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 04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Eleanor Nursing Care Center	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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews during a survey, the facility did not ensure the resident's legal representative upon written request was provided with a copy of the resident's medical records within 2 working days for 1 of 3 residents (Resident #117) reviewed for medical records. Specifically, on 3/10/25 Resident #117's representative requested copies of Resident #117 complete medical record. Resident #117's representative submitted an Authorization for Release of Health Information form to the facility on 3/10/25. The facility did not provide Resident #117's representative with copies of the medical records until 4/22/25. The Findings are:The facility policy titled Resident Medical Record, dated 5/2025, documented the facility will maintain records for each resident and ensure each resident's information is identified, records are secured and maintained in accordance with federal and state regulations. The facility did not have a written policy or procedure that directs staff to furnish records upon request from residents and/or their representatives. Resident #117 was admitted to the facility on [DATE] with diagnoses including but limited to Parkinson's Disease, Lewy Body Dementia and Chronic Kidney Disease.The admission Minimum Data Set, dated [DATE] documented the resident had severe cognitive impairment, required supervision for eating, moderate assistance for bathing, walked 10 feet with supervision and was frequently incontinent of bladder and bowel.Review of the Authorization for Release of Health Information form completed and dated 3/10/25 documented the resident's representative requested the resident's records from 2/14/25-present. The resident's representative signed and dated the form. Review of a letter from the facility Administrator to the resident representative dated 4/11/25 documented the cost of copies of the resident's record would be $315.00. The payment would need to be received prior to release of the records, and the check would need to be payable to the nursing facility. The package was sent on 4/22/25 by mail to the residents' representative who was the requestor after the check for payment was received by the facility. During an interview with the Finance Officer on 4/27/26 at 12:12PM they stated they were responsible for reviewing record requests and obtaining fees before releasing records. They stated they reviewed all the forms, requested payment and when that was received, they released the records. They stated they made sure the forms were properly dated. In this case the former Administrator received the request from the resident representative, provided a fee amount for the copies and sent a letter requesting payment for the records to the resident representative. Once payment was received the records were mailed to the resident representative. They stated the former Administrator took the task upon themselves and did not date the records and did not send them timely. They stated this was not their process. They reviewed the timeline of the documents requested and stated they were not aware of the two-day deadline and thought it was a 30-day window. 10 NYCRR 415.3(d)(1)(iv)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335323	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/28/2026
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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review conducted during the survey, the facility did not ensure residents' rights to a safe, clean, comfortable, and homelike environment on three (3) of three (3) units (Unit 1, 2 and 3). Specifically, 1. On Unit 2, room [ROOM NUMBER] had stains on the floor, a puddle of water near the radiator, spackle stains, molding peeling under the window, and the closet door was missing. In the bathroom, brown stains were on the toilet, wall tiles were missing. There were brown stains on the ceiling, and insect or debris accumulation inside the light fixture. room [ROOM NUMBER] had unpacked cardboard boxes, no closet doors, and broken drapes. 2) On Unit 1, room [ROOM NUMBER] had a hospital bed electrical power cord plugged into an electrical outlet that did not have an outlet cover in place. Exposed wires were observed in the electrical outlet. 3) On Unit 3, rooms [ROOM NUMBER] had either no curtains or curtains in disrepair. room [ROOM NUMBER] had broken dresser drawers.The findings are: The Policy and Procedure titled Resident Rights: Safe, Clean, Comfortable, and Homelike Environment, last revised 06/2025, documented that the facility will provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. 1.During the observation on 4/6/2026 at 12:15 PM, room [ROOM NUMBER] had stains on the floor measuring approximately three (3) to four (4) centimeters on either side of the bed. There was a puddle of water near the radiator. A large spackle stain was above the bed and spackle residue was above the sink. Approximately 10 centimeters of molding was peeling under the window, and the closet door was missing. In the bathroom, brown stains were present on the toilet, and three (3) wall tiles were missing. [NAME] stains were visible on the ceiling, and insect or debris accumulation was inside the light fixture. Review of the Unit 2 maintenance logbook on 4/23/2026, had no documentation of repairs needed for room [ROOM NUMBER]. During an interview on 04/23/2026 at 11:26 AM, Maintenance Supervisor #2 stated that the stained ceiling tiles resulted from a water leak caused by flooding on the floor above. The three (3) missing tiles would be replaced. Regarding the discolored flooring, the resident urinate on the floor, and repairs to the molding around the room would be completed. The spackle was work that was initiated. The debris in the light fixture would be cleaned. They stated the issues had not been addressed earlier as one staff member was absent and they were the only staff member currently working. They were responsible for maintaining the building and stated that the issues would be addressed immediately. During an interview on 04/23/2026 at 12:30 PM with the Licensed Practical Nurse Unit Manager #6, they stated room [ROOM NUMBER] required housekeeping and maintenance services. They stated that a process was in place to document maintenance concerns in a logbook when identified by unit staff. The Maintenance Department reviewed the log and addressed identified issues. The issues in room [ROOM NUMBER] were neither reported nor addressed. 2. During observations on 04/20/2026 at 10:50 AM and 04/24/2026 at 09:12 AM room [ROOM NUMBER] had a hospital bed electrical power cord plugged into an electrical outlet that did not have an outlet cover in place. Exposed wires were observed in the electrical outlet. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/24/2026 at 9:18 AM, the Maintenance Supervisor #1 stated the electrical cover was missing and someone probably changed the outlet and did not put the cover plate on. They stated they knew it was not good to have an electrical outlet with wires exposed and so close to the resident's bed. 3) During an observation and interview on 04/20/2026 at 11:04 AM, cardboard boxes were piled along the wall by the closet in room [ROOM NUMBER], there were no closet doors exposing all the items in the closet, and the drapes were not completely affixed to the track. The resident was present and stated they had a lot of boxes and things they wanted to put away. They purchased a shelf on 03/16/2026, but it had not been assembled, and they were waiting for approval. They stated the drapes had been broken since their arrival in the room. During observations of Unit 3 on 04/21/2026 between 10:39 AM and 2:24 PM, room [ROOM NUMBER] had no curtains or blinds on the window. room [ROOM NUMBER] had curtains falling, the rod was falling on left side of window and the hem was coming out on both sides. room [ROOM NUMBER] had a broken privacy curtain with 6 clips missing, and the window curtain was falling apart. room [ROOM NUMBER] had broken dresser drawers. During an interview on 04/22/2026 at 11:38 AM, Maintenance Supervisor #2 stated that housekeeping would fix the curtains, and maintenance would hang closet doors. Extra pieces of furniture needed approval prior to assembly. They rounded on the units daily, but they did not go to individual rooms on a regular basis. They stated they received work orders for specific repairs or requests, and rooms should have closet doors, but they did not have the doors for room [ROOM NUMBER], and they would need to be ordered. They stated the Director of Maintenance would need to approve and order the doors, but they were currently out on leave. The Administrator would cover approvals in their absence. During an interview on 04/22/2026 at 11:47 AM, the Administrator stated they were aware of the shelf that the resident in room [ROOM NUMBER] purchased and was not sure of the status. They stated all rooms should have closet doors and they would be ordered for room [ROOM NUMBER]. They stated the drapes were an ongoing project as they were replacing them instead of repairing them. They stated they ordered some of the replacements and have not put them up in all the rooms. 