STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335350	A. Building B. Wing	01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sutton Park Center for Nursing and Rehabilitation	31 Lockwood Avenue New Rochelle, NY 10801

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	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 observation and interview conducted during the recertification survey and abbreviated surveys (686919, 2690393) from 01/20/2026 to 01/28/2026, the facility did not maintain a homelike environment for two of four (third and sixth floor) nursing units, and a tub room on the 4th floor. Specifically, 1) resident rooms # 302 a-b, 307 a-d, 315 a-d, 316 a-d were not personalized, lacked adequate visitor seating, 2) fifteen resident rooms (602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 614, 616, 617, 619, and 620) were observed stark and bare without personalization; and 15 resident rooms (603, 604b, 605a, 606a-b, 609a, 610, 606 a-b, 607a-d, 609a, 610, 616a-d, 617a, 618b, 619a-b, and 620) did not contain a chair for resident/visitor use; and 3) the tub room on the 4th floor, had window insulation that was coming out and a cold draft was coming from the window. The findings included: A facility policy titled Resident Rights dated 08/2021 documented: Resident has the right to have a homelike environment, keep and use your personal belongings and property as long as they do not interfere with the rights, health, or safety of others. 1) During an observation on 01/22/2026 at 8:49 AM, room [ROOM NUMBER] (a four-resident room) was cluttered and the floor was dirty with debris. The walls were bare had no personalized items were present. No chairs were available for visitors or residents in the room. During observation on 01/23/2026 from 8:32 AM to 8:44 AM, room [ROOM NUMBER] did not have personalized photos of the residents or clocks; room [ROOM NUMBER] had bare walls and lacked chairs for the residents or visitors; room [ROOM NUMBER] (four-resident room) had no personalized items for 3 of the 4 residents; Rooms 316 (a four-resident room) had an activities calendar on the wall, but lacked any other personalization and no chairs were available. 2) During observations on 01/22/2026 at 3:31 PM and 01/23/2026 at 9:08 AM, the following resident rooms were stark and bare, without visible personalization such as photos, pictures on the wall or decorations: 602a-b, 603a, 604a-b, 605a, 606a-b, 607a-b, 608a-b, 609a-b, 610, 611, 614, 616c-d, 617a-b, 619a-b, and 620b; and the following resident rooms did not have a chair for residents or visitors: 603, 604b, 605a, 606a-b, 609a, 610, 606 a-b, 607a-d, 609a, 610, 616a-d, 617a, 618b, 619a-b, and 620a-b. During an interview on 01/27/2026 at 11:43 AM, Registered Nurse Supervisor #6 stated they were aware many of the resident rooms were not homelike or personalized. They stated residents who had visits from family members were more likely to have a personalized, homelike room than residents who did (continued on next page)

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

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	not have visitors. They stated many of the residents did not have family or friends who visited. They stated they were unaware there were no chairs in many resident rooms. During an interview on 01/27/2026 at 4:37 PM, Social Worker #2 stated resident family/friends frequently assisted with decorating or personalizing a resident's room. They stated the Social Work Department did not usually address creating a home-like environment and it would be a Recreation Department activity. During an interview on 01/27/2026 at 4:59 PM, the Administrator stated units were decorated by Recreation Department for the holidays, usually the day room, dining area, hallways, and nurse station and they were not sure if they also decorated resident rooms. They stated that resident rooms were frequently personalized by the resident families and that every resident room should have a chair for resident/visitor use. During an interview on 01/28/2026 at 11:02 AM, the Director of Recreation stated Recreation staff rounded resident rooms daily and when they observed rooms that were bare and not homelike, they would reach out to resident families. If a resident or family requested assistance in hanging pictures or printing out items such as photos, the Recreation Department would assist. They stated the Recreation Department decorated unit hallways, dayroom and dining room for the holidays and resident rooms were not decorated or personalized unless requested by the resident or staff. They stated they had not received requests from staff or residents to personalize resident rooms on the 6th floor unit and had not discussed personalizing and creating a homelike environment for resident rooms with managers or administration. 