ask for assistance, was ambulatory with a device, was incontinent and toileted with assistance, had a recent medication change, had a fall within the past 90 days, and received narcotics and psychotropic medication. The Nursing Note dated 05/04/2025 documented the Licensed Practical Nurse reported Resident #18 was on the floor away from their bed in the sitting position. The note documented Resident #18 complained of five out of 10 back pain and was unable to recall how they go there. No injury was noted. The note documented frequent rounds were made, safety precautions were taken, Resident #18's call bell was within reach, non-skid footwear was encouraged, and Resident #18 would be monitored. The Medical Director was made aware and there were no new Medical Doctor Orders. The facility Investigation dated 05/04/2025 documented Resident #18 had an unwitnessed fall and was found on the floor of their room without footwear on and away from their bed at 4:30 PM. Resident #18 was provided with safety precaution education regarding calling for assistance when needed, had their call bell placed within reach, and would wear non-skid footwear. The investigation documented Resident #18 had no injuries at the time of the incident, neuro checks were initiated. A predisposing factor for Resident #18's fall documented Resident #18 transferred themselves without assistance. The Nursing Note dated 05/06/2025 documented Resident #18's roommate came to the nursing station at 3:15 AM and told the nurse Resident #18 was on the floor in their bathroom. Resident #18 was found on their bathroom floor with their left leg underneath their right leg and a nickel-sized hematoma above their right eyebrow. Resident #18 yelled in pain from their right leg. The Nurse Practitioner ordered to transfer Resident #18 to the hospital for evaluation. The facility Investigation dated initiated 05/06/2025 and completed 05/23/2025 documented Resident #18 was found on the floor of their bathroom at 3:15 AM, Resident #18 reported they hit their head and felt a crack when they fell to the floor. Resident #18 remained on the floor in the bathroom until (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	emergency medical services arrived due to possible right hip fracture. The investigation findings documented Resident #18 required the maximum assistance of 1 person to perform bed mobility, transfer, and for toilet transfers. Resident #18 was non-ambulatory and wheelchair dependent. Resident #18 required reminders to call for assistance, non-skid shoes/slippers, reacher, non-skid slip mat on the resident's wheelchair seat, and non-skid strips on their floor. The investigation documented Resident #18 was noncompliant with their care plan at the time of the fall and did not request assistance from staff prior to getting out of bed and going to the bathroom. Furniture was rearranged to promote safe toileting, and a fall mat was placed on the left side of Resident #18's bed. The former Director of Nursing documented there was no break in Resident #18's care plan. The Care Plan related to falls documented revisions to interventions on 05/06/2025 for non-skid strips to be placed on Resident #18's floor and 05/07/2025 for furniture arrangement to promote safe toileting. The Hospital Discharge Instructions dated 05/09/2025 documented an x-ray of Resident #18's right hip revealed comminuted fractures of the right proximal femur and right acetabulum with right inferior and superior pubic rami fractures. No surgical repair was necessary. The Nursing admission Assessment completed 05/10/2025 documented Resident #18 was readmitted from the hospital with a hip fracture. The Fall Risk assessment dated [DATE] documented Resident #18 was at high risk for falls and be placed in high traffic areas when out of bed to prevent self-ambulation. The Nursing Note dated 05/10/2025 documented Resident #18's bed was at the lowest position. The Physical Therapy Evaluation dated 05/12/2025 documented Resident #18 was evaluated following readmission from the hospital and was ordered toe-touch-weight-bearing. Resident #18's increased pain limited their passive range of motion. Mechanical lift for transfers and recliner recommended for positioning as Resident #18 tolerates. Sitting tolerance was not assessed secondary to Resident #18's complaints of pain. The Care Plan related to falls was revised on 05/13/2025 and documented a gym mat be placed on the left side of Resident #18's bed. The Care Plan related to transfers was revised 05/13/2025 and documented Resident #18 required a mechanical lift and the assistance of two people for transfers. The Nursing Note dated 05/13/2025 documented an interdisciplinary care plan meeting was held without Resident #18 or their designated representative in attendance. Mechanical lift required for safety. Resident #18 had stress-related incontinence and was assessed by the Orthopedic Doctor to be partial weight bearing on their right leg. The Medical Doctor Note dated 05/13/2025 documented Resident #18 was readmitted to the facility via telehealth visit. Resident #18 had a history of frequent falls. The Nursing Note dated 05/19/2025 documented Resident #18 was noted with increased frustration regarding having a recliner. Resident #18 was unable to comprehend reminders from nursing staff of recent right hip fracture and began yelling when reminded their mobility was limited. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility Investigation dated 05/25/2025 documented Resident #18 had an unwitnessed fall from their recliner in their room at 12:30 PM. Resident #18 was found by the Certified Nurse Aide, reported they slid from their chair, and reported pain to their coccyx. The investigation documented actions taken to address Resident #18's fall included toileting and Resident #18 be kept in high traffic areas when out of bed. The Nursing Note dated 06/09/2025 at 1:24 AM documented Resident #18 was found by a Certified Nurse Aide wandering the downstairs lobby hallways in a wheelchair. Resident #18 was confused, escorted back to their unit, and was placed on 15-minute checks. On 08/27/2025 at 12:59 PM, Resident #18 was observed in the fetal position asleep in their bed with their privacy curtain pulled all the way around the bed so that Resident #18 was not visible from the hallway. A gym mat was on the floor at Resident #18's left bedside. The other side of Resident #18s bed was observed with pillows and sheets wedged into a seven-inch gap between the resident's mattress and a wall. A thick white coaxial cable cord that ran along the base perimeter of the wall adjacent to Resident #18's bed was observed with enough slack by the foot of the resident's bed, the cable jutted out several feet from the wall, creating a tripping hazard. Resident #18 was barefoot, and blue slippers were observed at bedside. On 08/28/2025 at 8:00 AM, Resident #18 was observed lying in bed with no staff attending to them in their room. Resident #18's feet were bare, and their blue slippers were observed on their mattress near the foot of their bed. Resident #18's gym mat was not on the floor at bedside and was leaning up against a dresser several feet away from the resident's bed. Resident #18's wheelchair was positioned close to the resident's bedside with the seat facing Resident #18 where they lay. On 08/29/2025 at 10:39 AM and 11:02 AM, Certified Nurse Aide #14 was interviewed and stated they were familiar with and normally assigned to Resident #18. Certified Nurse Aide #14 stated they