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

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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 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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. Based on observation, interview and record review, it was determined the Governing Body failed to ensure consistent and responsible management of the facility. Specifically, 1) the facility has had a change in Director of Nursing seven times in the last two (2) years. 2) the facility has had 3 Administrators in the last two years. 3) The facility had 11 repeat deficiencies from the recertification survey of 05/06/2025, and 12 repeat deficiencies from the recertification survey of 09/17/2024. 4) The facility has had one (1) elevator that has been out of service for at least 3 years, and a 2nd elevator that has not been functional at times and has caused residents to miss appointments (see F698).Findings include:1) Notifications from the facility to the New York State Department of Health dated 07/30/24 to 02/02/2026, documented 7 changes for the Director of Nursing. The facility hired four (4) Directors of Nursing during this period and had three (3) interim Directors of Nursing. The longest tenure of a Director of Nursing was less than 6 months. At time of survey, the current Director of Nursing started on 02/03/2026. During interviews for F600, F609, F610 the Director of Nursing stated they were not at the facility at the time of the incident. The last recertification survey ended 05/06/2025, the Director of Nursing has changed 3 times since then.2) The Administrator at the time of survey started 01/02/2026 and the prior Administrator worked from 09/25/2025 to 01/02/2026.3) The facility had 11 repeat citations from the recertification survey of 05/06/2025 including F558, F584, F609, F628, F640, F656, F698, F725, F756, F812 and F880. The facility had 12 repeat deficiencies from the survey of 09/17/2024 including F584, F600, F609, F610, F656, F677, F686, F689, F695, F725, F756, and F812.Sufficient nursing staff (F725) was cited during the 2 prior recertification surveys. Interviews with the Director of Nursing, Human Resources and nursing staff identified low staffing and the ability to complete tasks with the minimum staffing levels in the Facility Assessment was not adequate.4) Based on staff and resident interviews, the facility's one functional elevator was out of service on multiple occasions resulting in residents missing appointments. Residents complained of food being late and cold due to only one functioning elevator (see F804).10 New York Codes, Rules, Regulations 415.26(b)(3)(1)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. Based on interviews and record review during the post-survey revisit from 06/24/2026 to 06/29/2026, the facility did not ensure an antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. Specifically, the Director of Nursing/Infection Preventionist was unable to provide documentation of facility antibiotic surveillance / line listing from 06/18/2026 through 06/25/2026. Findings include:During an interview on 06/25/2026 at 3:15 PM, the Director of Nursing stated they could not provide antibiotic surveillance/line list for the month of June 2026 for the facility. They stated the unit managers were responsible for the completion of the surveillance reports, and they did not receive reports for May or June 2026. They stated the last time a full monthly antibiotic surveillance report was completed in the facility was in April 2026. The Director of Nursing stated that a full house audit of residents prescribed antibiotics was not completed as stated in the plan of correction (F684 recertification surevey). The Director of Nursing stated they have also not received reports documenting missed antibiotic administrations and since no audits were completed, there were no corrective measures put in place if applicable. The Director of Nursing stated there were two Assistant Directors of Nursing who were Infection Preventionists since April 2026, however they did not remain employed at facility long and did not complete surveillance and lines listings. ˆDuring an interview on ˆ06/25/26 at 3:51 PM, Licensed Practical Nurse Unit Manager #6 stated they started employment at the facility in 02/2026 and were not aware of antibiotic surveillance/tracking at the facility until the Director of Nursing requested audits of unit antibiotic usage in April 2026. They stated there was no official tool such as McGreer used in the facility to track antibiotic usage and there was not an official conversation or policy stating unit managers were responsible tracking daily antibiotic surveillance / line listings. They stated they did not complete the requested antibiotic surveillance/tracking in May or June 2026 due to workload and time constraints. They stated the facility has had three (3) Assistant Directors of Nursing since they started at facility in 02/2026 who were involved in infection control/antibiotic surveillance in the facility and all three ended employment after a few weeks. ˆDuring interviews on 06/25/2026 at 4:17 PM and 06/29/2026 at 2:15 PM, Licensed Practical Nurse Unit Manager #1 stated they were requested by the Director of Nursing to audit new antibiotic physician orders for their unit in April or May 2026. They stated they were provided with audit tools and were not aware of daily log to monitor antibiotic administration. They stated the audit tools were to be completed and submitted weekly to the Director of Nursing. They stated they have not been completing the audit tools since the beginning of May 2026 due to workload and short staffing. During an interview on 06/26/26 at 11:15 AM, the Administrator stated they were not aware antibiotic surveillance / line listings were not being completed, and the Director of Nursing did not request help/assistance with the task. They stated the Director of Nursing had delegated tasks to an Assistant Director of Nursing who only worked at the facility for a couple of weeks. 10 NYCRR 415.19 (c)

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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 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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(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	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)

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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 - Some	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 - Some	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 - Some	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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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 - Some	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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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **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 the attending physician documented in the resident medical record, review of identified drug regimen review recommendations, and completion of any actions taken to address the recommendations for two (2) of five (5) residents (Resident #4 and Resident #23) reviewed for unnecessary medications, psychotropic medications, and medication regimen review, and one (1) of one (1) resident (Resident #13) reviewed for psych/opioid medications. Specifically, 1) Resident #4 had five (5) drug regimen reviews from 11/19/2025to 03/22/2026, with no documented evidence the Medical Director reviewed; 2) Resident#23 had five (5) drug regimen reviews from 10/28/2025 to 03/18/2026 and there was no documented evidence that the Medical Director reviewed; and 3) Resident #13 had six (6) drug regimen reviews from 10/27/2025 to 03/18/2026 and there was no documented evidence that the Medical Director reviewed or responded. The findings are: The Policy and Procedure titled Pharmacy Services Drug Regimen Review, revised 05/2025, documented the drug regimen of each resident will be reviewed at least monthly by a licensed pharmacist. The pharmacist will report any irregularities to the attending physician, the facility medical director, and the director of nursing, and reports will be acted upon. Additionally, the attending physician must document in the resident's medical record the review of identified irregularities and any action taken to address them. If no change in medication is made, the attending physician must document the rationale in the resident's medical record. 