3) During an observation on 1/20/26 at 3:44 PM of the 4th floor tub room, two (2) windows in the bathroom had insulation that was coming out and there was a draft by the window. During an interview on 1/28/2026 at 1:14 PM the Director of Building Services stated the building was being renovated and the 4th floor was 95% renovated. They further stated they were not aware of any concerns with the window insulation in the 4th floor tub room and there had been no work orders for it. 10NYCRR 415.5(h)(1)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on observation, interview, and record review conducted during the recertification and abbreviated (2569922) surveys from 01/20/2026 to 01/28/2026, the facility did not ensure that all alleged injuries of unknown origin, were reported to the State Agency for one (1) of seven (7) residents. (Resident #51) reviewed for abuse. Specifically, Resident #51 had an x-ray that confirmed the dislocation of the right femoral head (top of long bone in the thigh) prosthesis (hip replacement). The 01/18/2025 Accident/Incident Report documented the date, location, and time of occurrence as unknown, and there was no documented evidence that the injury of unknown origin was reported to the State Agency. The findings include: The facility's Policy and Procedure titled Abuse Identification and Investigation; Prevention; and Reporting, revised 12/05/2025, documents that an injury should be classified as an injury of unknown source when the criteria are as follows: the injury was not observed by any person, the injury could not be explained by the resident, or the injury is suspicious because of the extent or location of the injury, especially if it is in an area not generally vulnerable to trauma. It is also the policy of the facility to investigate and report abuse and crimes per New York State Department of Health and the Centers for Medicare and Medicaid Services regulations. Resident # 51 had diagnoses including a right hip replacement, dementia, and osteoarthritis. The quarterly Minimum Data Set (an assessment tool) dated 04/23/2025 documented that Resident # 51 had severe cognitive impairment and was dependent on staff to complete their daily activities of living. A physician progress note dated 1/17/2025 at 10:46 PM documented the resident was seen for lethargy and tenderness in the right thigh. An X-ray report dated 01/17/2025 of the right femur documented acute posterior dislocation of the femoral head prosthesis with inward rotation of the femur. The accident and incident report dated 01/18/2025 documented that Resident #51 had tenderness in the right thigh. The resident had a dislocated right hip prosthesis according to an x-ray on 01/17/2025. The resident could not give an account of what had happened. Multiple statements were obtained on 01/18/2025 and 01/20/2025 from staff, with all staff documenting that they were not aware of or had not witnessed any incident involving the resident falling. The incident report documented the date, location, and time of occurrence as unknown. The facility investigative summary, dated 01/22/2025 documented that based on the investigation, there was reasonable cause to believe that abuse, mistreatment, or neglect had not occurred. Boxes for Y, N or N/A, (yes, no, or not applicable) for reporting the incident to the Department of Health was not checked. During a telephone interview with the resident's representative on 01/22/2026 at 1:33 PM, they stated they had spoken with the resident's physician, who told them the resident had a dislocated hip. They stated the facility did not provide any information on how the resident's right hip was dislocated. During an interview on 01/28/2026 at 8:58 AM, the Director of Nursing stated an x-ray on 1/17/2025 was done and showed the acetabular prosthesis was dislocated. They stated that the resident did not have a fracture, so it was not reported to the Department of Health (State Agency). They stated the facility followed proper protocols. They stated the resident was not cognitively intact to explain what happened. They stated that they did not know how it happened and based on their judgment and the facility's protocols, it was not a reportable incident. They stated they did not consider it an injury of unknown origin. 