received daily report from the outgoing overnight shift aides letting them know what resident care was completed and what care tasks still needed to be addressed. Resident #18 had episodes of agitation and refusing care on the night shift. Nursing staff communicated changes on resident condition and/or falls verbally during shift change. Certified Nurse Aide #14 stated Resident #18 did have a fall, but they could not recall the details. Resident #18 was more independent with their activities of daily living and declined, requiring a mechanical lift for transfers after they fell. Resident #18 fell trying to self-transfer without calling for assistance. Resident #18 was inconsistent with their call bell use and made ongoing attempts to transfer themselves without staff assistance. Resident #18 had times where their attempts to transfer themselves were goal-oriented and, at times, wandered without clear direction. Certified Nurse Aide #14 stated Resident #18's fall prevention interventions included having a floor mat at resident bedside and never leaving the resident's wheelchair directly by the resident's bed. Resident #18 did not receive any special or increased supervision to address or prevent falls and was not on a toileting schedule. Certified Nurse Aide #14 stated the facility used 30- and 15-minute checks of residents at high risk for falls, but they were unsure whether this was ever implemented following Resident #18's falls. Resident #18 was sometimes unpredictable and refused to have their soiled brief changed depending on the mood the resident was in that day. Resident #18 had always been at risk for falls and Certified Nurse Aide #14 stated it was the resident's noncompliance with their plan of care and their unsafe behaviors that put the resident at increased risk for falls. Certified Nurse Aide #14 stated they reported any behaviors and refusals of care to the unit managers so the nurse could document. Certified Nurse Aide #14 stated the aides did not document all activity of daily living care provided to the residents, including resident bladder care, transfers in and out of bed, and turning and positioning. The Certified Nurse (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Aides were only required to document a resident's nutrition/meal intake and bowel monitoring record. On 08/29/2025 at 11:35 AM, the Unit Manager for Resident #18's unit, Registered Nurse #1, was interviewed and stated Resident #18 was at risk for falls, fell fracturing their right hip a few months ago, and now required more staff assistance with activities of daily living. Care plan interventions currently in place to prevent falls included floor mats at Resident #18's bedside, low bed, and rounding. Registered Nurse #1 stated Resident #18 called staff for assistance and did not attempt to transfer themselves without staff assistance. Registered Nurse #1 stated they were responsible for rounding on residents at the start of their shift and did not document their rounds. Registered Nurse #1 did not know the frequency of rounding on Resident #18 following their previous falls and was unsure if Resident #18 was ever placed on increased supervision/monitoring following falls to address their fall risk. Resident #18 was not on a toileting schedule, did not have a turning and positioning schedule, and did not have a schedule for being transferred out of bed. Registered Nurse #1 stated the nursing staff communicated with each other verbally regarding resident care needs and actual care provided to residents throughout the shift. The facility did not have a system in place for Certified Nurse Aides to document assistance provided to residents during transfers in and out of bed, bladder care, and/or bed mobility. Registered Nurse #1 stated they were able to gather the necessary information from the resident medical record to determine care provided to each resident. After reviewing Resident #18's medical record, Registered Nurse #1 stated they did not know details of bladder incontinence care provided to Resident #18 on the overnight shift or when Resident #18 last received bladder care from staff. On 08/27/2025 at 4:10 PM and 08/29/2025 at 1:43 PM, the Administrator was interviewed and stated incident investigations into incidents resulting in major injury involved gathering witness statements as a part of the process. Investigations into incidents without major injury were conducted without gathering witness statements. Resident #18's fall on 05/04/2025 did not result in an injury and no witness statements were gathered as part of the investigation. Resident #18's fall on 05/06/2025 resulted in a fracture and included witness statements from staff. The Administrator stated they were responsible for reviewing accident/incident investigation reports for completion, thoroughness, staff statements, and checking that new interventions were implemented. Certified Nurse Aides were expected to complete care tasks listed on each resident's Kardex (instruction list). Certified Nurse Aides verbally reported to other nursing staff when a resident refused care, and it was not provided. On 08/29/2025 at 1:47 PM and 3:12 PM, the Director of Nursing was interviewed and stated they started in this role as of 08/25/2025 but had been employed in various other nursing roles with the facility for a few years. The facility nursing department staffed on-call Registered Nurses available by phone when skilled assessment was necessary, and a Registered Nurse was not on site at the facility. The on-call Registered Nurses asked pertinent questions about a resident's status dependent upon the situation and received a verbal response from the Licensed Practical Nurse on site at the facility. Without conducting a first-hand visual observation of the resident in person or via video feed, the on-call Registered Nurse provided instruction to the staff at the facility. The verbal assessments conducted over the phone did not follow any formal set of questions or areas of assessment and were not documented in the resident's medical record by the Registered Nurse conducting them. The Director of Nursing stated they did not know if residents required a fall risk assessment following each fall incident and upon each fall incident. The Director of Nursing was asked to review Resident #18's Incident Investigation dated 05/06/2025 as they were documented as being he on-call nurse contacted by the nurse after Resident #18 was found on the floor. After reviewing the medical record, the Director of Nursing stated they did not recall which nurse called to report Resident #18's fall or the content of their conversation. The Director of Nursing stated they did not document in the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident's medical record because they were on-call. The Director of Nursing stated that if they were in the facility, they would document their notes in the medical record. After reviewing the medical record, the Director of Nursing stated Resident #18 also had a fall on 05/04/2025 and non-skid footwear was put in place a fall prevention intervention. The Director of Nursing stated nursing staff also documented frequent rounding of Resident #18 and stated that the term frequent rounding was not clearly defined or documented in the resident's record. Resident #18 was hospitalized following the 05/06/2025 fall and was readmitted on [DATE] with a right hip fracture and required a mechanical lift for transfers which was a significant decline from their previous mobility. Resident #18 received a Fall Risk Evaluation on 05/10/2025 upon readmission and was at high risk for falls. Resident #18 had another fall on 05/25/2025 when they slid from their recliner and the subsequent intervention was to keep Resident #18 in high traffic areas when out of bed. The Certified Nurse Aides received their instruction for each resident by posting a printed-out document on the back of each resident's door. When a nurse or physical therapist revises the resident's care plan interventions, that staff member was responsible for printing new Certified Nurse Aide Instructions and taping them to the resident's door, so the Certified Nurse Aides were made aware of any changes. On 08/29/2025 at 2:29 PM, the Medical Director was interviewed via telephone and stated they were on vacation and did not have access to Resident #18's medical record. Resident #18 was at risk had a fall in 5/2025 resulting in an inoperable right hip fracture. Since their hip fracture, Resident #18 was at a lower fall risk their mobility changed, and they required more assistance with activities of daily living. The Medical Director stated they reviewed Resident #18's prescribed medications to determine whether they were a contributing factor in the resident's fall risk, determined all medications were necessary, and made no changes to Resident #18's medication regime. The Medical Director stated Resident #18 did experience lasting pain from their right hip fracture and was still ordered to receive narcotic pain medications. 2) Resident #4 diagnoses included unspecified transient cerebral ischemic attack, congestive heart failure and atrial fibrillation. The facility policy titled Neurological Checks, revised 09/23/2022 documented: Neurological checks will be initiated if determined clinically necessary (resident was unable to verbalize head injury and/or resident on blood thinners) and following an unwitnessed fall, or a witnessed fall where the head is struck. If the fall was unwitnessed or there is a question of a head injury, neurological checks are completed as follows: upon fall/initiation, every 15 minutes for one hour, every 30 minutes for one hour, every one hour for two hours, every four hours for 24 hours and every shift for 48 hours. The Quarterly Minimum Data Set (a resident assessment tool) dated 08/01/2025 documented Resident #4 had mild cognitive impairment, was independent with transfers and was prescribed an anticoagulant medication (blood thinner). A physician order dated 5/9/25 documented to administer Eliquis oral tablet five (5) milligrams, one (1) tablet by mouth two (2) times a day for pacemaker. A care plan titled Falls dated 5/9/25 documented Resident #4 was at risk for falls related to a history of falls. Interventions included: Physical/Occupational therapy referral as needed and Fall Risk Tool completed per policy. The care plan was not updated with new interventions after the unwitnessed falls on 08/23/2025 and 08/24/2025. There was no anticoagulant care plan in place and there were no interventions to monitor for bleeding (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	due to anticoagulant use on other care plans. The Fall Risk Assessment Form dated 05/9/2025 documented Resident #4 was at risk for falls. A licensed practical nurse progress noted dated 8/23/25 at 11:52 AM documented the resident was found on the floor in bedroom. Upon entering room, the resident was laying on the floor, on their back, near the foot of bed with wheelchair by their feet. The resident had proper footwear on. The resident was attempting to self-transfer, reminded to ask for assistance as resident required assist of one (1) with transfers. Range of motion was within normal limits and vital signs stable. No complaint of pain or discomfort. The resident continued to have good humor and normal behavior for self. The resident was unsure if they hit their head. No bruising or swelling noted at this time. Physician and family made aware. Neurological checks initiated. A nursing progress noted dated 8/24/24 at 4:25 PM documented the Certified Nurse Aide reported that Resident #4 was found on the floor. Upon entering the room, resident found lying on their back with arms above their head, fingers clasped behind their head, next to bed with wheelchair behind them. Range of motion was within normal limits and vital signs stable. Resident had no complaints of pain or discomfort. Resident stated that they were unplugging cell phone charger and lost balance, sat back on the edge of the bed and slid to the floor. Physician notified, on-call registered nurse and family made aware. Resident reminded to ask for assistance. Recommend laying resident down in the afternoon. There was no documentation in medical record documenting Resident #4, who was taking a blood thinner medication, was assessed in-person or virtually/telehealth status post fall by a registered nurse, nurse practitioner or physician. There was no documentation in medical record of a status-post fall evaluation completed by Physical Therapy. A review of the Neurological Evaluation Form documented neurological checks started 08/23/2025 at 10:45 AM and ended during the 11:00 PM to 7:00 AM shift on 08/25/2025. There was no documentation that neurological checks were restarted back to every 15 minutes, 30 minutes, hourly and every four hours after Resident #4's second fall on 08/24/2025. The Accident and Incident report dated 08/23/2025 documented Resident #4 had an unwitnessed fall, was on anticoagulant therapy and neurological checks were initiated. The Accident and Incident reported dated 08/24/2025 documented Resident #4 had an unwitnessed fall and did not document Resident #4 was on anticoagulant therapy or that neurological checks were initiated. During an interview and observation on 08/28/2025 at 10:27 AM and 08/28/2025 at 11:15 AM, the Director of Nursing stated that when a resident has a fall and it is unwitnessed or they hit their head, neurological checks should be completed as per facility policy, an Accident and Incident report started, and the resident care plan should be updated with new interventions immediately. The Director of Nursing provided a copy of neurological check documentation starting at 10:45 AM on 08/23/25 and ending 08/25/2025 during the 11:00 PM-7:00 AM. They stated they had no further neurological check documentation. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interviews on 08/28/2025 at 10:51 AM and 08/28/2025 1:27 PM, Licensed Practical Nurse #11 stated they were working when Resident #4 had falls on 08/23/2025 and 08/24/2025. They stated both falls were unwitnessed and that they contacted the physician via text message and had telephonic conversations with on-call registered nurse after both falls. They stated they reported to on-call registered nurse that Resident #4's vital signs and range of motion were within normal range. Licensed Practical Nurse #11 stated Resident #4 was not assessed in-person due to the fall occurring during the weekend and there was no nurse in facility until the night shift. They stated they started neurological checks as per facility policy. Licensed Practical Nurse #11 stated they do not update resident care plans, and they were not aware if Resident #4's care plan was updated status-post the two falls. They stated they provided safety education to Resident #4 after the falls and did not receive new orders from the physician status-post falls. Licensed Practical Nurse #2 stated Resident #4 was not assessed by the night shift