1) Resident #4 had diagnoses of diabetes mellitus, dementia, and bipolar disorder. The Quarterly Minimum Data Set (MDS), an assessment tool, dated 01/29/2026, documented Resident #4 had moderately impaired cognition, was usually able to understand others, and was able to make needs understood. Resident #4 received antipsychotic, anti-anxiety, antidepressant, hypoglycemic, and anticonvulsant medications during the prior seven (7) days. The drug regimen review for Resident #4, dated 11/19/2025, documented no rationale for initiation of Fluoxetine on 11/06/2025. The drug regimen review documented a recommendation to obtain a carbamazepine level for seizure management. During a review of Resident #4's record on 4/24/2026 there was no documentation addressing the rationale for Fluoxetine use. There was no evidence carbamazepine levels were obtained. The drug regimen review for Resident #4, dated 12/22/2025, documented Coreg required daily pulse monitoring and weekly blood pressure monitoring. Review of January 2026 and February 2026 Medication Administration Records (MAR) had no documentation of daily pulse or weekly blood pressure monitoring. The drug regimen review documented the use of antipsychotic medications required monitoring for orthostatic hypotension, with monitoring to be documented on the medication administration record monthly. Review of January and February 2026 medication administration records and the electronic health record (EHR) did not indicate documentation of daily pulse, weekly blood pressure, or orthostatic (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hypotension monitoring. The drug regimen review for Resident #4, dated 01/26/2026, documented hepatic impairment. Laboratory values included alanine aminotransferase (ALT) 79, aspartate aminotransferase (AST) 54, and alkaline phosphatase (ALP) 376. The drug regimen review documented that medications such as carvedilol and metformin should be avoided with hepatic impairment. Review of Resident #4's record on 4/24/2026 revealed no documented evidence the attending physician addressed the drug regimen review recommendations. The drug regimen review for Resident #4, dated 02/23/2026, documented current orders for acetaminophen with the potential to exceed three (3) grams per day maximum dosage. The drug regimen reviews documented recommendations to adjust orders to reduce this risk. Review of the electronic health record (EHR) on 4/24/2026, documented acetaminophen 325 milligram tablet, two (2) tablets (650 milligrams) by mouth every six (6) hours as needed for pain level one (1) to five (5). Record review also documented acetaminophen 325 milligram tablet, two (2) tablets (650 milligrams) by mouth two (2) times daily. The drug regimen review documented a recent elevation in liver function tests (LFTs) and recommended consideration of reducing the acetaminophen dose or frequency or discontinuation. There was no documented evidence that the acetaminophen dose was reduced or reviewed. The psychiatric evaluation dated 03/22/2026 documented disorganized behavior. The evaluation included recommendations to discontinue Tegretol, initiate Depakote 500 milligrams two (2) times daily, increase Fluoxetine (Prozac) to 20 milligrams, increase Clonazepam (Klonopin) 2.5 milligrams three (3) times daily, and follow up in two (2) weeks. A review of Resident #4's electronic health record (EHR) revealed no documented evidence that these recommendations were reviewed or implemented. During an interview with the Medical Director on 04/27/2026 at 12:37 PM, the Medical Director stated this was the first time they had seen the psychiatric recommendations, which included decreasing carbamazepine, initiating divalproex (Depakote), increasing fluoxetine (Prozac), and increasing clonazepam (Klonopin). The Medical Director explained that, as a new psychiatrist, they were unfamiliar with the facility process. The Medical Director stated that follow-up would occur to ensure the recommendations were reviewed and addressed by the appropriate staff. During an interview on 04/28/2026 at 1:48 PM, the Director of Nursing stated the psychiatric consultation dated 03/22/2026 for Resident #4, in which recommendations were made without documented physician follow-up, would be investigated. The Director of Nursing later confirmed that no documented follow-up had been provided to the physician. 2) Resident #23 had diagnoses that included dementia, anxiety, and depression. The Annual Minimum Data Set, dated [DATE] documented moderately impaired cognition and medications including antipsychotic, anticoagulant, and hypoglycemic. The pharmacy progress notes dated 10/28/2025, 12/22/2025, 01/26/2025, 02/23/2026 and 03/18/2026 all documented medication regimens reviewed, irregularities noted, see report. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The unsigned pharmacy recommendation dated 10/28/2025 documented please obtain complete blood count, comprehensive metabolic panel, lipid panel and HbA1C (lab to monitor average blood sugar levels). The physician notes dated 11/07/2025, 11/20/2025, 11/28/2025 documented continue medications and contained no documented evidence that the pharmacy recommendations were reviewed or responded to by the physician. Labs results were reviewed and documented that a complete blood panel and basic metabolic panel were completed on 11/29/2025. There was no documented evidence of a comprehensive blood panel, lipid panel, or HbA1C at that time. The unsigned pharmacy recommendation dated 12/22/2025 documented Resident #23 was on seroquel, naltrexone, namenda, paxil, and more than six (6) months since last psychiatrist evaluation. Please consider psychiatry follow up to evaluate effectiveness, adverse effects and gradual dose reduction. Receives antipsychotic Seroquel, black box warning of increased mortality in elderly patients with dementia receiving antipsychotics. Please consider gradual dose reduction and discontinuation and or document risk/benefit evaluation if this med continues. The last documented Psychiatry Consultation was dated 05/25/2025. The physician notes dated 12/26/2025, 01/02/2026, 01/06/2026, 01/13/2026, and 01/23/2026 documented continue medications and contained no documented evidence that the pharmacy recommendations were reviewed or responded to. There was no documented evidence of the pharmacy reviews from 01/26/2026, 02/23/2026, or 03/18/2026 or that the physician reviewed and responded to any recommendations. 3) Resident # 13 had diagnoses that included bipolar disorder, seizure disorder, and anxiety. The Quarterly Minimum Data Set, dated [DATE] documented moderately impaired cognition, no behaviors, and medications including antipsychotic, antianxiety, antidepressant, diuretic, opioid, hypoglycemic, and anticonvulsant. The pharmacy progress notes dated 10/27/2025, 11/19/2025, 12/22/2026, 01/26/2026, 02/23/2026, and 03/18/2026 documented medication review completed, irregularities noted, see report. There was no documented evidence of the pharmacy recommendations or that the physician reviewed and responded to the recommendations. During an interview on 04/27/2026 at 11:14 AM the Medical Director stated when they received the pharmacy reviews they should be responded to in 48 hours. The Nurse Practitioner also reviews the recommendations. All recommendations should be reviewed. They could not say if any reviews were missed or not reviewed as they are forwarded to them when they come in and left for review. They could not recall the unsigned reviews presented from months ago. During an interview on 04/28/2026 at 9:07 AM, the Director of Nursing stated that they were uncertain where the requested missing pharmacy reviews were. They only started at the facility in February and could not speak to those before they arrived. They stated that the medication recommendation review process needed to be evaluated and fixed. The Psychiatrist did recently start (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and would be completing assessments as recommended and psychotropic medication evaluations. During an interview on 04/28/2026 at 10:27 AM, Licensed Practical Nurse (LPN) Unit Manager #6 stated there was a breakdown in the process for handling pharmacy consultant recommendations. Under normal procedures, the pharmacy consultant reports were submitted to the Director of Nursing , who then forwardsed the reports to the physician for review and follow-up. Due to the absence of the Director of Nursing, this process was not consistently followed, and resulted in missed or unaddressed recommendations. During an interview on 04/28/2026 at 10:43 AM, the Nurse Practitioner stated there was a breakdown in the process for handling pharmacy consultant recommendations. The Nurse Practitioner stated reports were submitted to the Director of Nursing, then forwarded to the physician for review and follow-up. The Nurse Practitioner stated due to the absence of a Director of Nursing, recommendations were not consistently addressed. During an interview with the Director of Nursing on 04/28/2026 at 1:48 PM, the Director of Nursing stated that, before their current appointment, the facility did not have a Director of Nursing and that drug regimen reviews were not consistently conducted. They stated that since assuming the role, pharmacy consultant reports were reviewed and forwarded to physicians. 415.18 (C) (1)

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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)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews conducted during the survey, the facility did not store food or maintain equipment with food contact surfaces in accordance with professional standards for food service safety. Specifically, 1) unlabeled and undated food were stored in the kitchen freezer, and dry storage; 2) insufficient supply of emergency food; 3) food, water and supplies were not stored six (6) inches off the floor; and 4) food preparation and service equipment was not maintained. The findings are: The undated facility policy titled Dietary Department documented No boxes of food shall be stored on the floor. Food must be covered when stored. Cutting boards should be inspected frequently for wear and replaced as needed.During the initial tour of the kitchen on 04/20/2026 at 10:25 AM with the Food Service Director an observation of frozen hashbrowns, box of farina, pan of thickener, pan of instant potato and pan of sugar all unlabeled and undated; an opened box of cornstarch undated; and an open box of salt unsealed. The emergency food supply was short cans of tuna, beef stew, mixed vegetables, and canned fruit. The emergency water supply was stored directly on the floor; a rack of food in the freezer was observed on the floor; six (6) five (5) gallon buckets of detergent were stored on the floor, and a box of napkins were stored on the floor in the main kitchen. There were three (3) observed damaged meal service trays with sharp edges and two (2) cutting boards with deep cuts and nicks.During the initial tour the Food Service Director was interviewed. They stated they were not sure why the food items were not dated, labeled and sealed. They stated the emergency food supply was low because they could only order within the budget and ordered a little each time to replenish the supply. The Food Service Director did not know if there was shelving available for the items that were stored on the floor. During an interview on 04/23/2026 at 11:14 AM the Food Service Director stated they found out new staff had been using the food from the Emergency food supply racks on the weekend and using it for the current meal service and that was why it was deficient in supplies.During an interview on 04/27/2026 at 1:33 PM the facility Administrator stated they would purchase shelving to make sure food, and supplies were not stored on the floor. 10 NYCRR 415.14(h)