10NYCRR 415.15 (h)(1)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a grievance process that was clear and consistent, and prompt efforts were made to resolve grievances for one (1) of nine (9) residents (Resident #114) reviewed for activities of daily living, and 3 of 12 residents (Resident #61, Resident #107, and Resident #121) at a Resident Council meeting. Specifically, 1) Resident #114's resident representative reported a grievance on 06/16/2025 and there was no documented evidence that a thorough investigation was conducted, and the complainant was notified of the resolution. 2) Resident #7 filed a grievance on 04/07/2026 and did not receive a response. 3) Resident #61, Resident #107, and Resident #121stated at the Resident Council meeting that the grievance process was unclear and inconsistent.The findings included: An undated facility policy titled Grievance/Complaint Procedure documented that the Administrator was the Grievance Officer and that the Nursing and Social Service Departments participate in the implementation of the process. The facility must act upon grievances and recommendations promptly and must be able to demonstrate its response and rational. Grievance/Complaint forms should be filled out completely with as much detail as possible, including date of event, date of report and signature. Within ten working days of date filed, complainant will be informed orally of the results of the investigation and receive a written summary of the investigation. 1) Resident #114's diagnoses included diabetes mellitus type two (2) without complications, Wernicke's encephalopathy and cognitive communication deficit. The quarterly Minimum Data Set, dated [DATE] documented Resident #114 had severe cognitive impairment, no rejection of cares, required partial/moderate assistance with toileting, showering/bathing and dressing and was occasionally incontinent bladder/always incontinent bowel. A Concern Form dated 06/16/2025 at 8:30 AM documented it was reported by Resident #114's representative that on Sunday 06/15/2025 at 3:00 PM, Resident #114 was found with a soiled adult brief, in a gown, with no sheets on the bed and was wrapped in a throw cover. In addition, Resident #114's wheelchair had a towel soiled with feces. The rest of the form was blank; there was no documentation of investigation, follow-up, resolution, complainant notification of outcome or facility staff signatures. During an interview and observation on 04/22/2026 at 9:19 AM, the Director of Social Work stated the Concern Form dated 06/16/2025 was not completed, investigated or resolved. The Concern Form only contained the Documentation of Concern, and no facility signatures were present. They stated that when a resident/representative completed a Grievance/Concern form, usually found on the units, the nursing staff would provide the form to Social Work. Social Work, along with unit nursing staff perform an investigation and complete the form. Upon completion of the investigation, the Social Work Department will contact the resident/representative with resolution and plan of action to resolve the concern. They stated they started working at facility in 10/2025 and could not provide an answer as to why concern was not addressed. During an interview and observation on 04/22/2026 at 9:30 AM, the Director of Nursing stated the Grievance/Concern Report dated 06/16/2025 was not completed, investigated or resolved. They stated the Grievance Report should have been presented to Social Work, an investigation and (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resolution including resident/representative notification of resolution completed. They stated the nursing staff involved should have been counselled/in-serviced. The Director of Nursing stated they were not aware why the concern was not addressed as they were not employed at the facility at the time. 2) During a Resident Council meeting on 04/21/2026 at 10:27 AM, Resident #107 stated they completed a grievance regarding a sleeping staff member recently on an overnight shift but there was no follow up and they did not know what happened. During an interview on 04/23/2026 at 1:47 PM, the Director of Social Work stated they were aware of the grievance filed by Resident #107 and did not have it. They stated that they forwarded it to nursing and were unaware of the result. A Resident Concern/Grievance Form completed by Resident #107 documented an event on 04/07/2026 when they allegedly found a staff member sleeping during the night. The grievance had a response to the allegation from the staff member dated 04/24/2026 and an undated disciplinary action. There was no documentation of any follow-up with Resident #107. 3) During a Resident Council meeting on 04/21/2026 at 10:27 AM, Resident #121 stated they were unaware of the grievance process and there was poor follow up when a complaint was made. Resident #61 stated that when they made a complaint, staff said they would investigate but there was little follow-up. Resident #107 stated they completed a grievance regarding a sleeping staff member recently on an overnight shift but there was no follow up and they did not know what happened. During an interview on 04/22/2026 at 10:41 AM Licensed Practical Nurse #2 Unit 200 stated grievance forms were available in the dining area on Unit 200 and were placed in a locked box when completed. They were uncertain whether the Administrator or the Social Worker collected the forms. They would refer to Social Work for grievances. During an interview on 04/23/2026 at 1:47 PM, the Director of Social Work stated that there were grievance forms and collection boxes on Unit 100 and Unit 200. They collected the grievances and would address if applicable to Social Service, or they would be forwarded to the appropriate department. They stated the Grievance Policy needed to be reviewed. The new administration team was trying to review the facility policies and procedures, including grievances. Review of the Grievance binder had grievances from 2025 and none from 2026, the Director of Social Work stated they had a file with copies of others, and they did not keep a log to track them. During an interview on 04/27/2026 at 10:23 AM, the Director of Nursing stated that according to the policy, the Administrator was the Grievance Officer. The grievance boxes were installed on Unit 100 and Unit 200 recently, and the Administrator should be collecting the grievances from the box. The Grievance Officer should track the status of and response to grievances. During an interview on 04/27/2026 at 3:56 PM, the Administrator stated that according to the policy, they were currently the Grievance Officer and would be monitoring the grievances. There was no tracking process or log for grievances, but they would be working to fix the process. The grievance boxes were in the dining rooms on the 1st floor and 2nd floor units, but they were uncertain who collected the forms. The Administrator stated that the process was unclear and would be reviewed again. The grievances needed to be responded to in a few days. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10 New York Codes Rules and Regulations 415.3 (d)(1)(ii)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview during the survey, the facility did not ensure that residents who were unable to carry out activities of daily living received the necessary services to maintain personal hygiene for three (3) of nine (9) residents (Resident #114, Resident #6, Resident #1) reviewed for activities of daily living. Specifically, 1) Resident #114's did not receive showers or assistance as planned for activities of daily living. 2) Resident #6 did not receive showers as scheduled; and 3) Resident #1 was observed with scruffy stubble whiskers and stated they wanted to have their face shaved.The findings included: A policy titled Activities of Daily Living/AM/PM Care, last revised 05/2025 documented residents of the facility will be maintained at the highest practicable of well-being and will receive hygienic care at routine intervals during a 24-hour period as well as when needed to achieve above stated goal. A facility policy titled Certified Nurse Aide Documentation, last revised 12/2025 documented that documentation of activities of daily living performance will be maintained in the certified nurse aide record area of the electronic medical record. Certified Nurse Aides are expected to document the following items in the electronic medical record each shift: bathing/showers (includes complete bed bath), personal hygiene (includes wash by sink, partial hygienic care), toileting/bowel movements, eating/meal consumption, dressing, transfers, bed mobility, ambulation, skin condition and safety interventions. It is the responsibility of the certified nurse aide to document care provided for residents upon/following provision of care by certified nurse aide but no later than the end of the shift. Oversight of certified nurse aide documentation will be provided by Nursing Leadership; failure to complete documentation as required may result in outcomes including re-education, verbal and written counseling and up to and including suspension and termination for persistent failure to remediate practice. 