registered nurse on 08/23/2025 or 08/24/2025 and that Resident #4 would have been assessed by a registered nurse if the fall occurred during Monday to Friday when a registered nurse is in the facility. During an interview on 08/28/2025 at 3:19 PM, the Assistant Director of Nursing stated they were the on-call registered nurse on 08/23/2025 and 08/24/2025. They stated they had verbal conversation with Licensed Practical Nurse #11 on both occasions while the Licensed Practical Nurse was in Resident #4's room. They stated they would have presented to the facility if needed to assess Resident #4 if abnormal range of motion was reported. They stated range of motion was reported as unremarkable, vital signs stable and normal speech was reported by Licensed Practical Nurse #11. They stated based on the normal findings, Resident #4 did not require an in-person assessment. They stated that the expectation at weekends, would be the night shift registered nurse would assess Resident #4 at start of their shift after they received report of fall during shift change or review of the twenty-four (24) hour summary report on the facility electronic medical record. They stated the physician is notified of incidents and if emergency would provide a telehealth visit. During interviews on 8/29/25 at 1:43 PM and 3:28 PM, the Administrator stated that when a resident has a fall and there is no registered nurse in the building, the licensed practical nurse telephones the on-call registered nurse and/or the physician. Based on the information provided by phone to the registered nurse regarding the fall, the registered nurse provides the licensed practical nurse with verbal assessment directions. The Administrator stated Licensed Practical Nurse #11 contacted the physician and on-call registered Nurse and completed the assessment over the phone as the on-call registered nurse instructed. They stated the expectation would be that the night shift registered nurse would have rounded every resident in the facility during their shift and that they are not required to document on every resident they round on. During an interview on 08/29/2025 at 2:50 PM, the Medical Director stated they are contacted after a resident fall on cell phone either by text or call. They stated they usually ask if resident on anticoagulants, had a history of falls, and if the resident was hurt. They stated neurological checks are standard after every fall for 48 hours. They stated they were made aware of Resident #4's two falls and they did not assess Resident #4 via telehealth and did not document notes on electronic medical record due to no significant change in status. 10 NYCRR 415.11

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews during the recertification survey from 08/21/2025-08/25/2025, the facility did not ensure that the menus were followed for five (5) of 13 residents (Resident #65, Resident #19, Resident #29, Resident #44, and Resident #33) observed during dining. Specifically, 1) Resident #65 had requested a vegetarian diet and received meat items during meals, 2) Resident #19 did not receive cranberry juice as specified on their meal ticket and received soup that was not on their meal ticket; 3) Resident #29 received pureed tuna salad rather than pureed grilled cheese as specified on their meal ticket; 4) Resident #44's lunch meal ticket listed tomato soup on multiple occasion and tomato soup was not observed on the resident's food tray, and 5) Resident #33 received a baked potato rather than rice as specified on their meal ticket.The findings included: A facility policy titled Food Preferences, revised 03/2010, documented: It is the responsibility of the dietitian/diet technician/designee to interview each resident and /or family member to obtain the resident's preferences. The diet technician/dietician notes resident's preferences on the Nutritional Assessment. 1) Resident #65 had diagnoses which included unspecified fracture of left femur, asthma, and gastro-esophageal reflux disease. The admission Minimum Data Set, dated [DATE] documented Resident #65 was cognitively intact and was independent in eating. Physician orders dated 08/09/2025 and 08/11/2025 documented: house diet, regular texture, regular liquid consistency and weekly weights every Monday. The 08/11/25 resident care plan titled Nutritional Status, documented that Resident #65 was at risk for alteration in nutrition related to hip fracture, status post-surgery and below ideal body weight. Interventions included: house diet, regular consistency, and four (4) ounces Mighty Shake every day. Adjust meal plan as needed. A Dietary Nutritional Screen dated 08/11/25 documented no religious, cultural, ethnic food preferences, house diet provided with regular consistency and food/fluid preferences to be obtained by facility staff. During an interview on 08/25/2025 at 12:14 PM, Resident #65 stated the facility did not honor their requested vegetarian diet. They stated they informed staff, including certified nurse aides, nurses and dietary that they did not eat meat products. Resident #65 stated they had not met with a nutritionist/dietician since admission, just unit staff. During an interview and observation on 08/25/2025 at 1:20 PM, Resident #65's lunch tray contained a turkey sandwich, baked potato and broccoli. The lunch meal ticket did not document a vegetarian diet. Meal ticked documented: country pork with gravy (not observed on tray), baked potato, margarine, sour cream, broccoli. Diet was documented as regular house diet and regular liquids. Resident #65 stated they will request a tuna or egg salad sandwich as an alternative which is what they usually do at meals due to meat products consistently being included on trays. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 08/26/2025 at 8:57 AM, Resident #65's breakfast tray contained one (1) slice of French toast, one mighty shake, and coffee. The meal ticket documented two slices of bacon (not on tray). Resident #65 stated the one slice of French toast was not enough food and that they were hungry. Resident #65 requested staff provide some eggs for protein if possible. The Assistant Director of Nursing responded that eggs were not on menu this morning and the kitchen would send farina to the room. During an interview and observation on 08/27/2025 at 8:52 AM, Resident #65's breakfast tray included eggs, hashbrown and a mighty shake. Resident #65 stated they received a cheeseburger for dinner last night and turkey with stuffing for lunch on 8/26/26. The resident stated they did not request alternative during these meals and that they gave up. During an interview on 08/27/2025 at 12:03 PM Resident #65 stated they were offered a hot dog or hamburger for lunch. Resident #65 stated they refused offered items and requested non-meat item (potato salad). During an interview on 08/27/2025 at 12:04 PM, Certified Nurse Assistant #3 stated Resident #65 was a vegetarian and did not eat meat. They stated the kitchen/dietary had been informed Resident #65 did not eat pork /meat. They stated that Resident #65 had been served meat and had been offered a mighty shake, potato or non-meat alternative when this occured. During interviews and observations on 08/27/2025 at 12:08 PM and 08/27/2025 at 1:22 PM, the Assistant Director of Nursing/North Unit Manager stated the facility Dietician worked off-site. They stated Resident #65 was on a regular diet, no meat, and received mighty shakes. They stated they had not observed Resident #65 receiving meat products on meal trays. They