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

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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review during the survey, the facility did not ensure the residents right to participate in care planning meeting for 1 of 3 residents (Resident #68) reviewed for Activities. Specifically, Resident #68's quarterly care plan meeting was cancelled due to snow in January 2026 and not rescheduled.Findings include:Resident #68 had diagnoses that included, but not limited to Non-Alzheimer's Dementia, Multiple Sclerosis, and depression.The Minimum Data Set assessment dated [DATE] documented Resident #68 had moderately impaired cognition, and required set-up assist for eating, and was dependent on staff for rolling, sit to lying and transfers.During an interview on 04/21/2026 at 11:26 AM, Resident #68 stated they were supposed to have had a care plan meeting, and it was canceled due to snow, and not rescheduled. Resident #68 stated care plan meetings were important to them for communication with their family members.During a record review of social work progress notes, there was documentation regarding care plan meetings. A care plan meeting note dated 09/17/2025, a quarterly assessment note dated 01/20/2026 with no corresponding meeting note, and an invitation sent to a family member for an upcoming care plan meeting dated 04/20/2026.During an interview on 04/23/2026 at 9:27 AM, the Social Worker stated there was an upcoming quarterly care plan meeting scheduled for 04/29/2026 and Resident #68's family member had been invited to attend. They did not recall why the January 2026 care plan meeting was not rescheduled. They were aware they should hold quarterly care plan meetings for residents. During an interview on 04/23/2026 at 2:01 PM the Director of Nursing stated quarterly care plan meetings should be held for all residents and if needed, the facility should reschedule a care plan meeting if necessary.10 NYCRR 415.11(c)(2)(i-iii)

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview during the survey, the facility did not ensure residents needs and preferences were considered to create an individualized home-like environment for one (1) of two (2) residents (Resident #6) reviewed for choices. Specifically, Resident #6 purchased a shelf for their room and asked about purchasing a recliner for their room. The were waiting for approval to install the shelf and purchase a recliner; there was no documented evidence the facility responded to their request. The Personal Items in Resident Rooms policy dated 03/31/2026 documented that the Facility will accommodate, within reason, items of resident choice within the room environment that will enhance the homelike atmosphere. Items that may be considered for screening and approval may include: floor standing shelving unit (1) that does not extend outward from the wall at a distance that impedes safe passage, does not extend upward at a height that is at risk for tipping forward and does not extend along the wall at a distance that intrudes upon a roommate's environment; smooth or upholstered seating that accommodates one person, ie recliner or upright chair, given that the upholstery has been treated with a moisture-proofing material and meets requirements for fire-retardation and infection control.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 the resident had intact cognition and required maximal assistance with most activities of daily living and was dependent on staff for transfers.An email from the Director of Rehabilitation to the Regional Nursing Coordinator dated 12/15/2025 documented a request for the policy on recliners because Resident #6 was requesting a recliner for their room. During an observation on 04/20/2026 at 11:04 AM, cardboard boxes were piled along the wall by the closet in Resident #6's room. When interviewed during the observation, Resident #6 stated they had a lot of boxes and things they wanted to put away. They stated they purchased a shelf on 03/16/2026, but it had not been assembled, and they had to wait for approval. They also asked about a recliner so that they would have somewhere to sit other than the wheelchair and bed but were told that they could not have the recliner. Resident #6 stated they had purchased a shelf and wanted to purchase a recliner for their room to make it more comfortable, organized, and homelike, but needed approval. Observation of the resident's private room appeared large enough to accommodate a recliner.During an interview on 04/22/2026 at 11:24 AM, the Director of Nursing stated that they were aware of the shelf that was purchased and it was being stored in their office. The shelf has been at the facility for a month, but it was not approved until a couple of weeks ago and no one had time to assemble it. The policy on recliners had been pending so they had not approved that yet. Residents were not supposed to have them, but they were uncertain why. The Administrator was aware of the requests.During an interview on 04/22/2026 at 11:38 AM, Maintenance Supervisor #2 stated that extra pieces of furniture needed approval prior to assembly. During an interview on 04/22/2026 at 11:47 AM, the Administrator stated they were aware of the shelf that Resident #6 purchased, and the shelf was at the facility but they were not sure of the status. They knew that staff were concerned about Resident #6 hoarding and Social Work discussed that with them. They stated residents were allowed to bring in the personal items if they were deemed safe. They stated they would have to check again about the recliner policy. They were not aware of the recliner request. During an interview on 04/22/2026 at 12:03 PM Director of Rehabilitation stated that they did request the policy for personal recliners back in December but never received the policy. They stated that they were going to obtain it. They stated that they would evaluate the chair prior to purchase if it was permitted. 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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility did not ensure that residents remained free from abuse from one (1) of four (4) residents (Resident #23) reviewed for behavioral-emotional concerns. Specifically, Resident #37 was not kept free from abuse when Resident #23 was observed by staff touching Resident #37's breast on 08/23/2025. Additionally, Resident #23 had psychiatric diagnoses that included sexual disorders there were no interventions in place prior to the incident that would ensure Resident #37 and other residents were free from being abused by Resident #23.The findings include:Resident #37 had diagnoses including dementia, anxiety and bipolar disorder. The Minimum Data Set (resident assessment tool) dated 06/10/2025 documented Resident #37's cognition was severely impaired, had no behavior symptoms and mobility devices included a walker and wheelchair.Resident #23 had diagnoses that included dementia, hydrocephalus (chronic condition of accumulation of fluid within the brain), and anxiety. The Quarterly Minimum Data Set, dated [DATE] documented Resident #23 had severely impaired cognition, no behaviors, and was independent with activities of daily living and ambulation.A physician order dated 02/06/2025 documented Resident #23 was prescribed naltrexone 50 milligram tablet, give one- and one-half tablets once daily for sexual disorders.Resident #23's At Risk for Unsafe Behavior Care Plan initiated 03/25/2025 and entered on 04/29/2025 documented at risk for unsafe behavior due to cognitive deficit. There were no related diagnoses, behaviors, or interventions documented.The most recent Psychiatric Consultation dated 05/13/2025 documented Resident #23 had psychiatric diagnoses that included frontotemporal neurocognitive disorder with speech/language deficits, major depressive disorder, and sexual disorders.Resident #23's At Risk for Unsafe Behavior Care Plan dated 07/03/2025 documented at risk for unsafe behavior due to cognitive deficit due to significant mental health and neurological diagnoses including frontotemporal neurocognitive disorder. Interventions included maintaining safety devices, anticipating and meeting needs, observing for signs and symptoms of evolving mood or temperament change and intervening promptly.The Accident and Incident Report dated 08/23/2025 at 1:00 PM documented that Resident #23 was observed touching Resident #37's breast with their hands. A recreation staff member was present and witnessed the interaction. Residents were separated immediately. No injuries noted. Relevant