1) Resident #114's diagnoses included diabetes mellitus, Wernicke's encephalopathy and cognitive communication deficit. The quarterly Minimum Data Set, dated [DATE] documented Resident #114 had severe cognitive impairment, no rejection of cares, required partial/moderate assistance with toileting, showering/bathing and dressing and was occasionally incontinent bladder/always incontinent bowel. The resident's care plans, dated 04/18/2025, Elimination: bowel incontinence and Elimination/Urinary Incontinence documented Resident #114 was incontinent of bowel and bladder function and required incontinent care. Interventions included monitoring redness or broken areas during toileting/diaper change every two (2) to four (4) hours. A review of the certified nurse aide documentation record documented Resident #114 did not receive a shower during the month of June 2025 and did not receive assistance with dressing, personal hygiene, toilet use, certified nurse aide care or skin check care for 12/30 days or transfers for 11/30 days for the month of June 2025. During an interview on 04/23/2026 at 12:10 PM Certified Nurse Aide #3 stated they did not always document all resident cares every day/shift due to lack of time and short staffing. They stated cares for some residents frequently would be performed late in the shift or left for the next shift to complete due to short staffing and high acuity of unit. Certified Nurse Aide #3 stated facility supervisors/unit (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	managers were aware that cares were not always documented on the electronic medical record and they have been in-serviced regarding documentation policy. During an interview on 04/23/2026 at 12:28 PM, Licensed Practical Nurse #4 stated they oversee certified nurse aide task completion on units. They stated they were aware that certified nurse aides frequently did not document completion of tasks on the electronic medical record. They stated when they observed cares not completed for a resident, they addressed it with certified nurse aide staff. They stated short staffing delayed cares and that Unit 3 had high acuity that increased difficulty in completion of tasks. They stated the Supervisor and Administration were aware of certified nurse aides not documenting cares and certified nurse aides had been in-serviced in the past. During an interview on 04/23/2026 at 2:56 PM Registered Nurse Supervisor #5 stated they were aware that some facility certified nurse aides did not document task completion. They stated they recently provided the Director of Nursing with daily reports of certified nurse aide tasks that were not documented. They stated the Director of Nursing had discussed this with certified nurse aide staff and provided in-services on documentation. They stated certified nurse aides had reported login/password problems and short staffing as primary barriers to completing task documentation. They stated that when certified nurse aides did not document task completion, it could not be determined if tasks were completed. They have reminded certified nurse aide staff that if tasks were not documented, they were not completed. During an interview on 04/24/2026 at 2:40 PM, the Director of Nursing stated they were aware of problems with certified nurse aides not documenting task completion in the electronic medical record and addressing this has been a priority improvement area since they started employment at the facility in 02/2026. They stated certified nurse aides have been in-serviced and disciplinary action has been started for not completing task completion during shift. They stated unit managers/supervisors were responsible for ensuring task completion on units. 2) Resident #6 had diagnoses that included multiple sclerosis (disease of the nervous system affecting mobility), neurogenic bladder (bladder dysfunction caused by nerve function), and anxiety. The Quarterly Minimum Data Set, dated [DATE] documented Resident #6 had intact cognition and was dependent on staff for showers. The March 2026 Certified Nurse Aide Accountability Record for Resident #6 documented omissions for bathing on 03/03, 03/06, 03/10, 03/13, 03/20, 03/27, and 03/31/2026. The April 2026 Certified Nurse Aide Accountability Record for Resident #6 documented omissions for bathing on 04/03, 04/10, 04/14, and 04/17/2026. During an interview and observation on 04/20/2026 at 10:49 AM, Resident #6 was observed in bed and stated they were waiting for morning care. They stated that showers rarely happen. They stated they were often given bed baths instead but wanted their showers when they were scheduled. During an interview and observation on 04/21/2026 at 10:35AM, Resident #6 arrived in their wheelchair for Resident Council and stated they had not received their shower and complained about their hair being dirty. Their hair appeared greasy. During an interview on 04/22/2026 at 11:14 AM Licensed Practical Nurse #2 stated that the assigned (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	showers were listed on the daily assignment. The certified nurse aides documented the showers in the electronic medical record. During an interview on 04/23/2026 at 3:58 PM, Licensed Practical Nurse #6 stated that showers were scheduled once to twice a week. They had been reviewing and adjusting the shower schedule to make sure all residents were offered showers twice weekly. They received a few complaints about missed showers but not from Resident #6. When reviewing the certified nurse aide documentation for Resident #6 from March and April 2026, they stated that bathing was not signed for Resident #6 on 04/03, 04/10, 04/14, and 04/17/2026, as well as 03/03, 03/06, 03/10, 03/13, 03/20, 03/27, and 3/31/2026. During an interview on 04/28/2026 at 12:26 PM Certified Nurse Aide #7 stated that Resident #6 was dependent on staff assistance for showers. They stated that it was not possible to give all showers as scheduled on days when there were only two certified nurse aides on the floor, especially for a dependent resident like Resident #6. It was possible some showers were missed. A bed bath should have been completed on those days instead. Both showers and bed baths should be signed for under the bathing section on the certified nurse aide documentation. 3) Resident #1 had diagnoses that included metabolic encephalopathy, unspecified psychosis not due to a substance or known physical condition and respiratory failure. The 5-day Minimum Data Set, dated [DATE] documented Resident #1 had moderate cognitive impairment and was independent for activities of daily living. A resident care plan titled Activities of Daily Living effective 03/11/2026 documented self-care deficits for personal hygiene related to cognitive status and medical condition requiring daily support of staff. Interventions included to set supervision for personal hygiene and supervision for bathing was effective 04/20/2026. During an observation and interview on 04/21/2026 at 12:50 PM, Resident #1 was had scruffy stubble whiskers on their face and stated they wanted to be shaved. The April 2026 Certified Nurse Aide Accountability Record for Resident #1 documented omissions for bathing from 04/01/2026 through 04/26/2026 and not performed on 04/27/2026; and documented omissions for personal hygiene from 04/01/2026 through 04/20/2026, 04/22/2026, and 04/24/2026-04/26/2026. During an observation and interview on 04/23/2026 at 9:56 AM Resident #1 still appeared with visible scruffy stubble whiskers. An interview at that time with Certified Nurse Aide #9 stated they provided assistance for Resident #1 with dressing, brushing teeth and shaving with an electric razor and that residents were offered a shave on their assigned shower days. Shaving did not occur every day, but they ensure Resident #1 has a clean shave. During an interview on 04/23/2026 at 2:00 PM the Director of Nursing stated Certified Nurse Aides should offer a shave to residents on their assigned shower day but can also offer everyday and as the resident requests. During an interview on 04/24/2026 at 11:10 AM Certified Nurse Aide #7 stated Resident #1 has a shower day on Monday 7-3 shift. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/27/2026 at 4:31 PM the Director of Nursing stated shaving would be documented under the Certified Nurse Aide task as personal hygiene. The lack of documentation for Resident #1 bathing and personal hygiene tasks were reviewed and the Director of Nursing stated they were aware of certified nurse aides not documenting task completion in the electronic medical record. 10 NYCRR 415.12 (a)(3)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335323	A. Building B. Wing	04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Eleanor Nursing Care Center	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 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 observations, interviews, and record review during the survey, the facility did not ensure that residents received treatment and care in accordance with professional standards of practice and the comprehensive care plan for 1 of 2 (Resident # 117) residents reviewed for antibiotics. Specifically, the resident was to receive 18 doses of Amoxicillin for a urinary tract infection, but three doses were omitted, resulting in receiving 15 of 18 doses.The findings include: The policy titled Administering Medications dated 5/2025 documented a licensed nurse will be responsible for passing medications to residents in accordance with techniques approved for use in the Facility, in compliance with New York State Codes, rules and regulations and with other applicable Federal and State LawsResident #117 was admitted to the facility on [DATE] with diagnoses Acute Urinary Tract Infection, Parkinson's Disease, Lewy Body Dementia.The admission Minimum Data Set, dated [DATE] documented the resident had severe cognitive impairment, required supervision for eating, moderate assistance for bathing, walked 10 feet with supervision and was frequently incontinent of bladder and bowel.The Comprehensive Care Plan titled Urinary Tract Infection dated 2/14/25 documented the resident had diagnosis of urinary tract infection requiring treatment with antibiotics. Interventions included to administer medications as ordered.The Physician Order dated 2/14/25 documented Amoxicillin 500 milligram capsule, give 1 capsule every eight hours for six days (6AM 2PM and 10 PM), for urinary tract infection.The February 2025 Medication Administration Record had omissions for Amoxicillin on 2/16/25 at 2PM and 2/17/25 at 2 PM and 10 PM. There was no documentation that explained the reason for omissions. The nurse's notes for the month of February 2025 had no documentation as to why the doses were not given.During an interview on 4/24/26 at 1:45 PM the Licensed Practical Nurse Unit Manager #1 stated if there was no documentation on the Medication Administration Record then the medication was not given. They stated the facility provided many in-service education sessions about signing off for medications and stated it was preventable. They stated nurses needed to check at the end of their shift to make sure medications were signed or put in a note if the medication was refused. They stated the resident really needed their antibiotics and should have received all doses.During an interview on 02/14/25 at 10:52 AM, the Director of Nursing stated the expectation was no omissions on the medication or treatment administration records. The Director of Nursing stated if a medication was not administered, the medication nurse should have documented the reason why the medication was not administered in a progress note or on the medication or treatment administration record. 10NYCRR 415.12

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and record review during the Recertification Survey conducted from 04/20/2026 to 04/28/2026, the facility failed to ensure residents received care consistent with professional standards of practice, to prevent pressure ulcers and to prevent worsening of pressure ulcers for one (1) of four (4) residents (Resident #115) reviewed for pressure ulcer. Specifically, Resident #115 was assessed at risk for pressure ulcers, had excoriation to the coccyx on admission and developed a Stage 3 sacral wound. The resident had deep tissue injury to both heels and a right post-surgical metatarsal toe amputation wound. Wound care treatments were not completed as ordered. The resident was not seen on wound rounds and there was no wound assessments documented from 04/21/2025 until 06/18/2025.The findings included:A facility policy titled Pressure Ulcer Identification, Prevention and Treatment, last updated 05/2025 documented Residents with actual pressure ulcers will be provided preventative measures in addition to the following: individualized treatment plan of care; to be reviewed frequently and revised as appropriate, treatments administered as ordered by physician, and weekly Wound Care Rounds with Facility Wound Specialist.A facility policy titled Licensed Nurse Documentation last revised 05/2025 documented purpose to ensure that all licensed nurses document patient care in a manner that is timely, accurate, complete, and legally defensible. Documentation must accurately reflect the resident's condition, the skilled services provided, and the resident's response to care, supporting the necessity of skilled nursing intervention. Documentation must occur as soon as possible after care is provided.Resident #115 was admitted with diagnoses including peripheral vascular disease with nonhealing right transmetatarsal amputation (mid-foot surgical procedure that removes toe and long bone before toe), diabetes mellitus, and Osteomyelitis.The hospital discharge instructions dated 04/21/2025 documented to follow-up with primary care provider at facility within 1 to 2 days, wound care center within one week after discharge, infectious disease within 2 weeks after discharge, and vascular surgery on 04/28/2025.The admission Nursing assessment dated [DATE] documented Resident #115 had deep tissue injury (DTI) to both heels, a wound at the right groin, a right foot wound/toe amputation, and excoriation to the coccyx.The admission Minimum Data Set, dated [DATE] documented Resident #115 had moderately impaired cognition, no behavioral symptoms or rejection of care. The resident was at risk for developing pressure ulcers and did not have any pressure ulcers. The resident had one venous ulcer, an infection of the foot and surgical wound. The resident required substantial/maximal assistance for bed mobility.The Treatment Administration Record and Physician order dated 04/21/2025 documented weekly skin checks on shower days, document any open areas in moment box and enter progress note with detailed description of any compromise with notification to physician and any treatment orders received. The Treatment Administration Records dated April 2025, and May 2025 had no documented evidence weekly skin checks were completed. The care plan dated 05/04/2025, Skin integrity: At Risk for Skin Breakdown, documented the resident was at risk related to incontinence and decreased ability to reposition self. The goal was the resident would maintain skin integrity and interventions included certified nurse aide evaluation of skin condition daily during care and report any skin abnormalities to the nurse, pressure reducing cushion in wheelchair, pressure reducing mattress, turning and position, off load extremities and encourage frequent changes in position. The care plan dated 05/04/2025 Skin Integrity-Presence of Vascular Ulcer documented the resident has ulcer of heel as a result of venous statis requiring local treatment and monitoring by wound round team. Interventions included administering medications as ordered, monitor for decline in status and intervene appropriately. Monitor for effectiveness of treatment and modify as indicated. Surgical consultation as ordered. Vascular consultation as ordered. Wound rounds weekly. The Treatment Administration Record and Physician order dated 04/25/2025 documented to apply zinc oxide to buttocks every shift; off load lower extremities and apply bilateral (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	heel booties every shift. The April 2025 Treatment Administration Record lacked documentation for these treatments on 7 of 42 shifts. May 2025 Treatment Administration Record lacked documentation for these treatments on 48 of 93 shifts.The Treatment Administration Record and Physician order dated 04/25/2025 documented to apply foam dressing to the left heel every other day. The May 2025 Treatment Administration Record lacked documentation for this treatment from 05/01/2025 to 05/14/2025.The Nurse Practitioner's wound care order dated 05/28/2025 documented to cleanse left heel unstageable ulcer with normal saline, pat dry, apply betadine, let dry and cover with dry clean dressing daily.The Nurse Practitioner's wound care order dated 05/28/2025 documented to cleanse the sacral ulcer with normal saline, pat dry, apply hydrocolloid and change every other day. The June 2025 Treatment Administration Record lacked