10 NYCRR 415.4(b)(2)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. Based on observation, interview, and record review during the recertification and abbreviated (2569922) surveys from 01/20/2026 to 01/28/2026, the facility did not ensure a thorough and complete investigation was done to rule out abuse, neglect, or mistreatment for one (1) of seven (7) residents (Resident # 51), reviewed for abuse. Specifically, Resident # 51 had their right hip replacement dislocated, and the facility did not thoroughly investigate to determine if the care plan was followed when determining a root cause analysis for the dislocated hip. The findings include: The facility's Policy and Procedure titled Abuse Identification and Investigation; Prevention; and Reporting, revised 12/05/2025, documented that it was the policy of the facility to ensure all residents and families that the facility had taken the necessary steps within its control to prevent and prohibit abuse, neglect, and mistreatment. An injury should be classified as an injury of unknown source when the criteria were as follows: the injury was not observed by any person, the injury could not be explained by the resident, or the injury was suspicious because of the extent or location of the injury, especially if it was in an area not generally vulnerable to trauma. Resident # 51 had diagnoses including right hip replacement, dementia, and osteoarthritis. The quarterly Minimum Data Set (an assessment tool) dated 04/23/2025 documented that Resident # 51 had severe cognitive impairment and was dependent on staff to complete activities of daily living, including transfers with two-person assistance. A physician progress note dated 1/17/2025 at 10:46 PM documented the resident was seen for lethargy and tenderness in the right thigh.An X-ray report dated 01/17/2025 of the right femur documented acute posterior dislocation of the femoral head prosthesis with inward rotation of the femur. The accident and incident report dated 01/18/2025 documented Resident # 51 had tenderness in the right thigh. The resident had a dislocated right hip prosthesis, confirmed by an X-ray dated 01/17/2025. The report documented that the resident was unable to give an account of what happened. The report documented the date, location, and time of the occurrence as unknown. The resident's transfer status was documented as 2 person assist and ambulatory status was 1-person assist. The 01/18/2025, typed and signed statement by the Assistant Director of Nursing documented they called staff that were assigned to the 3rd floor and there was no report of any fall or other incidents. Certified Nurse Aides #15. #16, and #17's statements documented they did not see the resident fall or complain. The statements did not document the care the resident was provided. Licensed Practical Nurses #10, #13, and #14 statements documented they did not see or hear about the resident falling. There was no documentation as to the resident's activities.Fifteen (15) written statements by nursing staff, dated 1/20/2025, documented they were unaware of the resident having any falls or incidents. There was no documentation as to the care provided by staff.Three (3) written statements provided by the physical therapy department, dated 01/20/2025, documented the resident was provided physical therapy on 01/16/2025 and 01/17/2025. During treatment the resident denied pain and discomfort and was participative.The facility's investigative summary completed by the Assistant Director of Nursing, dated 01/22/2025, documented on 01/17/2025 the resident had tenderness to the right thigh, and an x-ray showed an acute posterior dislocation of the right femoral head prothesis. The resident required maximum assist of 1 staff for bed mobility and maximum assist of 2 staff for transfers and ambulation. The resident was unable to state how they sustained the dislocation. The investigation included statements from staff indicating there were no recent falls or incidents which may have contributed to the injury. The summary documented it was determined the resident most likely sustained the right femoral head prosthesis dislocation due to history of right hip arthroplasty and osteoarthritis to both hips and recent decline in ADLs. The report documented there was no deviation from the care plan and that abuse, mistreatment, or neglect had not occurred.Further (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	review of the investigative summary dated 01/22/25 revealed no documented evidence as to who provided what care, when it was provided, and the number of staff performing care, including transferring the resident in and out of bed, to determine the care plan was followed.During a telephone interview with the resident's representative on 01/22/2026 at 1:33 PM, they stated they had spoken with the resident's physician, and told the resident had a dislocated hip. They stated they were not provided with any other information as to how the resident's right hip replacement was dislocated. During an interview on 01/28/2025 at 11:44 AM, the Assistant Director of Nursing stated they determined the care plan was followed through interviews with the certified nurse aides. They asked about the resident's activities of daily living and confirmed with the certified nurse aides that the care guide was followed including transfer status. They were unable to provide an explanation as to why it was not documented in the interviews or written statements they obtained from the staff. 10 NYCRR 415.4(b)(3)