diagnoses were listed for Resident #23 as dementia and cognitive communication. Other contributing factors listed were cognitive deficit, perceptual impairment, and poor safety awareness. The physician was notified with no interventions or new orders listed. No investigation was completed. The report was signed by the supervising nurse and the Administrator. There was no signature from the Director of Nursing or the Medical Director.Activity Aide #26's written statement dated 08/23/2025, documented they and a coworker took a few residents outside for some fresh air. Resident #37 was strolling around in their wheelchair. Activity Aide #26 saw Resident #23 walking around Resident #37, and they decided to keep an eye on Resident #23. Time went by and they (Activity Aide #26 and the coworker) were bringing people back in and they were also bringing in tables for a party that was happening later. As they opened the door to get the rest of the people, they saw Resident #23 grabbing Resident #37's private areas. Resident #37 screamed to stop, and Activity Aide #26 screamed for Resident #23 to stop and told them to go the their room.The Registered Nurse #8 nursing progress note dated 08/23/2025 at 1:49 PM documented they were made aware of Resident #23's behavior during shift. Residents involved were immediately separated and assessed; no signs or symptoms of injury noted. Resident denied pain or discomfort. Resident #23 was educated on appropriate behavior and the importance of reporting any concerns to staff. Administration notified of the incident. Will continue to monitor for any changes in behavior or condition.The Medical Director note dated 08/26/2025, in Resident #23's record, documented assessment completed, resident to resident interaction. Residents (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were separated immediately and assessed. Continue present medications.There were no nursing notes or evidence of monitoring Resident #23 from 08/23/2025 to 08/29/2025.The Licensed Practical Nurse Regional Nursing Coordinator's note dated 08/29/2025 at 2:17PM, in Resident #23's record, documented a request was communicated to the attending physician for medication review related to intrusive behavior.The Licensed Practical Nurse Regional Nursing Coordinator's note dated 08/29/2025 at 2:41PM documented attending physician (Medical Director) reviewed medications for Resident #23, order received for Namenda five (5) milligrams.The physician phone order dated 08/29/2025 at 2:43 PM documented Resident #23 to receive Namenda five (5) milligrams daily for other sexual disorders. The Behavior Problem care plan dated 08/29/2025 documented Resident #23 with sexual and socially inappropriate behavior. Interventions included medical and psychiatric management per physician orders, psychiatric evaluation and follow up, and provide sight supervision when out of room.The Sexual Disorders Care Plan dated 08/29/2025, by the Licensed Practical Nurse Regional Nursing Coordinator, documented that Resident #23 has exhibited sexually inappropriate behavior. Interventions included medical management to minimize signs and symptoms of sexual behaviors, psychiatric evaluation and follow up, administer psychoactive and sexually suppressive medication per physician order, sight supervision when out of bed, and observe when out of room and near female residents; do not leave unattended in room with female resident; if approaches female resident, redirect and report any behavior to nurse immediately.The Other Sexual Disorders/Hypersexuality care plan dated 08/29/2025 documented Resident #23 has a diagnosis of and has demonstrated behavior which is sexually and socially inappropriate behavior. Interventions included sight supervision when out of bed, observe when out of room and near female residents; do not leave unattended in room with female resident; if approaches female resident, redirect and report any behavior to nurse immediately, Namenda five (5) milligrams orally daily added to medication regimen.During an interview on 04/23/2026 at 12:15 PM, Licensed Practical Nurse Unit Manager #1 stated they could not recall all the details of the incident, they may have been on leave on or around that time. They stated Resident #23 has had 1:1 supervision due to the inappropriate touching incident on 08/23/2025.During an interview on 04/23/2026 at 1:04 PM, the Director of Nursing stated that they were not at the facility when the incident occurred on 08/23/2025 and could not speak to Resident #23's behaviors prior to the incident or about incident specifics. During an interview on 04/27/2026 at 11:47 AM, the Medical Director stated Resident #23 had frontotemporal neurocognitive disorder. They did not recall the incident with the resident touching another inappropriately and would have to review notes. During an interview on 04/27/2026 at 4:04 PM, the Administrator stated that they were not at the facility at the time of the incident so they could not provide details about Resident #23's behaviors prior to the incident or about incident specifics.10NYCRR 415.4(b)(1)(i)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews during the survey, the facility did not ensure that alleged violations involving abuse were reported no later than two hours after the incident for one (1) of four (4) residents reviewed for behavioral emotional. Specifically, Resident #23 was witnessed touching another resident inappropriately on 08/23/2025 and the incident was not reported to the State Agency.Findings include:The facility policy titled Resident Abuse Prevention and Reporting, last revised 05/2025, documented upon suspicion of abuse of any kind, all employees are required to stop the abuse, protect the residents, immediately notify immediate supervisor or person in charge of the building (if during off-hours), make immediate statement of observations or cause for suspicion and provide to above-identified person. If deemed a reportable incident, reporting of the incident is to be made in accordance with the requirements stated in manual for specific incident. Resident #23 had diagnoses that included dementia, hydrocephalus (chronic condition of accumulation of fluid within the brain), and anxiety.The Quarterly Minimum Data Set, dated [DATE] documented Resident #23 had severely impaired cognition, no behaviors, and was independent with activities of daily living and ambulation.The Accident and Incident Report dated 08/23/2025 at 1:00PM documented that Resident #23 was observed touching a female resident's breast with their hands. A recreation staff member was present and witnessed the interaction. The residents were separated immediately and no injuries were noted. The physician was notified with no interventions or new orders listed. The report was signed by the supervising nurse and the Administrator. There was no signature from the Director of Nursing or the Medical Director. Activity Aide #26's written statement dated 08/23/2026, documented they and a coworker took a few residents outside for some fresh air. Resident #37 was strolling around in their wheelchair. Activity Aide #26 saw Resident #23 walking around Resident #37, and they decided to keep an eye on Resident #23. Time went by and they (Activity Aide #26 and the coworker) were bringing people back in and they were also bringing in tables for a party that was happening later. As they opened the door to get the rest of the people, they saw Resident #23 grabbing Resident #37's private areas. Resident #37 screamed to stop and Activity Aide #26 screamed for Resident #23 to stop and told them to go the their room.Registered Nurse #20's note dated 08/23/2025 at 12:20 PM documented activities staff witnessed Resident #23 touching another resident's breast while out on back patio. Resident was in a supervised area and was immediately separated and redirected to room after incident. Supervisor was made aware, and psychology would follow up. During an interview on 04/24/2026 11:54 AM, the Regional Nursing Coordinator stated they could not recall if the incident was reported and they were unable to find any record of the reporting of the incident involving Resident #23.During an interview on 04/24/2026 at 1:02 PM, the Director of Nursing stated that the incident should have been reported while an investigation was completed. During an interview on 04/27/2026 at 11:14 AM, the Medical Director stated that the incident should have been reported. They stated that they do typically review the incident reports but do not recall seeing the report from 08/23/2025.During an interview on 04/27/2026 at 4:04 PM, the Administrator stated that a more thorough investigation should have been conducted. They stated they were working at a sister facility at the time of this incident, and the prior Administrator had asked them for guidance. They stated they explained to them that it needed to be reported and investigated due to the inappropriate touching. 