documentation for this treatment 06/01/2025-06/06/2025.Nursing and medical progress notes dated 04/29/2025 to 06/06/2025 lacked documentation related to the sacral ulcer, including when it developed. There were no wound measurements for any of the resident's wounds. There was no documented evidence the resident was seen on wound rounds.A nursing progress note dated 06/06/2025 documented the resident was transferred to the hospital for abdominal pain.A nursing progress note dated 06/13/2025 documented Resident #115 returned from the hospital.The five (5) day re-entry Minimum Data Set, dated [DATE] documented Resident #115 was cognitively intact, had no rejection of cares, was occasionally incontinent urine, always incontinent bowel, was at risk for pressure ulcers, had two (2) Stage 3 and one (1) unstageable pressure ulcers present upon admission.A wound care note dated 06/18/2025 documented Resident #115 had a Stage 3 wound on the sacrum that measured 0.8 centimeters x 0.7 centimeters x 0.1 centimeter (length x width x depth) with moderate drainage, the treatment was hydrocolloid dressing; a Stage 3 pressure wound on the right heel that measured 1.5 centimeters x 1.2 centimeters x 0.1 centimeter, the wound bed was 100% eschar (dry dead tissue) with scant drainage, the treatment was betadine and a dry protective dressing: and an unstageable pressure injury on the left heel that measured 1.5 centimeters x 1.3 centimeters x 0.1 centimeters, the wound bed was 1000% eschar with scant drainage, treatment betadine and dry protective dressing.The sacral wound care order restarted 06/13/2025 documented to cleanse the sacral ulcer with normal saline, pat dry, apply hydrocolloid and change every other day. The June 2025 Treatment Administration Record lacked documentation for this treatment 5 of 16 days from 06/14/2025-06/30/2025.The left heel wound care order restarted 06/13/2025 documented to cleanse left heel unstageable ulcer with normal saline, pat dry, apply betadine, let dry and cover with dry clean dressing daily. The June 2025 Treatment Administration Record lacked documentation for this treatment 10 of 16 days from 06/14/2025-06/30/2025.During an interview and record review on 04/24/2026 at 12:57 PM Licensed Practical Nurse Unit Manager #1 stated they had provided treatments for multiple wounds for Resident #115. During the interview, Licensed Practical Nurse Unit Manager #1 reviewed the Treatment Administration Records, they stated there were numerous dates when the ordered wound treatments were not documented as completed. They stated there was no documentation to support why the treatments were not provided and that the cares may or may not have been completed. Licensed Practical Nurse Unit Manager #1 stated there had been shifts when they forgotten to document treatments for residents in the past due to workload and not remembering to complete treatment administration record documentation by the end of shift. They stated they were frequently the only nurse assigned to unit and were responsible for administering all the medications and treatments which left little time to complete documentation or an emergency could occur which prevented documentation.During an interview and record review on 04/24/2026 at 2:24 PM, the Director of Nursing stated they were aware of poor documentation by facility nursing staff. During a review of the Treatment Administration Record for Resident #115, they stated there were dates when physician ordered wound care treatments were not documented as completed by nursing staff. They stated they did not know if the prescribed wound care treatments were completed. During an interview on 04/27/2026 at 10:53 AM, the Medical Director stated Resident #115 was admitted with (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wounds including surgical wound. They stated they did not enter an order for wound care consultation upon initial admission in April 2025 and this was an oversight. They stated nursing staff should have added them to the wound consult list anyway and Resident #115 had one consult in the community by vascular physician early in admission. They stated Resident #115 was ordered to receive a weekly wound consult upon readmission [DATE]. The Medical Director stated they were not aware wound care treatments were not documented as completed and that nursing was responsible for documenting and completing treatments as prescribed. 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 record reviews and interviews conducted during a survey, the facility did not ensure that each resident received adequate supervision/assistance to prevent accidents for two (2) of five (5) residents reviewed for falls. Specifically, Resident #116 required two (2) person assistance for bed mobility and was provided one (1) staff assistance by Certified Nurse Aide #10 which resulted in a fall from bed. 2) Resident #114 sustained an unwitnessed fall on 06/04/2025. A thorough investigation to prevent re-occurrence was not completed, the Accident/Incident report dated 06/04/2025 did not document injuries sustained due to the fall, or notification of the resident representative and physician. Neurological checks were not completed as per facility policy for a head injury. The Accident/Incident Report was not reviewed by the Medical Director. The findings Include: 1) The May 2025 policy titled 'Activities of Daily Living Care' documented it was the procedure to assist residents to appropriate positions for time of day; check transfer status and bed mobility status to make sure proper support is provided per care plan. Ask co-worker for assistance as indicated by Kardex/care plan. Resident #116 had diagnoses of Diabetes Mellitus, Cerebrovascular Accident, and Adult Failure to Thrive. The admission Minimum Data Set, dated [DATE] documented the resident had severe cognitive impairment and was dependent on staff for rolling from back to left and right. They had physical limitations on one side for upper and lower extremities. They were occasionally incontinent of urine and was dependent on staff for toileting hygiene. A Care Plan for Rehab dated 4/26/25 documented the resident was dependent for bed mobility requiring total assistance for effective turning and positioning while in bed. A Care Plan for Activities of Daily Living dated 05/21/2025 documented the resident required two (2) person assistance with bed mobility and transfer. The Certified Nurse Aide Care Guide (care instructions) dated 8/21/25, documented the resident was totally dependent with a two (2) person physical assist for bed mobility and totally dependent with a 1 person assist for toilet use, used incontinence briefs. The facility Investigation Summary documented, on 08/22/2025, Resident #116 sustained a fall from bed witnessed by Certified Nurse Aide #10, while performing incontinent care. The resident fell onto the mat next to the bed. The nurse and nurse supervisor were notified; the physician and family were notified. Certified Nurse Aide #10 was terminated upon the conclusion of the investigation. Certified Nurse Aide #10's written statement, dated 08/22/2025, documented they were doing cares(changing) for the resident and the resident slipped out of the bed while on their side while being cleaned. The resident fell onto the mat next to their bed. A statement from Licensed Practical Nurse#12 dated 08/22/2025, documented they were outside the resident's room refilling the transmission precautions cart when they heard a noise and went to the resident's room and saw the resident on the floor. Then they went to get Registered Nurse Supervisor #5. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/23/26 at 3:13 PM, Registered Nurse Supervisor #5 stated they were called to the unit on 8/22/25 and the resident was on the floor mat next to their bed. It was a witnessed fall, and the Certified Nurse Aide #10 remained in the room. The resident was assessed then returned to bed. The resident was asked if they had pain and they stated no. They stated there were no observed injuries. They stated they got the story from Certified Nurse Aide #10 who stated they did not have another person to help them and thought they could do the cares by themselves and when the resident was on their side they slipped off of the bed. They stated the Certified Nurse Aides were supposed to go to the assignment sheet, and the nurse gave them report for any new changes. They stated all instructions about resident care were in the care guide and they should have checked there as well. Certified Nurse Aide #10 knew they were responsible for checking the guide, and they did not do that. They stated the Licensed Practical Nurse #12 was right outside the door and could have helped them if they asked. They stated Certified Nurse Aide #10 did not follow the care plan or look in the care guide for instructions. During an interview on 04/24/2026 at 11:19 AM, the Director of Nursing stated they read the Accident and Incident report and saw the resident required extensive assistance for care and turning was provided by one certified nurse aide. There was a licensed practical nurse right outside the door and they could have asked them for help. They stated Resident #116 required extra help, was an amputee and had just come back from the hospital. It was important to check to see if the residents' Activity of Daily Living status changed. They stated the accident could have been prevented if the Certified Nurse Aide got help according to the plan of care. 2) Resident #114 diagnoses included diabetes mellitus, Wernicke's encephalopathy (brain dysfunction) and cognitive communication deficit. The quarterly Minimum Data Set, dated [DATE] documented Resident #114 had severe cognitive impairment, was at risk for falls and required supervision/touch assistance for chair to bed transfers. An untitled facility policy last reviewed 10/2024 documented: it is the purpose of the Facility to investigate and document all accidents and incidents and develop corrective measures to prevent reoccurrence. The Nurse/Nursing Supervisor is responsible to evaluate the resident for injury. The attending physician will be notified to receive orders for treatment, in the event the attending physician cannot be reached, the Medical Director will be notified of the resident's condition. The Accident/Incident Report shall be forwarded to the Medical Director and Administrator for review and signatures. An undated facility policy titled Neurological Check Policy documented purpose to ensure prompt identification of neurological deterioration following any unwitnessed fall, fall with head strike, or incident with suspected or potential head injury, and to ensure safe monitoring, evaluation, intervention, and escalation of care consistent with CMS regulations and evidence-based practice. A neurological assessment (neuro check) must be initiated immediately for any resident who has experienced an unwitnessed fall, experienced a witnessed fall in which the head did or may have struck an object, or been involved in any incident where head injury cannot be ruled out. Unless otherwise directed by the medical provider, neuro checks must be completed as follows: Every 15 minutes for one (1) hour, every 30 minutes for one (1) hour, every hour for four (4) hours and every four (4) hours for 24 hours. Minimum duration of monitoring: 30 hours. The physician/nurse practitioner may extend or shorten the schedule based on clinical condition. An Accident/Incident Report dated 06/04/2025 at 4:15 PM documented Resident #114 had an unwitnessed fall in the resident's room and the resident was not able to describe the event. The (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	report documented the resident's baseline prior to the fall was alert, oriented X 1, and confused. The resident used a wheelchair and required extensive assist of one (1) staff for ambulation, transfers and bed mobility, and was dependent on one staff for toileting and dressing. The rest of first page of the report was blank including if safety/preventative measures were in place, new interventions to minimize re-occurrence, type of injury, notifications of resident representative or physician/nurse practitioner, and there was no nurse signature. The post fall investigation documented the resident was last toileted/care provided at 2 PM and incontinence status was dry. The last time the resident was observed by staff prior to fall was 4 PM. The resident was self-transferring in their room from the wheelchair to the bed. Certified Nurse Aide #21's statement dated 6/4/2026 documented they were not assigned to the resident, the last time they saw the resident, they were rolling around in their chair, and they were on a break when the accident happened. Certified Nurse Aide #9's statement dated 6/4/2025 documented Resident #114 was on their assignment and the last they saw the resident; they were in their chair in the hallway. They documented another certified nurse aide told them that Resident #114 was on the floor, and the nursing supervisor was called. They did not witness the incident. Certified Nurse Aide #9's statement did not include what time they last saw the resident or when they last provided care. Certified Nurse Aide #22's statement dated 6/4/2026 documented they heard hello, hello coming from Resident #114's room and found Resident #114 on the floor at foot of bed and notified the nurse. There were no other statements and none of the statements documented the time the resident was last seen prior to the fall, or the last time care was provided to the resident. Registered Nurse Supervisor #8's progress note dated 06/04/2025 at 6:37 PM documented at approximately 4:15 PM, Resident #114 was found in their room lying on right side beside the bed in a sitting position on the floor with legs extended towards foot of bed. The fall was unwitnessed. Due to poor cognition, the resident was unable to verbalize what led to the fall. There was an abrasion to the right mid-back, a laceration to right parietal scalp (upper part of head) region, and Resident #114 complained of head pain. Tylenol was administered with positive effect. Neurological assessment was performed per fall protocol and within normal limits. The resident was assisted by two (2) staff from the floor back into wheelchair. A message was left for the resident representative with fall update. The Nurse Practitioner made aware and provided orders to cleanse laceration, apply topical ointment, and leave laceration open to air. A rehabilitation screen was ordered for a mobility and safety evaluation. Interventions documented wound care initiated as per provided order, fall precautions reinforced, and resident monitored closely post fall. A physician order dated 06/04/2025 documented cleanse left parietal lobe with normal saline and apply bacitracin daily open to air, every day during 7:00 AM to 3:00 PM shift. The Neurological Flow Sheet dated 6/4/2025 to 6/5/2025 documented vital signs and Neuro Checks to be done every 15 minutes for one (1) hour, every 30 minutes for 1 hour, every hour for 4 hours, then every 4 hours for 24 hours. The vital signs and neuro checks were documented on 6/4/2025 at 4:15 PM, 4:30 PM, 4:45 PM, 5:00 PM, 5:15 PM, 5:45 PM, 6:15 PM, 7:15 PM, 8:15 PM and 9:15 PM. There were no documented neuro checks or vital signs after 9:15 PM on 6/4/2025. The resident's blood pressure was not documented after 4:30 PM on 06/04/2025. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A resident care plan dated 06/05/2025 titled Falls: at high risk for falls related to incident of fall in the past 30 days, documented interventions including anticipate resident needs with regard to activities of daily living, fall mat to right side of bed and rehabilitation referral for evaluation secondary to fall. There were no nursing notes or evidence of monitoring documented after 06/04/2025 at 6:37 until 06/09/25 at 5:31 PM. Registered Nurse #27's progress note dated 06/09/2025 at 5:31 PM documented the resident representative was updated on Resident #114's status as baseline, and the representative requested for scalp abrasion area to be re-evaluated. The nurse practitioner was made aware and ordered an x-ray per the resident representative's request. The nurse practitioner's order dated 06/09/2025 at 2:01 PM documented STAT (immediate) AP and Laterals (3 Views) x-ray of the skull. The nurse practitioners progress note dated 06/10/2025 at 4:16 PM documented they reviewed the x-ray of the skull status post fall with injury, resident's chart, medications, and nursing notes. The x-ray was negative. The plan was to continue to monitor. There was no documented evidence that the nurse practitioner observed the resident at any time since the fall. During an interview on 04/24/2026 at 2:40 PM, the Director of Nursing reviewed the Accident/Incident Report dated 06/04/2025 and stated it was not complete. They stated injuries sustained by Resident #114 should have been documented, signatures and notifications sections completed, statement obtained from unit nurse, and neurological checks should have been completed as per facility policy. During an interview on 04/27/2026 at 10:53 AM, the Medical Director stated Accident/Incident Reports were reviewed and signed when provided by the Director of Nursing. 