stated they verbally informed the Director of Dietary of Resident #65's food preferences. During the interview, Resident #65's Dietary Assessment was observed. They stated they were not aware that entering a resident's dietary preference on the Dietary Assessment was an in-house staff responsibility and that the Dietary Assessment and resident care plan did not contain documentation that Resident #65 preferred a vegetarian diet. The Assistant Director of Nursing stated Resident #65's dietary preference of no meat products should have been included in Dietary Assessment and the resident care plan should have been updated to reflect resident dietary preferences. During an interview on 08/27/2025 at 4:08 PM, the Dietary Technician stated they were an offsite consultant and that new admission residents received nutritional assessments telephonically or by record review. They stated if a resident's dietary preference was documented on the hospital discharge documentation, they would enter it on dietary assessment form. If not documented on hospital discharge documents, in-house staff were responsible for capturing the resident's dietary preferences, documenting on dietary assessment form, providing the dietary preference information to dietary/nutrition staff and updating resident care plan. 2) During an observation on 08/25/2025 at 5:51 PM, Certified Nurse Aide #3 was observed assisting Resident #19 and Resident #29 with dinner. Resident #19's meal ticket had cranberry juice listed but it was not received, and no soup was listed but received and being fed to the resident. Resident #29 had pureed tuna on their plate, but their meal ticket documented pureed grilled cheese. During an interview on 08/25/025 at 5:51PM, Certified Nurse Aide # 3 stated the meal ticket for Resident #19 did not have the soup listed and was missing the cranberry juice as listed on the ticket. Resident #29 documented pureed grilled cheese, but they received pureed tuna salad. They stated (continued on next page)

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Roscoe Regional Rehab & Residential H C F	420 Rockland Road Roscoe, NY 12776

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	they checked that the consistency and ordered diet was correct but not that the contents of the tray matched the ticket exactly. The kitchen was responsible for making sure the tickets were correct. During an interview on 08/27/2025 at 12:18 PM, the Director of Dietary stated they were aware that Resident #65 did not eat pork/meat products, and that Resident #65 had received meat products on meal trays. They stated they were having difficulties with the meal ticket system and due to this, they were unable to change Resident #65's meal tickets to reflect dietary preference changes. The Director of Dietary stated they started the position in April 2025 and had just learned to change resident meal tickets on Monday, August 25, 2025. Therefore, Resident #65 had been served meat products since admission and had been provided alternatives when requested. During a follow-up interview on 08/27/2025 at 12:41 PM, the Director of Dietary stated that they that the meal tickets should match the contents of the tray and should be checked by the staff providing the prepared tray or the staff serving the meal in the dining room. 10NYCRR 415.14(c)(1-3)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews during the recertification survey from 08/21/2025 to 08/29/2025, the facility did not ensure that food was stored in accordance with professional standards for food service safety. Specifically, during observations of the main kitchen refrigerators and the North and South unit refrigerators, unlabeled, undated, and improperly dated food was discovered. The findings are:The facility policy, Food Receiving and Storage, last revised 12/2012 documented that food and nutrition products are inspected upon receipt and stored under proper conditions of sanitation, temperature, light, moisture, ventilation, and security. All opened items will be labeled and dated and discarded after three days once opened. All non-potentially hazardous foods/temperature controlled for safety food items will be labeled and dated and discarded after five days once opened.The facility policy, Food and Fluids Brought in for Residents by Family and Friends, last reviewed 3/21/21 documented that food may be brought in by family. Take out foods brought in for individual residents must be received in a covered container free from obvious signs of contamination. All foods and fluids brought in must be labeled with an individual resident's name and the date in which it was prepared or procured.During the kitchen tour with the Director of Dietary, that started on 08/25/2025 at 11:17 AM, an open loaf of bread with the expiration date of 05/24/2025 was observed in the walk-in refrigerator. In the aide two door fridge two open bottles of honey consistency cranberry juice had 6/4 written on the bottles. In the stand alone prep fridge, a personal lunch bag was observed. During an observation of the North Unit Refrigerator with the Director of Dietary on 08/25/2025 at 12:14 PM, a brown paper bag with [NAME] #2 written on it was observed. In the bag was a small hard plastic cup with a soiled napkin pushed in over noodles and broccoli. A black disposable food container was observed with a resident name, but no date. Two open containers of cream cheese spreads were observed with no name or open date written on the package. A yellow pudding was observed open with no name or open date written on the package. A Kentucky Fried Chicken take out cup with an exposed straw and frozen pink/red substance was in the freezer with no name or date written on the cup. During an observation of the South Unit Refrigerator with the Director of Dietary on 08/25/2025 at 12:25 PM, ice cream in a clear disposable container with a lid was observed with freezer burn on it and no name or date written on the container. An open sherbet container was observed with no name or date written on the package. Five containers were observed with a resident name written on them and a disposal date of 08/30/2025 on two containers and a disposal date of 08/31/2025 on three of the containers. There was no date indicating when the food was received or prepared. A plastic bag with an open container of ham lunch meat was observed with no name or date. A bag of crab meat was open, unsealed, with no name or date. An open bottle of juice with no name or open date. A yellow substance in a clear container with no name and a date that was unclear but appeared to read 5/15. During an interview on 08/25/2025 at 6:17PM, Registered Nurse Unit Manager # 1 stated that when the family brings in food, the family may put the sticker on the food with a date that the food will be disposed of as they did with the five containers dated 08/30/2025 and 08/31/2025. They do try to put the date the food comes in. They would have to check the policy to see the length of time it may stay in the refrigerator. They believe it is 4 days, 3 days and then dispose of it on the fourth day.During an interview on 08/27/2025 at 12:41 PM the Director of Dietary stated that staff should not have put their personal belongings in the refrigerator in main kitchen. There is a staff refrigerator. All food should be labeled when opened with a date. Personal resident food items in the unit refrigerators should be labeled with a name and date opened, or the date it was prepared. Food that is in the fridge should only be kept for three days. Uncertain if there is a time frame for freezer foods but should be labeled with name and date received. They are responsible for the kitchen and the unit refrigerators, but nurses should be labeling the food when received. 