10NYCRR 415.4(b)(3)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review conducted during the survey, the facility did not ensure that they initiated and completed a thorough investigation to determine if alleged abuse could have been prevented and to prevent further abuse while the investigation was in progress for one (1) of four (4) residents (Resident #23) reviewed for behavioral-emotional concerns. Specifically, Resident #23 was observed touching another resident inappropriately on 08/23/2025. The Accident/Incident report dated 08/23/2025 did not document a thorough investigation to prevent reoccurrence of the situation and protect other residents during the investigation. Additionally, the Medical Director was not aware of the nature of the incident, and the report was signed by the supervising nurse and only reviewed and signed by the Administrator. Findings included: Resident #23 had diagnoses that included dementia, hydrocephalus, and anxiety. The Quarterly Minimum Data Set, dated [DATE] documented severely impaired cognition, no behaviors, and independent with activities of daily living and ambulation.The facility policy titled Resident Abuse Prevention and Reporting, last revised 05/2025, documented that upon receiving a report of suspicion of abuse of any kind, supervisory/administrative staff are required to immediately initiate an investigation into the alleged incident. The investigation will proceed per the criteria on the investigative report, with documentation of all actions taken on an ongoing basis for the duration of the investigation. All abuse investigations will be reviewed by the Administrator, Medical Director and Director of Nursing.The Dementia Care Plan initiated on 06/18/2025 documented resident has impaired decision making. Interventions included psychological services and psychiatric and medical management per physician orders.The At Risk for Unsafe Behavior Care Plan dated 07/03/2025 documented at risk for unsafe behavior due to cognitive deficit due to significant mental health and neurological diagnoses including frontotemporal neurocognitive disorder. Interventions included maintaining safety devices, anticipating and meeting needs, observing for signs and symptoms of evolving mood or temperament change and intervening promptly.Registered Nurse #20's nursing behavior note dated 08/23/2025 at 12:20PM documented activities staff witnessed Resident #23 touching another resident's breast while out on back patio. Resident #23 was in a supervised area and was immediately separated and redirected to room after incident. Supervisor was made aware; psychology would follow up. Registered Nurse #8's nursing progress note dated 08/23/2025 at 1:49 PM documented they were made aware of resident behavior during shift. Residents involved were immediately separated and assessed; no signs or symptoms of injury noted. Resident denied pain or discomfort. Resident was educated on appropriate behavior and the importance of reporting any concerns to staff. Administration notified of the incident. Will continue to monitor for any changes in behavior or condition.Review of the New York State Department of Health complaint database revealed the incident was not reported to the State Agency.When requested on 04/2302026, the Director of Nursing stated they would look for the investigation. On 04/24/2026 at 7:59 AM, the investigation was requested again. The investigation was received on 04/24/2026 at 10:30 AM. The investigation included an Accident/Incident Report dated 08/2302025, a written statement by Activity Aide #26, and an Inservice sign-in sheet dated 09/01/2025.The Accident and Incident Report dated 08/23/2025 at 1:00 PM documented that Resident #23 was observed touching a female resident's breast with their hands. A recreation staff member was present and witnessed the interaction. Residents were separated immediately. No injuries noted. Relevant diagnoses were listed for Resident #23 as dementia and cognitive communication. Other contributing factors listed were cognitive deficit, perceptual impairment, and poor safety awareness. The physician was notified with no interventions or new orders listed. The report was signed by the supervising nurse and the Administrator. There was no signature from the Director of Nursing or the Medical Director.Activity Aide #26's written statement dated 08/23/2025, documented they and a coworker took a few residents outside for some (continued on next page)

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	fresh air. Resident #37 was strolling around in their wheelchair. Activity Aide #26 saw Resident #23 walking around Resident #37 and they decided to keep an eye on Resident #23. Time went by and they (Activity Aide #26 and the coworker) were bringing people back in and they were also bringing in tables for a party that was happening later. As they opened the door to get the rest of the people, they saw Resident #23 grabbing Resident #37's private areas. Resident #37 screamed to stop, and Activity Aide #26 screamed for Resident #23 to stop and told them to go their room.There was a sign-in sheet dated 09/01/2025 for education that was signed by the two activity aides that documented Increased supervision for residents with behaviors. titled Supervising residents with behaviors. There was no other information regarding this in-service, and it lacked documentation as to who provided the in-service. There was no documented evidence that a thorough investigation was completed.During an interview on 04/24/2026 at 1:02 PM, the Director of Nursing stated that there should have been a more thorough investigation completed for this incident.During an interview on 04/27/2026 at 11:14 AM, the Medical Director stated that they could not recall the incident on 08/23/2025 involving Resident #23 touching another resident inappropriately. The incident should have been investigated and they stated they would have likely ordered a psychiatric consultation and medication review had they realized the nature of the incident. They stated that they do typically review the incident reports but do not recall seeing the report from 08/23/2025. During an interview on 04/27/2026 at 4:04 PM, the Administrator stated that a more thorough investigation should have been conducted. They stated they were working at a sister facility at the time of this incident, and the Administrator had asked for guidance. They stated they had explained to them that it should be reported and investigated due to the inappropriate touching. The Medical Director should have been involved and aware as well.10NYCRR 415.4(b)(3)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review during the survey, the facility did not ensure notification to the resident representative or ombudsman regarding transfer or discharge, including the reason for the transfer/discharge, in writing and in a language and manner understood, for three (3) of three (3) residents (Resident #111, Resident #3, and Resident #5) reviewed for hospitalization. Specifically, 1) Resident #111 was hospitalized on [DATE] and the facility did not complete a discharge notice or bed-hold notification, and the ombudsman did not receive notification; 2) Resident #3 was hospitalized [DATE] and the facility did not provide a discharge notice or bed-hold notification to Resident #3's representative and did not notify the ombudsman; and 3) Resident #5 was hospitalized [DATE] and the facility did not provide a discharge notice or bed-hold notification and did not notify the ombudsman. Findings include: The Policy and Procedure titled Notice of Transfer/Discharge, last revised 05/2024, documented that social workers, nurse supervisors, and unit managers are responsible for ensuring residents and resident representatives are notified of any transfers and discharges promptly, including the reason for the transfer or discharge. The policy documented that the social worker must provide a written discharge notice to the resident and the resident representative and must also provide a copy of the discharge notice to a representative of the Office of the State Long-Term Care Ombudsman. 1) Resident #111 had diagnoses including cardiac arrest (heart stops suddenly), breast cancer, and chronic kidney disease. The Five-Day Minimum Data Set (an assessment tool) dated 02/05/2026 documented Resident #111 had intact cognition and required minimal assistance with activities of daily living. A Nursing Progress Note dated 01/30/2026 documented resident #111 was transferred to the hospital from the Heart Center due to lethargy and hypotension and was admitted for observation. There was no documented evidence that Resident #111 or the resident representative received a discharge notice or bed-hold notification. There was no documented evidence that the ombudsman was notified of Resident #111's hospitalization. During an interview with the Director of Social Work on 04/22/2026 at 4:44 PM, the Director of Social Work stated the resident was transferred from the Heart Center directly to the hospital on [DATE]. They stated the Ombudsman was not notified, the transfer/discharge notice was not mailed, and the resident representative was not notified of the bed-hold policy. The Director of Social Work stated they were responsible for all three (3) tasks; however, because the resident was transferred directly from the Heart Center to the hospital and did not leave the facility, the tasks were not completed. 2) Resident #3 had diagnoses that included Alzheimer's dementia, Schizophrenia, and diabetes mellitus. The Minimum Data Set assessment dated [DATE] documented Resident #3 had severely impaired cognition and required moderate assistance for sit to stand, transfers from chair to bed, and used a walker for ambulation. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/20/2026 at 4:34 PM Resident #3's adult child stated the Resident had been hospitalized a few months ago and they were unsure if Resident #3's spouse was notified. A nursing progress note dated 01/16/2026 documented that Resident #3 was observed to be sitting in a chair in their room, nonverbal with left sided weakness and head tilted to the right. Resident #3 was alert to self and unable to follow commands. The emergency medical service was called for possible stroke. The Assistant Director of Nursing, the physician and Resident #3 spouse were notified of transfer to the hospital. A Social Work progress note titled Transfer/Discharge Notice dated 1/16/2026 documented that Resident #3's representative had been notified by phone of the discharge but there was no documented evidence that the representative had received a discharge notice or bed-hold notification. There was no documented evidence that the ombudsman was notified of Resident #3's hospitalization. During an interview on 04/23/2026 at 9:39 AM the Social Worker stated they did notify Resident #3's spouse by phone and did not have documentation of sending notification by mail. The Social Worker was unable to provide documentation of notification to the ombudsman. 