

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335323	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER The Eleanor Nursing Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 419 North Quaker Lane Hyde Park, NY 12538	
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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, during an abbreviated survey (2596130) the facility did not ensure that residents received care in a safe, clean, and comfortable environment. Specifically, multiple ceiling tiles in multiple rooms had visible dark water stains: on Unit 1 (one) room [ROOM NUMBER], 109, & 110; on Unit 2 (two) in 218 the community room, the bathroom in 220, and room [ROOM NUMBER] & 227; on Unit 3 (three) room [ROOM NUMBER], 325 and 326. There were also multiple rooms with window curtains that were torn as well as tiles missing from under the bathroom sinks. The undated policy titled Policy and Procedure Manual Work Orders documents that maintenance work orders shall be completed in order to establish a priority of maintenance. The policy further documents that in order to establish a priority of maintenance service, items of concern to be addressed by the Maintenance Department are to be entered into the Maintenance Binder on each floor. Items that must be addressed immediately (loss of service, implications for safety, etc.) are to be notified to the Administrator or Director of Nursing, who will contact Maintenance to notify. On 09/18/2025 during the initial observation tour of the units the following was observed: stains on the ceiling tiles on unit 1 (one) in resident rooms [ROOM NUMBER]; on unit 2 (two) in 218 the community room, the bathroom in 220, and resident rooms [ROOM NUMBERS]; and on Unit 3 (three) in resident rooms 323, 325 and 326. In an interview with the Director of Maintenance on 09/17/2025 at 2:40pm they revealed that no formal system was in place to track maintenance needs or requests. They stated that there is a binder on each Unit for staff to record issues needing maintenance attention. They stated that staff are inconsistent in recording issues in the binder and instead often just mention the issues to maintenance staff when they are conducting their rounds through the facility. On reviewing the entries in the binder, it was noted they are not specific, some do not identify who made the entry some had no date of when the entry was made, and some had no date of when the issue was resolved and or who resolved the issue. The Director of Maintenance stated, I keep it all in my head-I know what needs to be fixed. A full building walkthrough was conducted with the Director of Maintenance from 2:45pm until 3:45pm, during which the surveyor identified torn curtains in resident rooms [ROOM NUMBERS], noisy exhaust fans in room [ROOM NUMBER], and sinks in rooms [ROOM NUMBERS] that produced banging and rattling noises when left dripping. During the walk through it was noted that the wall underneath the sinks in the bathrooms in rooms [ROOM NUMBERS] were missing ceramic tiles and had a piece of sheet rock screwed in place that did not cover all the gaps and openings in the wall. Also, during the walk through any observed stained or missing ceiling tiles were pointed out to the Director of Maintenance. Regarding the ceiling tiles, the Director of Maintenance stated that there are various leaks affecting the ceilings and some of the window/wall air-conditioning [NAME] units leak into the rooms because they were not installed properly. The Director of Maintenance was unable to state how many ceiling tiles needed to be replaced, when the tiles would be replaced, or when the work to remedy the leaks would be completed. The issues observed during the walk through were not documented on any maintenance list or schedule. The facility also failed to document a significant plumbing incident in which a pipe burst in the first floor Physical Therapy room, which resulted in water running through the hallway and towels being placed on the floor throughout the unit. Multiple staff interviews confirmed the event occurred, and eventually one corporate Human Resources staff member provided a date of 02/01/2025, referencing a text message requesting all hands-on deck. No formal documentation of the incident or of any corrective action taken was available. The Director of Maintenance stated they were not aware that the leak had occurred and did not know what had caused the leak, when it was fixed, or who fixed the leak. 10NYCR S483.10(i)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and interviews during an abbreviated survey (2596130) the facility did not ensure that sufficient nursing staff were available to meet the needs of residents as determined by the facility's own assessment. Specifically, the facility assessment date reviewed 03/25/2025 by Quality Assurance and Performance Improvement documented that the day shift would have a Charge Licensed Practical Nurse and a Med nurse per unit, this was not reflected in the staffing assignments. This staffing pattern contributed to medications being administered late for residents on the units with only 1(one) nurse providing care. The facility's documented assessment dated [DATE] indicated that on day shift each unit would be staffed with a medical nurse and a Charge Licensed Practical unit manager. However, on multiple dates including the observed date of 09/18/2025, units were staffed for the day shift with only one nurse responsible for approximately 30 residents. This staffing pattern did not align with the facility's stated plan and failed to support the clinical needs of residents. Review of the staffing assignment sheet for 09/18/2025 the 3rd floor and 2nd floor units were observed to be operating with only one nurse assigned to work on the day shift. Review of the staffing sheets for multiple dates in an approximate 1(one) month time frame reflected this same staffing pattern all for day shift, each floor is designated as a unit the first floor is the rehabilitation unit, the 2nd floor is the long-term unit, and the 3rd floor is the dementia unit and they all had approximately 30 residents at any given time: On 08/04/2025 there was one nurse assigned to work on the 2nd floor, on 08/14/2025 there was one nurse on the 2nd floor, on 8/22/2025 there was one nurse assigned on the 2nd and 3rd floor, on 09/01/2025 there was one nurse on the 2nd and 3rd floor, on 09/07/2025 there was one nurse assigned for both the 2nd and 3rd floor, on 09/08/2025 there was one nurse on the 2nd and 3rd