10NYCRR 415.14(h)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interviews and record review during the recertification survey from 8/25/25 to 8/29/2025, the facility did not ensure that resident grievances were acted on promptly, or responded to, for one (1) of one (1) resident (Resident #42) investigated for personal property. Specifically, Resident #42 reported a missing blanket and clothing to the Unit Manager/Assistant Director of Nursing and did not receive the results of the investigation or replacement of the items. Additionally, the facility ensure an inventory of the resident's personal property was conducted on admission or when items were brought in.The findings included:The facility policy titled Loss/Misappropriation of Resident Property, revised 06/28/2023, included: The facility shall exercise reasonable care for protection or resident's property from loss or theft. A Lost or Damaged Property Report is initiated by Nursing or Social Work. Written statements and other pertinent information are attached to the Lost Property Report. The facility policy titled Inventory and Release of Resident's Personal Property, revised 4/2025, included: The facility protects the personal property of a resident who has been admitted , transferred or discharged . Clothing and non-clothing items are inventoried on the Personal Property Inventory Record which is kept in the Medical Record and updated as needed following admission.Resident #42's diagnoses included cerebral infarction, type 2 diabetes mellitus and chronic kidney disease. The admission Minimum Data Set (a resident assessment tool) dated 08/04/2025, documented Resident #42 was moderately cognitively impaired and required partial moderate assistance with dressing. During an interview on 08/25/2025 at 2:19 PM, Resident #42 stated they were missing shirts, pants and a blanket. They stated they reported to the items to the Social Worker and Assistant Director of Nursing/Unit Manager over a week ago. They stated the missing clothing had been labeled with their name. They had not received follow-up on investigation or a return of any of the missing items/ reimbursement. During an interview and observation on 08/27/2025 at 1:31 PM , the Assistant Director of Nursing/Unit Manager stated Resident #42 reported a missing red blanket and did not report missing clothing. They stated they contacted the laundry department and the south wing staff where Resident #42 was previously located, and a search was conducted for missing blanket. They stated the red blanket was not located and staff reported they did not remember a red blanket with resident. They stated when a resident reports missing items, a Grievance/Missing Items Report should be completed and given to Director of Social Work who will investigate. The Assistant Director of Nursing/Unit Manager stated they did not complete a Grievance Report or report to Director of Social Work. They stated Resident #42 was informed a red blanket could not be located and a different blanket was offered to Resident #42. The Assistant Director of Nursing/Unit manager stated a Resident inventory form should be completed when residents are admitted and when new items are bought in to the facility. During interview and observation, the Assistant Director of Nursing/Unit Manager stated they were unable to locate a Resident Inventory checklist on the electronic medical record for Resident #42 and that the Minimum Data Set Coordinator or Activities Department may have a paper copy. During an interview and observation on 08/27/2025 at 1:57 PM with the Minimum Data Set Coordinator, they stated that Resident Inventory forms were documented on the facility electronic medical system by nursing staff. During an observation of Resident #42's electronic medical record, the Minimum Data Set Coordinator stated they were unable to locate a Resident Inventory Form for Resident #42 and that they did not have a paper copy of the document. During an interview on 08/27/2025 at 2:02 PM, the Director of Activities stated they were responsible for resident inventory documentation up until April 2025. After that, the nursing department was responsible. They stated they did not complete a Resident Inventory Form for Resident #42 and did not know who might have completed the form. They stated they did not have paper copies of Resident Inventory forms. During an interview on 08/28/2025 at 11:20 AM, the Director of Social Work stated they were not aware of, and did not receive a Grievance/Missing Item Report, for Resident #42's (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	missing items. They stated the procedure for reporting missing items usually involved a resident or staff member verbally reporting missing items directly to them or to a member of the nursing staff and they would then complete a Grievance Report and start an investigation. Once the investigation was completed, they would report findings to the Unit Manager, Director of Nursing, Administration and the resident. If missing items were located during the investigation, they were returned to the resident and if not found, items could be replaced, or resident would be provided a refund for the cost of the item. 10NYCRR 415.5(c)(6)

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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 observation, record review and interview during the recertification survey from 08/25/2025 to 08/29/2025, the facility did not ensure the development and implementation of comprehensive person-centered care plans for each resident, consistent with resident rights that included measurable objectives and time frames to meet a resident's needs for two (2) of five (5) residents (Resident #28 and Resident #5) reviewed for unnecessary medications and medication regimen review. Specifically, Residents #28 and #5 were on anticoagulant therapy and there was no documented evidence that a care plan to address the risk of bleeding was developed with measurable objectives, goals and interventions. The findings include: The facility policy, Interdisciplinary Care Planning, last reviewed 4/15/2024 documented that at a minimum the initial care plan consists of Advance Directives, Transfer, Bed Mobility, Ambulation, Falls, Smoking (if applicable), Skin Integrity: At Risk, Elopement, Bladder, Bowel, and Nutrition/Feeding. All remaining focuses are entered within 24 hours of admission and include etiologies, initial goals and interventions as applicable. Care Plans for long term care residents will be reviewed by the Interdisciplinary Team within 21 days of admission and at least quarterly thereafter. Care Plans for subacute residents will be reviewed by the Interdisciplinary Team within seven (7) days of admission and at least weekly thereafter. 