3) Resident #5 had diagnosis that included lung cancer, respiratory failure, and diabetes mellitus. The quarterly Minimum Data Set assessment dated [DATE] documented Resident #5 was severely impaired cognition and required supervision for eating and was dependent on staff for sit to lying and transfers. A nursing progress note dated 12/10/2025 documented that Resident #5 had a decline of status. Oxygen at 60%, non-responsive to verbal and tactile stimuli, foaming at the mouth, labored/distressed breathing, change in mental status, not responding to breathing treatments. Nurse Practitioner at bedside to assess the resident and order to transfer to the hospital for respiratory failure. A nursing progress note titled Transfer/Discharge Notice dated 12/10/2025 documented that Resident #5's designated representative had been verbally informed of the discharge but there was no documented evidence that the representative had received a discharge notice or bed-hold notification. There was no documented evidence that the ombudsman was notified of Resident #5's hospitalization. During an interview on 04/23/2026 at 2:43 PM the Social Worker stated Resident #5 had no family to notify and no case worker. During an interview on 04/24/2026 at 9:15 AM the Social Worker stated they were unable to provide documentation that ombudsman was specifically notified about Resident #5's discharge. They did have an email to the ombudsman on 12/26/2025 about the monthly discharges but did not know if Resident #5's notification was included. 10NYCRR 415.3(i)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. Based on record review and interviews conducted during survey, the facility did not electronically transmit encoded and completed Minimum Data Set (MDS) assessments to the Centers for Medicare and Medicaid Services (CMS) system within 14 days of the final MDS completion date, as required for payment information and quality measure purposes. This was evident for one (1) resident (Resident #101).The findings are: The facility policy titled Minimum Data Set, last revised 07/2025, required each resident to have a comprehensive functional capacity assessment recorded on a designated Minimum Data Set (MDS) form and electronically submitted to the State Department of Health in accordance with federal and state regulations. Review of facility Minimum Data Set assessment data completion and submission activities conducted on 04/27/2026 revealed the following. The Minimum Data Set record exceeded fourteen (14) days from the date of completion. It was not electronically transmitted to the Centers for Medicare and Medicaid Services system within the required timeframe. The 12/22/2026 Discharge Minimum Data Set assessment for Resident #101 had a completion date of 04/22/2026 and a transmission date of 04/25/2026, which was eighty-nine (89) days past the required submission timeframe. During an interview conducted on 04/27/2026 at 10:24 AM, the Director of Minimum Data Set stated the delay in completion occurred due to a pending registered nurse sign-off on the assessment. The Director of Minimum Data Set stated transmission occurred after completion and acknowledged responsibility for submission. 10 NYCRR 415.11

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **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 a comprehensive person-centered care plan was developed and/or implemented, to meet a resident's needs for two (2) of three (3) residents (Resident #46 and #106) reviewed for Respiratory, one (1) of three (3) residents (Resident #29) reviewed for Urinary Catheters and Urinary Tract Infections, and one (1) of three (3) resident reviewed for Dental. Specifically, 1) Residents #46 and #106 received oxygen and did not have a respiratory care plan; 2) Resident #29 had an indwelling catheter placed on 04/01/2026 and did not have a care plan in place for catheter care; and 3) Resident #98 did not have a comprehensive care plan to address dental issues.The findings include: The facility policy, Comprehensive Care Plans, last reviewed 05/2025, documented that it is to ensure that each resident is provided with individual goal directed care that was reasonable, measurable and based upon a resident's needs. A resident's care plan should have the appropriate interventions and provide a means of interdisciplinary communication to ensure continuity in a resident's care. 1) Resident #46's diagnoses included chronic kidney disease-stage four, liver cirrhosis and acute respiratory failure with hypercapnia. The Annual Minimum Data Set (an assessment tool) dated 02/20/2026 documented Resident #46 had intact cognition and was short of breath when lying flat. A physician order dated 03/11/2026 documented Resident #46 was to be administered oxygen at three (3) liters per minute via nasal cannula as needed. A review of Residents #46 care plans documented no evidence that an active respiratory care plan was in effect. During observations on 04/23/2026 at 9:53 AM and 04/24/2026 at 8:59 AM, Resident #46 was receiving oxygen via a nasal canula. During an interview on 04/24/2026 at 04:25 PM, Licensed Practical Nurse Unit Manager #1 stated care plans were put in by a registered nurse and licensed practical nurse could do updates. During an observation on 04/27/2026 at 8:20 AM, Resident #46 was receiving oxygen via a nasal canula. During an interview on 04/28/2026 at 11:02 AM, the Director of Nursing stated they expected nurses to update care plans as resident's conditions changed including injuries, new medical conditions or new medications. Care plans were added as needed when new conditions were found. The Director of Nursing stated there was no active care plan for respiratory care or oxygen therapy for Resident #46. 2) Resident #29 had diagnoses of benign prostatic hyperplasia, neurogenic bladder causing urine retention and osteomyelitis. The Annual Minimum Data Set (an assessment tool) assessment dated [DATE] documented that Resident #29 was cognitively intact. The resident was continent of bowel and bladder and did not (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have an indwelling catheter. The care plan, Continence Bowel/Bladder dated 7/01/2025, documented potential for incontinence for bowel and bladder. A Nurse Practitioner progress note dated 03/25/2026 at 04:09 PM, documented Resident #29 continued to have difficulty with urinary retention. Licensed Practical Nurse Unit Manager #1's progress note dated 3/29/2026 at 11:00 AM by, documented Resident #29 continued to have difficulty voiding. The Nurse Practitioner progress note dated 03/30/2026 at 11:08 PM, documented Resident #29 had difficulty emptying their bladder. They did not want to have a Foley (indwelling urinary) catheter placed at the facility. They requested to be scheduled with a urologist. Licensed Practical Nurse #4's progress note dated 03/31/2026 at 8:57 PM, documented Resident #29 went to a urology appointment and then were sent to a hospital emergency department for evaluation. Licensed Practical Nurse Unit Manager #1's progress note dated 04/01/2026 at 4:27 PM, documented Resident #29 returned to the facility from the hospital with an indwelling catheter placed due to urinary complications/retention. During an interview on 04/24/2026 at 4:25 PM, Licensed Practical Nurse Unit Manager #1 stated care plans were put in by a registered nurse and a licensed practical nurse could do updates. There were no interventions on indwelling catheter care in the care plans for Resident #29. The care plan was updated on 04/25/2026 to include the indwelling catheter placed on 04/01/2026. During an interview on 04/28/2026 at 11:02 AM, the Director of Nursing stated they expected nurses to update care plans as residents' conditions changed including new medical conditions or new medications. Care plans were added as needed when new conditions were found. Resident #29's care plans should have been updated when they returned from the hospital with a new indwelling catheter. 3) Resident #98 was admitted on [DATE], with diagnosis including non-Alzheimer's dementia, anxiety disorder, and cancer The admission Minimum Data Set assessment dated [DATE] documented Resident #98 had intact cognition, was independent or required set up assistance for all activities of daily living. During an interview on 04/20/2026 at 4:47 PM, Resident #98 stated they thought they lost their lower partial dentures at the facility. During an interview on 04/20/2026 at 5:13 PM, Resident #98's family member stated they were not sure if Resident #98 had their lower partial dentures when they were admitted to the facility. During an interview on 04/23/2026 at 4:31 PM, the Speech Therapist stated Resident #98 did not have a lower partial denture on admission to the facility. There was no documented evidence of a dental care plan for Resident #98. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10NYCRR 415.11(c)(1