10NYCRR 415.12(h)(2)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews conducted during the survey, the facility did not ensure that residents that receive dialysis receive such services consistent with professional standards of practice for one (1) of two (2) residents reviewed for dialysis. Specifically, Resident #46 missed dialysis appointments that needed to be rescheduled due to a malfunctioning elevator. Additionally, the hemodialysis communication book for Resident #46 was reviewed from 03/13 to 04/27/2026. The documentation of the assessments before and after dialysis was inconsistent with no documentation in the electronic medical record elsewhere. The findings include:The Care of Resident receiving Hemodialysis Policy last reviewed 05/2025 documented that the nursing responsibilities were to assess the resident pre and post hemodialysis. The pre-hemodialysis assessment included making sure that the residents have had daily care and entering pretreatment information in the communication book as indicated. The post hemodialysis assessment included obtaining vitals and assessing the access site, reviewing the communication book, and recording post assessment findings. Resident #46 had diagnoses that included heart failure, chronic kidney disease, and cirrhosis (chronic disease of the liver).The Renal Disease Care Plan effective 03/06/2025 and last updated 01/05/2026 documented resident currently on dialysis and that resident continues dialysis three times per week.The Quarterly Minimum Data Set, dated [DATE] documented intact cognition and that Resident #46 received dialysis. The Dialysis facility treatment records were reviewed from 09/01/2025-10/31/2025. The note dated 10/20/2025 documented Resident #46 was scheduled but absent due to a facility issue. The census information for Resident #46 documented a bed change to the first floor on 10/21/2025. The Elevator Repair Company invoice dated 11/05/2025 documented a repair completed on the elevator on 10/21/2025 to replace broken door closers second and third floor. The Annual Minimum Data Set, dated [DATE] documented intact cognition and that Resident #46 received dialysis. The Hemodialysis communication book for Resident #46 was reviewed from 03/13/2026-04/27/2026. Fifteen days during that period had dialysis sheets. Of those fifteen, ten were incomplete either omitting the pre or post assessment. There was no documented evidence elsewhere in the electronic medical record of the assessments.During an interview on 04/22/2026 8:51 AM, with an anonymous former employee, they stated that the elevator was a huge issue at the facility and residents missed appointments because of it, including hemodialysis. They could not recall specific dates but stated possibly October 2025. During an interview on 04/24/2026 at 8:20 AM, Resident #46 stated that only one elevator had been functional since they moved to the facility years ago. They had missed appointments for dialysis because the elevator was down. That was why they moved to the first floor. They were unsure of the dates, but it was up until they left the second floor in October of 2025. They stated they were scheduled Monday, Wednesday, and Friday. They had to attend dialysis on consecutive days when they missed dialysis because of the broken elevator, and it was difficult physically to do two days in a row. During an interview on 04/24/2026 at 11:06 AM, Licensed Practical Nurse Unit Manager #1 stated that when residents were on dialysis, the communication book should be completed before and after dialysis to document the assessment of the resident. There should not be omissions on the communication sheets. Resident #46 was moved to Unit 100 so they would not miss hemodialysis appointments because of the elevator.During an interview on 04/24/2026 at 11:22 AM, Licensed Practical Nurse #2 stated that Resident #46 moved to Unit 100 because the elevator kept breaking down. They did miss one or two dialysis appointments because of it. During an interview on 04/27/2026 at 4:20 PM, the Administrator stated that they were aware that residents were moved from Unit 200 to Unit 100 because of missed appointments. Resident #46 was already on Unit 100 when they started working at the facility, so they were uncertain of the details of their missed appointments.During an interview on 04/27/2026 at 11:14 AM, the Medical Director stated that the hemodialysis residents had communication books. They expected (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: The Eleanor Nursing Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 419 North Quaker Lane, Hyde Park, NY 12538	

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that the assessments of residents were completed by nursing as indicated in the hemodialysis communication books before and after dialysis. They could not recall anytime that Resident #46 missed an appointment because of the elevator being broken. They should be notified if a resident missed or refused dialysis. They knew Resident #46 was moved to the first floor, but they did not know it was because of the elevator. During an interview on 04/28/2026 at 1:43 PM, the Receptionist/Appointment and Transportation Scheduler stated that dialysis appointments had been missed in the past because the elevator was down. 10NYCRR 415.12

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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 survey, the facility did not ensure that there was adequate staffing to provide nursing and related services to assure resident safety and attain and maintain the highest practicable physical, mental, and psychosocial well-being of each resident as determined by the facility assessment and individual plans of care. Specifically, the actual staffing was reviewed from 03/20-04/20/2026. During that time the staffing did not meet the minimal staffing numbers for nurses on 03/24/2026, 04/01/2026, 04/05/2026, 04/07/2026, and 04/13/2026 for at least one shift. Additionally, the facility had minimal staffing numbers of certified nurse aides on at least one unit and one shift on 28 of the 30 days reviewed. Staff reported working with the minimum number of certified nurse aides could be challenging and could affect the amount and timeliness of work that could be completed. The findings included:The Facility Assessment tool last updated 11/12/2025 documented a facility capacity of 120 residents but had averaged between 90 and 95 residents for the preceding six (months). The minimal staffing for each of the three (3) units was documented as the following:One (1) to two (2) direct care nurses on the day shift and two (2) to four (4) certified nurse aides for each unit totaling three (3) to six (6) direct care nurses and six (6) to 12 certified nurse aides for the facility on the day shift.One (1) to two (2) direct care nurses on the evening shift and two (2) to three (3) certified nurse aides for each unit, totaling three (3) to six (6) direct care nurses and six (6) to nine (9) certified nurse aides for the facility on the evening shiftOne (1) direct care nurse on the night shift and one (1) to two (2) certified nurse aides for each unit, totaling three (3) direct care nurses and three (3) to six (6) certified nurse aides for the facility on the night shift.The staffing sheets dated 03/24, 04/01, 04/05, 04/07, and 04/13/2026 documented that there were two direct care nurses for the three units working on the overnight shift, with one of the two also working as the supervisor. The staffing sheet dated 03/24/2026 documented five (5) certified nurse aides, 04/01/2026 documented six (6) certified nurse aides, 04/05/2026 documented three (3) certified nurse aides, 04/07/2026 documented six (6) certified nurse aides, and 04/13/2026 documented five (5) certified nurse aides on the overnight shift in the facility. The staffing sheet dated 04/13/2026 documented that there were two direct care nurses working on the day shift with one nurse covering two units. The staffing sheet dated 04/13/2026 documented eight (8) certified nurse aides on the day shift in the facility.Staffing on 03/20, 03/21, 03/22, 03/23, 03/24, 03/26, 03/27, 03/28, 03/29, 03/30, 03/31, 04/02, 04/03, 04/4, 04/05, 04/06, 04/8, 04/10, 04/11, 04/12, 04/13, 04/14, 04/15, 04/16, 04/17, 04/18, 04/19, 04/20/2026 documented that for at least one shift and one unit there was minimal certified nurse aide coverage.During an interview on 04/21/2026 at 10:03 AM, Resident #17 stated that there were not enough staff to get people up in morning and the food was cold because it took too long to pass out trays.During an interview and observation on 04/21/2026 at 1:00 PM, Resident #31 was observed in bed in a hospital gown and stated that staffing was poor and there was no one around during the night. They stated there were not enough staff to get out of bed some days.During an interview on 04/22/2026 at 1:36 PM, Certified Nurse Aide #17 stated working day shift with only three (3) certified nurse aides on a unit was challenging but they worked hard to get everything done. However, on days when they only had two (2) certified nurse aides on a unit., it was difficult. Showers may not get done so they would try to make up missed showers on a day with more staff.During an observation on Unit 200 on 04/23/2026 at 9:15 AM, the breakfast cart was on the unit, and most residents were eating breakfast in their rooms, and 28 out of 39 residents were still in bed or in a hospital gown sitting up in their room. Breakfast