floor, on 09/09/2025 there was one nurse assigned to work the 2nd floor, on 09/10/2025 there was one nurse on the 1st and 2nd floor, on 09/12/2025 there was one nurse for the 2nd and 3rd floor, and on 09/17/2024 there was one nurse assigned to work on the 2nd floor. In an interview on 09/18/2025 at 1:27pm with Registered Nurse #1 they stated they are scheduled to arrive at 9am and that they often work alone on various units whenever they work. In an interview on 09/18/2025 at 1:38pm with the Staffing Coordinator they stated that they schedule one or two nurses on each unit on the day shift, if they have it. They further explained that the first floor and the third-floor units are priorities for staffing. If they have nurses available two nurses are assigned to those units. In reviewing the staffing sheets for the month of August and September they noted the dates where there was only one nurse. They also stated that they were never made aware that any nurse had a habit of arriving late. In an interview on 09/18/2025 at 2:20pm with the interim Director of Nursing, they stated that the day shift should have one charge licensed practical nurse and one medication nurse per unit. Upon reviewing the schedule for 09/18/2025 together it was agreed that there was only one nurse assigned to the unit. They further stated that they had done the medication pass on various units and that it is possible for one nurse to administer medication to all the residents, but not if the nurse arrived at 9:00am. They added that they were not aware that any nurse had made a habit of arriving late. In an interview on 09/19/2025 at 12:44pm with the Administrator, they stated that their role regarding staffing is to assign department heads to ensure coverage and monitor the schedule and performance of staff. They stated that they would be made aware if there was a scheduling matter that needed to be escalated. They stated when notified they would then identify the root cause and exercise whatever action was necessary to fix the issue. Upon review of the facility assessment the Administrator agreed that it indicated that there should be two nurses on every unit for the day shift, but after looking at the various staffing sheets they stated that there were days when the facility had less nurses than the assessment indicated. 10 NYCRR S483.35(a)(3)</p>		

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<p>F 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews during an abbreviated survey (2596130) the facility did not ensure that the facility assessment accurately reflected the resources and staff needed to care for residents. Specifically, the facility assessment dated [DATE] reviewed by Quality Assurance and Performance Improvement documented that the day shift would have a Charge Licensed Practical Nurse and a Med nurse per unit, but this was not reflected in the staffing assignments. This staffing pattern contributed to medications being administered late for residents on the units with only 1 (one) nurse providing care. Review of the facility's assessment dated [DATE] reviewed by Quality Assurance and Performance Improvement indicated that each unit would be staffed with a medical nurse and a Charge Licensed Practical Nurse unit manager for the day shift. Review of the staffing assignment sheet for 09/18/2025 the 3rd floor and 2nd floor units were observed to be operating with only one nurse assigned to work on the day shift. Review of the staffing sheets for multiple dates in an approximate 1(one) month time frame reflected this same staffing pattern all for day shift, each floor is designated as a unit the first floor is the rehabilitation unit, the 2nd floor is the long-term unit, and the 3rd floor is the dementia unit and they all had approximately 30 residents at any given time: On 08/04/2025 there was one nurse assigned to work on the 2nd floor, on 08/14/2025 there was one nurse on the 2nd floor, on 8/22/2025 there was one nurse assigned on the 2nd and 3rd floor, on 09/01/2025 there was one nurse on the 2nd and 3rd floor, on 09/07/2025 there was one nurse assigned for both the 2nd and 3rd floor, on 09/08/2025 there was one nurse on the 2nd and 3rd floor, on 09/09/2025 there was one nurse assigned to work the 2nd floor, on 09/10/2025 there was one nurse on the 1st and 2nd floor, on 09/12/2025 there was one nurse for the 2nd and 3rd floor, and on 09/17/2024 there was one nurse assigned to work on the 2nd floor. In an interview on 09/18/2025 at 1:27pm with Registered Nurse #1 they stated they are scheduled to arrive at 9am and that they often work alone on various units whenever they work. In an interview on 09/18/2025 at 1:38pm with the Staffing Coordinator they stated that they schedule one or two nurses on each unit on the day shift, if they have it. They further explained that the first floor and the third-floor units are priorities for staffing. If they have nurses available two nurses are assigned to those units. In reviewing the staffing sheets for the month of August and September they noted the dates where there was only one nurse. They also stated that they were never made aware that any nurse had a habit of arriving late. In an interview on 09/18/2025 at 2:20pm with the interim Director of Nursing, they stated that the day shift should have one charge licensed practical nurse and one medication nurse per unit. Upon reviewing the schedule for 09/18/2025 together it was agreed that there was only one nurse assigned to the unit. They further stated that they had done the medication pass on various units and that it is possible for one nurse to administer medication to all the residents, but not if the nurse arrived at 9:00am. They added that they were not aware that any nurse had made a habit of arriving late. In an interview on 09/19/2025 at 12:44pm with the Administrator, they stated that their role regarding staffing is to assign department heads to ensure coverage and monitor the schedule and performance of staff. They stated that they would be made aware if there was a scheduling matter that needed to be escalated. They stated when notified they would then identify the root cause and exercise whatever action was necessary to fix the issue. Upon review of the facility assessment the Administrator agreed that it indicated that there should be two nurses on every unit for the day shift, but after looking at the various staffing sheets they stated that there were days when the facility had less nurses than the assessment indicated. 10NYCR S483.70(e)</p>		