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview, and record review during the survey, the facility did not ensure that activities were provided based on the comprehensive assessment, care plan, and preferences of each resident that met the interests of and support the physical, mental, and psychosocial well-being for two (2) of three (3) residents (Resident #3 and Resident #68) reviewed for activities. Specifically, 1) Resident #3 was observed in their room on 04/20/2026 and 04/21/2026 and there was no documented evidence of attendance to group or in room visits on those days. 2) Resident #68 was observed in bed on 04/21/2026 and 04/24/2026 and there was no documented evidence of in-room activities on those days. Furthermore, there was no documented evidence of consistent activity attendance on any days.Findings include:A policy titled Activity Programs reviewed 05/2024 documented Activity programs designed to meet the needs of each resident are available on a daily basis; individual [NAME] group activities are included in evening, holiday and weekend hours; and are provided to ensure needed services identified in the resident's plan of care are met.The Activity calendar dated 04/20/2026 documented 11 AM Sun Catchers and 2:30 PM Sensory activities for Unit 300.The Activity calendar dated 04/21/2026 documented 11 AM Earth Day crafts and 2:30 PM Toss game for Unit 300.The Activity calendar dated 04/24/2026 documented 11 AM Toss game and 2:30 PM Tree planting for Unit 300.1)Resident #3 had diagnoses that included, but not limited to Alzheimer's, dementia, Schizophrenia, and diabetes mellitus.The Minimum Data Set assessment dated [DATE] documented Resident #3 had severely impaired cognition and required moderate assistance for sit to stand, transfers from chair to bed and used a walker for ambulation. An Activities quarterly progress noted dated 02/12/2026 documented Resident #3 liked small group activities or 1:1; liked religious services; TV- animal shows and staff would encourage Resident #3 to go to patio activities as the weather improved. The Activities Care Plan effective 02/12/2026 documented Resident #3 with limited participation in activities due to cognition. The goal was for Resident #3 to receive 1:1 visits and to be encouraged to participate in small group activities 5x/week to maintain socialization. Resident #3 was observed sitting in their room on 4/20/2026 and 4/21/2026.During an interview on 04/20/2026 at 4:13 PM Resident #3's daughter stated she wasn't sure if Resident #3 was attending facility activities. The daughter reported she thought someone was providing a manicure but did not think Resident #3 was encouraged to leave her room and go outside.During an interview on 04/22/2026 at 1:31 PM the Activity Director stated Resident #3 was passive and enjoyed parties and coloring. As of 04/22/2026 Resident #3 had attended an activity on five (5) days out of 22 opportunities for April 2026. There were no room visits documented for February, March or April 2026. The Activity Director stated they attempted to visit with Resident #3 five (5) days weekly. The Activity department was down two (2) staff members and actively interviewing.During an interview on 04/24/2026 at 11:07 AM, Activity Aide #19 stated they were trying to see Resident #3 in the morning to let them know the activities offered each day. At that time Activity Aide #19 stated they had not been to see Resident #3 yet. Activity Aide #19 stated they try to do 1:1 visits three (3) to five (5) times a week. 2) Resident #68 had diagnoses that included, but not limited to Non-Alzheimer's Dementia, Multiple Sclerosis, and depression.The Annual Minimum Data Set assessment dated [DATE] documented moderately impaired cognition, set-up for eating, dependent for rolling, sit to lying and transfers. It was documented that going outside when weather permitted was very important to Resident #68.The Activities Care Plan dated 02/02/2026 documented Resident #68 had limited participation in activities due to their choice and enjoyed watching TV. The goal was to receive 1:1 visits for sensory stimulation and invitations to facility events.During an interview on 04/21/2026 at 11:17 AM Resident #68 stated they did not care for the activities that were offered at the facility and that the staff did not come in often to ask they would like to attend activities. During an interview on 04/22/2026 at 2 PM the Director of Activities stated they had never seen Resident (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#68 out of their room, preferring to just stay in their room and watch TV, but should be seen for 1:1 visits. The Director of Activities stated there was only one (1) day of documented activity attendance out of 22 for the month of April 2026 and nothing for March 2026. They had difficulty getting previous staff to document attendance.During an interview on 04/24/2026 at 10:43AM Activity Aide #19 stated Resident #68 did not like to attend facility activities, but did like manicures, crafts and watching TV. Activity Aide #19 stated they saw Resident #68 in their room almost every other day for visits.During an interview on 04/27/2026 at 1:38 PM the facility Administrator stated the Activity Director had been working at the facility for three (3) months and was offering more activities including outside entertainers and holiday celebrations. The department had to let two (2) other staff members go and both the Activity Director and the Aide were trying to cover the whole facility. 10NYCRR 415.5(f)(1)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on 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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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility did not ensure care consistent with professional standards of practice was provided for two (2) of three (3) residents (Resident #46, #106) reviewed for Respiratory Care. Specifically, Residents #46 and #106 were administered oxygen at a liter flow greater than the physician order.The findings included: The facility policy, Oxygen Administration, last updated 5/2025, documented oxygen is administered by licensed nursing staff to patients requiring oxygen therapy in the presence of a physician order with a pertinent diagnosis relating to blood oxygenation. 1) Resident #46's diagnoses included chronic kidney disease-stage 4, cirrhosis of liver and acute respiratory failure with hypercapnia. The Annual Minimum Data Set (an assessment tool) dated 02/20/2026 documented Resident #46 had intact cognition and was short of breath when lying flat. A physician order dated 03/11/2026 documented three (3) liters/minute of oxygen via nasal cannula as needed. During observations on 04/23/2026 at 9:53 AM and 4/24/2026 at 8:59 AM, Resident #46 oxygen flow rate on the oxygen concentrator was set at 3.75 liters per minute. During an interview on 04/24/2026 at 9:03 AM, Licensed Practical Nurse #1 stated the oxygen flow rate was at four (4) liters per minute and they would check the orders and adjust it. During an observation on 04/27/2026 at 8:20 AM, Resident #46 oxygen flow rate on the oxygen concentrator was set at four (4) liters per minute. During an interview on 04/27/2026 at 8:25 AM, Licensed Practical Nurse #1 stated the oxygen flow rate was at four liters per minute. Licensed Practical Nurse #1 stated they talked to the nursing staff on 04/24/2026 about setting the oxygen flow rate correctly for each resident. 2) Resident #106 diagnosis included Multiple Sclerosis, Non -Alzheimer's Dementia, and respiratory failure. The Annual Minimum Data Set, dated [DATE] documented Resident #106 was not assessed for cognition due to resident rarely/never understood, shortness of breath when lying flat, and oxygen therapy. A physician order renewed 02/14/2026 documented oxygen device nasal cannula 2 Liter/minute continuous. During an observation on 04/20/2026 at 12:58 PM Resident #106 was lying in bed with nasal cannula in place, and the concentrator set between 2-3 Liters. During an observation on 04/21/2026 at 11:57 AM Resident #106 was lying in bed with nasal cannula in place, and the concentrator set at 2.5 Liters. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/21/2026 at 12:06 PM Licensed Practical Nurse #11 stated Resident #106's oxygen order was for 2 Liters. They observed the concentrator and stated it was currently set at 2.5 liters. They corrected the setting to 2 Liters and stated it should be checked at least once a shift and only nurses should be adjusting the oxygen settings. During an interview on 4/28/2026 at 11:02 AM, the Director of Nursing stated they expected nurses to set the oxygen flow rate as per physician orders. They stated only nurses were to adjust the oxygen flow rate since it was considered a medication. No other staff members were to adjust the oxygen rate for any reason. 