1). Resident #28 had diagnoses including atrial fibrillation, neoplasm of bone, soft tissue, and skin, and heart failure. The 12/15/2023 physician's order documented Eliquis Oral Tablet 2.5 mg (Apixaban) by mouth two times a day for atrial fibrillation. The 6/12/25 physician's order documented to apply protective sleeves to bilateral arms in the morning and take off at bedtime. The 7/16/25 physician's order documented to cleanse right forearm with normal saline, apply xeroform, cover with ABD pad and wrap with kling. When observed on 08/25/2025 at 12:38 PM, Resident #28 had an area of bright red colored uncovered skin to their right arm, above level of their protective sleeve. The 5/23/25 Quarterly Minimum Data Set (resident assessment) documented the resident was on anticoagulant medication, had no behavioral symptoms, had impairments to both upper extremities, and required partial supervision or touching assistance with upper body dressing. The 7/22/25 care plan did not include documented evidence of interventions to address the risk for bleeding related to the use of anticoagulant medication Eliquis for atrial fibrillation. The July 2025 Medication Administration Record documented Eliquis Oral Tablet 2.5 mg (Apixaban) was administered two times a day for atrial fibrillation. The 8/8/25 Annual Minimum Data Set (resident assessment) documented the resident was on (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	anticoagulant medication, had no behavioral symptoms, had impairments to both upper extremities, and required partial supervision or touching assistance with upper body dressing. The August 2025 Medication Administration Record documented Eliquis was administered as ordered every day through the current date. When interviewed on 08/28/25 at 10:34 AM, Registered Nurse Manager #1 stated they could not provide documented evidence that interventions were in place to address the risk of bleeding for the Resident #28 who was on Eliquis. They stated they were responsible for writing care plans and any other Registered Nurse could write a care plan. They stated the interdisciplinary team met quarterly to review resident care plans, and the anticoagulation care plan could have been written by anyone on the interdisciplinary team. When interviewed on 08/28/2025 at 12:55 PM, the Director of Nursing stated the Registered Nurse Manager was responsible for entering care plans. 2) Resident #5's diagnoses included schizoaffective disorder, deep vein disease, and major depressive disorder. A Quarterly Minimum Data Set (a resident assessment tool) dated 8/1/25 documented Resident #5 was severely cognitively impaired and was on an anticoagulant. A physician order dated 2/10/24 documented to administer Eliquis oral tablet 5 milligrams two times a day for deep vein disease. The Medication Administration Record from 07/01/2025 through 08/28/2025 documented Resident #5 was administered Eliquis oral tablet 5 milligrams two times a day for deep vein disease. When interviewed on 08/28/2025 at 3:39 PM, the Assistant Director of Nursing/Unit Manager stated they were aware there was not an anticoagulant care plan in place for Resident #5 and the care plan would be updated. 10 NYCRR 415.11 (c)(1)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on observation, record review and interview conducted during the recertification survey from 08/25/2025 to 08/29/2025, the facility did not ensure that necessary assistance and care were provided to carry out activities of daily living for one (1) of six (6) residents (Resident #37) reviewed for activities of daily living. Specifically, Resident #37 was observed lying in bed with urine soiled adult brief, pants and sheets. The findings included:A facility policy titled, Activities of Daily Living, revised 10/2023 documented: Each resident will receive, and the facility will provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. If a resident refuses care or has a change in condition, the certified nurse aide will alert the licensed nurse/nurse supervisor prior to the end of shift.Resident #37 had diagnoses including hemiplegia and hemiparesis following non-traumatic subarachnoid hemorrhage affecting right dominant side, type 2 diabetes mellitus and dementia with mood disturbance.The Quarterly Minimum Data Set (a resident assessment tool) dated 6/6/26 documented Resident #37 had moderate cognitive impairment, no behavior or rejection of cares concerns, and was always continent of urine and bladder. A resident care plan titled Toileting, updated 8/19/25, documented Resident #37 had self- performance deficiency related to cerebral vascular accident and right hemiparesis. Interventions included touching assistance for toilet transfers. A resident care plan titled Bladder, updated 6/17/25, documented Resident #37 was frequently incontinent of bladder. Interventions included to toilet upon request.There were no rejection of cares or behavior care plans in place. The certified nurse aide Kardex (care instructions) tasks included touching assistance for toilet transfers, moderate assistance with toileting, and minimal assist of one staff to provide verbal cues/encouragement for dressing.During an observation on 08/26/2025 at 9:10 AM, there was a strong smell of urine in Resident #37's room. A large (half the bed) urine stain was observed on Resident #37's bed sheets. During an observation on 08/27/2025 at 12:56 PM, Resident #37 was observed lying in bed with a urine soiled adult brief, pants and bedsheets.During an observation and interview on 08/27/2025 at 12:58 PM, Certified Nurse Aide #9 stated Resident #37 refused cares earlier in the shift. They stated Resident #37 did not have an adult brief changed since last night shift. They stated they reported rejection of cares to nursing staff earlier in shift. During interviews and observations on 08/27/2025 at 1:01 PM and 08/27/2025 1:13 PM, the Assistant Director of Nursing/Unit Manager stated Resident #37 had occasionally refused cares in the past. They stated Certified Nurse Aide #9 or #10 did not report refusal of cares earlier in shift and that the certified nurse aides should have reported and attempted to provide cares after initial refusal. During a review of the electronic medical record for Resident #37, the Assistant Director of Nursing/Unit Manager stated Resident #37 did not have a behavior or rejection of cares care plan in place and stated they should be in place. They stated nursing staff could have assisted in redirecting Resident #37 to allow cares had they been made aware of the refusal. During an interview and observation on 08/27/2025 at 1:04 PM, Certified Nurse Aide #10 stated Resident #37 refused cares this morning while they were assisting Certified Nurse Aide #9 with cares. They stated they did not report to nursing staff. They stated they did not recall if they came back to try to change Resident #37 another time. During an interview on 08/28/2025 at 3:54 PM, the Director of Nursing stated they were not informed by certified nurse aide staff on 08/27/2025 that Resident #37 was rejecting cares including toileting/dressing/hygiene. They stated Certified Nurse Aide #9 and/or #10 should have alerted a unit nurse and reapproached Resident #37 to complete tasks as needed. They stated residents should not be left soiled. During an interview on 08/28/2025 at 4:30 PM, the Administrator stated there were no certified nurse aide accountability records to document when a resident was provided cares except for bowel elimination and nutrition intake. They stated certified nurse aides followed the electronic medical record Kardex (care (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	instructions) guidelines. They stated certified nurse aide task completion was monitored by nursing staff on units and certified nurse aides were trained to report any task not completed to nurse staff. 