time on Unit 200 was 8:00 AM. There were four (4) certified nurse aides scheduled.During an interview on 04/23/2026 at 12:10 PM Certified Nurse Aide #3 stated they did not always document all resident cares every day/shift due to lack of time and short staffing. They stated cares for some residents frequently would be performed late in the shift or left for the next shift to complete due to short staffing and high (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	acuity of unit. Certified Nurse Aide #3 stated facility supervisors/unit managers were aware that cares were not always documented on the electronic medical record and they have been in-serviced regarding documentation policy. During an interview on 04/23/2026 at 12:28 PM, Licensed Practical Nurse #4 stated they oversee certified nurse aide task completion on units. They stated they were aware that certified nurse aides frequently did not document completion of tasks on the electronic medical record. They stated when they observed cares not completed for a resident, they addressed it with certified nurse aide staff. They stated short staffing delayed cares and that Unit 3 had high acuity that increased difficulty in completion of tasks. During an interview on 04/24/2026 at 6:42 AM, Licensed Practical Nurse #18 stated that there were two (2) certified nurse aides overnight last night, and they have had only one (1) at times. They stated it was very challenging overnight when they only had one certified nurse aide because they could only so much could get done.During an interview on 04/27/2026 at 1:41 PM, the Human Resources and Staffing Manager stated that the nursing staff minimums were one (1) nurse on each unit for every shift, two (2) certified nurse aides on each unit on the day and evening shifts, one (1) nurse on each unit on the night shift, and one (1) certified nurse aide on each unit on the night shift. The nursing supervisor may act as the direct care nurse for one of the units. They stated that they tried to stay above the minimum, but it was not always possible. They stated they did not have all the nurses on 03/24/2026 because there was a nurse that did not call or show up for work. On 04/01/2026 and 04/05/2026 they were short one nurse on the night shift. On 04/07/2026, they were short one nurse on the night shift, but another nurse came in early to assist with the morning medication pass. On 04/13/2026, they were short a nurse on the day and night shifts. They stated that staffing was a challenge. They offered incentives and bonuses. They also tried to adjust the schedules to meet their needs for other appointments and things. There stated there were open positions for nurses and certified nurse aides. They did not think that the facility offered sign-on bonuses, and no agency staff was used. They stated they would be participating in a job fair on 05/28/2026 and that they advertised. They stated they were actively looking for more nurses and certified nurse aides but not certain of how many open positions there were. They were not certain if it was the location or wages that made it difficult to find more staff.During an interview on 04/27/2026 at 4:23 PM, the Administrator stated that they needed more and were hiring more nursing staff. They stated that the two (2) certified nurse aides on a unit were the minimal numbers, but four (4) would be ideal. They were trying to adjust times for activities, so they were not missed due to minimal numbers of staff and delays in getting out of bed. Other disciplines try to assist as they can as well.During an interview on 04/28/2026 at 11:55 AM, the Director of Nursing stated that the minimum staffing numbers were as the Human Resources Staffing Manager provided. They did not think there was enough nursing staff and stated that the minimum numbers had to be reviewed again. They started at the facility in February and planned to review the staffing. They were aware of the shortage of nurses on the units, and they did not want only two certified nurse aides on the units for days and evening or one at night. They did not believe the current staffing numbers were adequate or safe, or that cares could not be completed as they should be either. They stated showers were affected as well with minimal staffing numbers. They stated they were realistic about what was possible when there was minimal staff. They stated they started a conversation with Corporate Human Resources to discuss the numbers and current openings.During an interview on 04/28/2026 at 12:26 PM Certified Nurse Aide #7, who was working on Unit 200, stated that it was not possible to give all showers as scheduled on days when there were only two certified nurse aides on the floor, especially for dependent residents. 10NYCRR 415.13(a)(1)(i-iii)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation and interviews conducted during the survey, the facility did not ensure residents were provided with food and drink that was palatable, and at an appetizing temperature. Specifically, 1) during a lunch observation on Unit 1, temperatures take at the time the last resident tray was served, revealed the chicken parmesan had a temperature of 107.6 degrees Fahrenheit, the pasta was 95.5 degrees Fahrenheit, the green beans were 105 degrees Fahrenheit and milk was 63 degrees Fahrenheit; and 2) for the lunch meal on 04/20/2026, hotdogs and french fries were served with no condiments (ketchup and/or mustard) available. The findings include: The facility policy, Dietary Department Policy and Procedure, documented that hot food should be held at 140 degrees Fahrenheit above and cold food at 46 degrees Fahrenheit or below. 1) During an observation on 04/23/2026 at 11:59 AM, with the Food Service Director, temperatures of the lunch tray line were tested before being served. Temperatures of the hot food were tested, and all were above 140 degrees Fahrenheit. During an interview on 4/27/2026 at 10:19 AM, the Registered Dietitian stated the complaints about the food had decreased. The food quality was pretty good, but they knew the food was cold. The food was hot out of the kitchen but the delivery was slow. They only had one working elevator which delayed the food trays being delivered to the units. Additionally, the plate warmer had not been working, and they did not have heating pellets under the plates. During an observation and interview on 4/27/2026 at 12:14 PM, the food tray carts arrived on Unit 1 and staff began passing out the food trays to the residents. At 12:33 PM, The Food Service Director tested the temperatures of the last tray served on Unit 1 and the chicken parmesan had a temperature of 107.6 degrees Fahrenheit, the pasta had a temperature of 95.5 degrees Fahrenheit, the green beans had a temperature of 105 degrees Fahrenheit and milk had a temperature of 63 degrees Fahrenheit. The Food Service Director stated they would like the food to be hotter, at least 140 degrees Fahrenheit. They stated the food was hot in the kitchen, but it took time to get delivered to the residents. They stated they needed to fix the plate warmer and needed the right tools to get food to the residents. During an interview on 04/28/2026 at 12:17 PM, Resident #2 stated most of the food served was always cold. They stated they did not know why the food was cold but had to eat it and did not like it. 2) During an observation on 04/20/2026 at 1:16 PM lunch meal trays were delivered to Unit 3. The lunch meal was a hotdog on a bun with french fries. All trays served did not have condiments (ketchup and mustard). Multiple residents requested the condiments, and staff reported the facility was out of ketchup and mustard. The staff offered residents mayonnaise or barbeque sauce. During an interview on 04/20/2026 at 4:46 PM, Resident #98 stated the food was sometimes bad. During an interview on 04/20/26 at 5:00 PM, the Food Service Director stated the kitchen aide opened the box of ketchup packets before tray line and the packets were moldy and they did not have any other ketchup to use. The box was not expired, but maybe an open packet may have caused the entire box to become moldy. They stated the facility ran out of mustard packets, and it was out of stock when they tried to place the order. The Food Service Director stated they must follow a budget and did not have an extra supply of the condiments. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/20/2026 at 5:15 PM, Resident #98's family member stated when they first visited Resident #98, they saw a sandwich wrapped lying by the bed and the bun was stale and rock hard. During an interview on 04/23/2026 at 11:46 AM, the Registered Dietitian stated the Food Service Director went to the local grocery store to get items for meals if needed. During an interview on 04/27/2026 at 1:33 PM, the facility Administrator stated the facility had no problem obtaining food items that were needed for residents' meals. 10NYCRR 415.14 (d)(1)(2)