10NYCRR 415.12 (k)(6)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews during the survey, the facility did not ensure that they had sufficient staff to provide nursing related services for residents with mental and psychosocial disorders to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of residents for one (1) of four (4) residents (Resident #23) reviewed for behavioral emotional concerns. Specifically, the facility determined that Resident #23 required one-to-one supervision during the day and evening shifts after an incident involving another resident and inappropriate touch on 08/23/2025. However, the need for one-to-one supervision was not documented clearly or consistently and the staffing sheets from 04/01/2026 to 04/27/2026 documented insufficient numbers of staff to cover the one (1) to one (1) supervision. The findings include:Resident #23 had diagnoses that included dementia, hydrocephalus (chronic condition of accumulation of fluid within the brain), and anxiety.The most recent Psychiatric Consultation dated 05/13/2025 documented that Resident #23 had psychiatric diagnoses that included frontotemporal neurocognitive disorder with speech/language deficits, major depressive disorder, and sexual disorders.The Quarterly Minimum Data Set, dated [DATE] documented severely impaired cognition, no behaviors, and independent with activities of daily living and ambulation.The Accident and Incident Report dated 08/23/2025 at 1:00 PM documented that Resident #23 was observed touching a resident's breast with their hands.The Sexual Disorders Care Plan initiated 08/29/2025 documented that resident has exhibited sexually inappropriate behavior. Interventions included medical management to minimize behaviors, psychiatric evaluation and follow up, administer psychoactive and sexually suppressive medication per physician order, and sight supervision when out of bed.Calendar assignment sheets from 09/16/2025 to 11/30/2025 were provided for review. The sheets were titled one to one without a resident identifier and documented staff names followed by a time. It was completed daily with varying times documented including 7am-3pm, 9am-3pm, 3pm-11pm, all day, 7pm-11pm. There was no documented evidence of any one-to-one supervision recorded from 12/1/2025 to 04/01/2026.Sheets titled Monitoring for Resident #23 7am-3pm and 3pm-11pm one-to-one and overnight 15-minute checks from 04/01/2026-04/27/2026 were provided for review. Of those sheets, there were omissions on the following days for one-to-one supervision on the 7AM-3PM shift; 04/04, 04/05, 04/12, 04/25, and 04/26/2026. There were omissions on the following days for one-to-one supervision on the 3PM-11PM shift; 04/04, 04/05, 04/11, 04/12, 04/16, 04/21, 04/23,04/25, 04/26, and 04/27/2026. The one-to-one supervision sheets were cross-referenced with staffing sheets from 04/01/2026 to 04/27/2026 and documented no assigned staff to provide the one-to-one supervision on the 7AM-3PM shift on the following dates: 04/04, 04/05, 04/12, 04/25, and 04/26/2026. The sheets documented no assigned staff to provide one-to-one supervision on the 3PM-11PM shift on the following dates: 04/04, 04/05, 04/11, 04/12, 04/16, 04/21, 04/23, 04/25, and 04/26/2026. There was a staff member assigned on 04/27/2026 from 3PM-11PM according to the staffing sheets. There was no documented evidence of an order for the one-to-one supervision for Resident #23.There was no documented evidence on the care plan of one-to-one supervision for Resident #23.During an observation and interview on 04/22/2026 at 10:35 AM, Resident #23 was observed with one-to-one supervision. Liaison #23 was sitting with Resident #23 and there were no observed behavior concerns. They stated they were familiar with Resident #23 and had been assigned to supervise them frequently. Liaison #23 stated that Resident #23 was receptive to but did need redirection. During an observation on 04/23/2026 at 10:13 AM, Resident #23 was observed ambulating on Unit 100. They walked briskly without assistance to the patio door. Liaison #25 was observed supervising Resident #23's activity and providing one-to-one supervision.During an interview on 04/23/2026 at 11:02 AM, Certified Nurse Aide #24 stated that they were not very familiar with (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #23 but that they knew they were supposed to have one-to-one supervision during the day and evening shifts, and frequent checks on the overnight shift. Depending on the staffing, either liaisons or certified nurse aides provided supervision.During an interview on 04/23/2026 at 12:15 PM, Licensed Practical Nurse Unit Manager #1 stated that Resident #23 had one-to-one supervision on the day and evening shifts. The facility implemented the one-to-one supervision for inappropriate touching in August 2025. They stated that there was no order for the one-to-one supervision, and the one-to-one supervision was not on the care plan for Resident #23 but could not say why it was not. However, there was an order for 15-minute checks that were documented in the electronic medical record. The one-to-one supervision was now documented on log sheets that were kept in a book at the nurses' station but not in the electronic medical record.During an interview on 04/23/2026 at 1:04 PM, the Director of Nursing stated that Resident #23 received one-to-one supervision during the day and evening shifts. They stated they were not at the facility when the supervision was implemented so they were uncertain why the one-to-one supervision was implemented before trying something else. There was no order for the one-to-one supervision or consistent documentation prior to 04/01/2026, but they implemented one-to-one log sheets that started on 04/01/2026 and they should be completed daily now. During an interview on 04/27/2026 at 11:14 AM, the Medical Director stated they were unaware of the nature of the incident involving Resident #23 in August 2025. If they were aware they would have likely ordered a psychiatric consultation and medication review. They had not ordered one-to-one supervision for Resident #23 and did not know they were receiving one-to-one supervision.During an interview on 04/27/2026 at 1:41 PM, the Human Resources and Staffing Manager stated that they did not always but were now listing the staff member who was assigned to the one-to-one supervision for Resident #23. They stated that there were days that there were not enough staff to provide one-to-one supervision. If they did not have the staff, 15-minute checks were performed. They did not notify anyone if there was not enough staff for the one-to-one supervision. They stated it was understood that the staff would complete the 15-minute checks in place of the one-to-one supervision if there were not enough staff on a given day. 10NYCRR 415.12(f)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews, the facility did not ensure infection control practices and procedures were maintained when handling linens on two of three units (Unit 1 and 2). Specifically, 1) On Unit 2, room [ROOM NUMBER] had bagged soiled linens on the floor that had been there for a prolonged period; Certified Nurse Aide #14 was observed with soiled linens unbagged directly on the floor while changing the bed in room [ROOM NUMBER]; and carts holding clean linen were observed uncovered in the clean linen room. 2) On Unit 1, Certified Nurse Aide #15 was observed drinking and placing their personal drink cup into the clean linen and supply cart in hallway and then leaving the immediate area with the clean supply cart flaps open. The findings include: The facility Linen Management policy, last reviewed 05/2025, documented that clean linens are to be kept covered and protected from dust and other contaminants prior to use. Soiled linen is to be placed in a bag at the point of care, within the resident room or resident care area, immediately upon use. At no time are soiled bags or soiled linens to be placed on the floor. Bags are then placed into the appropriate container. Dirty linen should be removed in a manner that contains contamination to the inside as much as possible and placed immediately into a plastic bag. 1) During an observation and interview on 04/23/2026 at 9:39 AM, bagged soiled linen was observed sitting on the floor in room [ROOM NUMBER]. Certified Nurse Aide #13 stated that the resident in that room strips their bed and leaves the bags on the floor. Those bags were from the overnight shift. They stated they would move the bags of linens after breakfast. Typically, when they changed bed linens, they would not leave them on the floor in the room but would take them to the soiled utility room after stripping the bed. During an observation and interview on 04/23/2026 starting at 9:43 AM, Certified Nurse Aide #14 was observed making the bed by the window in room [ROOM NUMBER]. While Certified Nurse Aide #14 was putting the clean linens on the bed, the soiled linens were observed unbagged directly on the floor. Certified Nurse Aide #14 bagged the linens after the bed was made. When asked if the soiled linens should be directly on the floor, Certified Nurse Aide #14 stated they were unsure. The clean linen storage room was then observed with Certified Nurse Aide #14 and the cart holding the linens did not have a cover. Certified Nurse Aide #14 was not certain if the carts ever had covers in the storage room. During an interview on 04/28/2026 at 11:15 AM, the Director of Nursing stated that soiled linens should not be thrown on the floor. They should be bagged immediately after being removed from the bed and taken to the soiled utility room. Soiled linens should not be stored in or out of a bag on the floor in the room. Clean linens should be covered when transported and when they are stored 2) During an observation and interview on 04/24/2026 at 08:48 AM, Certified Nurse Aide #15 was observed drinking and placing their personal drink cup into the clean linen and supply cart in the Unit 1 hallway. Certified Nurse Aide #15 then left the immediate area of the cart with the flaps open keeping the clean supplies exposed to the environment. Certified Nurse Aide #15 stated they knew they were not supposed to keep the personal drink cup in the clean supply cart, but they drank a lot of water and knew to close the flaps on the cart when leaving. During an interview on 04/28/2026 at 11:02 AM, the Director of Nursing stated personal drink cups were not supposed to be placed in any clean linen or supplies cart. Staff should have closed the flaps (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	when leaving the cart to ensure the lines and supplies were kept clean. 10 NYCRR 415.19 (c)