10 NYCRR 415.12(a)(3)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews conducted during the recertification and abbreviated surveys (NY00331127/803522)) from 8/25/2025 to 8/29/2025, the facility did not ensure that a resident received treatment and care in accordance with professional standards of practice for one (1) of six (6) residents reviewed for medications. Specifically, Resident #85 had a physician's order for Levothyroxine Sodium Tablet 125 mcg by mouth daily, and there was no documented evidence that the resident received the medication as ordered on 12/30/2023. The findings are:The Policy and Procedure titled Medication Treatment Administration, last revised 6/2024, documented that all drugs and medications must be charted as administered by signature or initials in the Electronic Medical Treatment Administration record. Resident #85 had diagnoses including Adult Failure to Thrive, Hypertension, and Hypothyroidism.The Five-Day Minimum Data Set, dated [DATE] documented severe cognitive impairment. The resident was dependent on staff for activities of daily living. The Comprehensive Care Plan for Nutrition, dated 12/29/2023, directed administration of Endocrine medications per the physician's orders.A physician's order dated 12/29/2023 documented Levothyroxine Sodium Tablet 125 mcg, one tablet by mouth once daily.The Medication Administration Record for December 2023 did not include documented evidence that Levothyroxine Sodium Tablet 125 mcg had been administered on 12/30/2023.During an interview on 8/28/2025 at 9:34 A.M., Licensed Practical Nurse #7 stated that if a medication had not been signed in the Medication Administration Record, the medication had likely not been administered.During an interview on 8/28/2025 at 3:30 P.M., the Director of Nursing stated when medication was administered, the expectation was to sign for the medication to confirm administration. 415.12

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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 observations, interviews, and record review conducted during the recertification survey from 08/25/2025 to 08/29/2025, the facility did not ensure all drugs and biologicals were stored in locked compartments. This was evident for one (North Unit) of two units during dining observation. Specifically, Resident #44 was observed with a cup of medication at their bedside during lunch. The findings are: On 08/25/2025 at 1:22 PM, an observation was made of Resident #44 in their wheelchair in their bedroom with a small clear cup containing four pills (three tablets and one capsule) on the overbed table in front of them. Certified Nurse Aide #13 delivered a lunch meal tray to Resident #44 and placed it next to the cup of pills. On 08/25/2025 at 1:34 PM, Licensed Practical Nurse #12 was interviewed and stated they were the medication nurse for Resident #44 and delivered medication to the resident at approximately 11AM. Licensed Practical Nurse #12 was brought to Resident #44's room and observed the cup of pills on the resident's overbed table. Licensed Practical Nurse #12 stated they should have watched Resident #44 take their medication but the resident swallows one pill at a time and Licensed Practical Nurse #12 needed to ensure morning medications for the unit were administered prior to lunch service. Resident #44 was administered metformin, calcium plus vitamin D, omega, and fish oil. Licensed Practical Nurse #12 stated they would contact the Medical Doctor to review Resident #44's orders. 10 NYCRR 415.18(e)(1-4)

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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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on observation, record review, and interviews conducted during the recertification and abbreviated surveys (NY00331127/803522, NY00371177/803531) from 08/25/2025 to 08/29/2025, the facility did not ensure the facility-wide assessment was updated to determine what resources were necessary to care for residents competently during day-to-day operations. Specifically, the facility assessment did not indicate whether sufficient qualified staff were available on the night shift to meet resident needs. The findings are:The November 2024 facility assessment documented the maximum capacity as eighty-five residents and two respite, with an average census of seventy-five residentsDirect care staff included two Certified Nursing Aides on the night shift.Critical staffing on the night shift consisted of one Certified Nursing Aide to eighty residents.Mandatory overtime was used to maintain the above numbers, while these represented minimum staffing. Attempts were made to provide additional staff, up to ten per day, on the evening shift, and five per night shift.The facility provided a list of all incontinent residents in the facility. The North Unit had a forty-three-bed capacity with three (3) empty beds, and twenty residents were incontinent. The South Unit had a forty-four-bed capacity with seven (7) empty beds; twenty-two of the thirty-seven residents were documented as incontinent. A total of forty-two of the seventy-seven residents were documented as incontinent.The facility also provided a list of all the residents that wander. There were eight (8) documented residents that wandered.Residents #85 and #87's family members expressed concerns about low staffing, long wait times in response to call bells, and delays in receiving care.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 resident council meeting, and they still did not have enough staff. Resident #13 stated that they used the call bell to get changed on the 11 PM to 7 AM shift. They stated they could call at 12 AM and wait until 3 AM to get help. The call bell stayed on until answered.During an observation on 08/25/2025 at 12:00 PM, a strong urine odor was detected in the unit residents' dining room and hallway. During a telephone interview on 08/26/2025 at 11:22 PM with the nursing supervisor, it was reported that the regular Certified Nursing Aide had called out, and two Certified Nursing Aides had been mandated. Staffing for that night included the North Unit with one Licensed Practical Nurse and one Certified Nursing Aide. The South Unit had the Registered Nurse supervisor, one Certified Nursing Aide, and one float Certified Nursing Aide to assist.During an interview with a Certified Nursing Aide on 08/26/2025 at 11:26 PM, they stated they were mandated to stay until 3:00 AM. The Certified Nursing Aide stated that assistance was limited to providing brief changes and answering call lights, with no expectation of getting residents out of bed or showered.During an interview with residents' families on 08/27/2025 at 1:10 PM, concerns were expressed that staffing was unsafe, particularly at night. Families questioned how residents would be evacuated in case of a fire when only one Certified Nursing Aide was assigned to forty-three residents.During an interview on 08/26/2025 at 3:32 PM, the Administrator stated that the facility's minimum staffing numbers were considered adequate. The Administrator confirmed that staff provided quality care despite minimal staffing, but acknowledged challenges in recruiting additional staff for the night shift. Efforts were made to fill vacancies and meet the minimum requirements. Many staff members were cross-trained to cover shifts when needed. Recruitment included offering competitive salaries, consistent unit assignments, incentives, sign-on bonuses, and referral bonuses. Residents did not complain directly to the Administrator. Issues with call bells were noted in the resident council minutes; however, improvements were documented.10 NYCRR 415.26