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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on 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 not have visitors. They stated many of the residents did not have family or friends who (continued on next page)

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	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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, 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 residents received treatment and care in accordance with professional standards of practice for one (1) of seven (7) residents (Resident # 51) reviewed for Activities of Daily Living and one (1) of one (1) residents (Resident #158) reviewed for non-pressure skin conditions. Specifically, 1) Resident #158 did not have their daily wound dressing changed for 7 days and did not receive treatment according to the physician order. 2) Resident # 51 dislocated their hip and did not have an orthopedic follow-up as recommended in the hospital discharge summary. The findings are: 1) Resident # 158 had diagnoses of lumbosacral and pelvis fractures, Type II Diabetes Mellitus and skin graft right arm. The admission nursing note dated 1/10/2026 documented the resident was alert and oriented and had traumatic wounds from being dragged by a car. Wound sites included the right thigh donor site, bilateral knees, posterior back cluster wounds and a left scalp wound. The physician orders dated 1/17/2026 documented to clean left lower back with normal saline, pat dry, apply Santyl (an ointment used to remove dead tissue) and xeroform (a moist non adherent gauze) to wound bed, apply telfa (non-adhering dry gauze) and cover with absorbent non adherent dressing daily and as needed. The care plan for Actual Skin Impairment to the left lower back wound dated 01/17/2026, documented interventions included providing wound treatments as ordered, monitor for signs and symptoms of infection including redness, warmth, drainage and odor. During an observation and interview on 01/20/2026 at 10:28AM, Resident #158 stated they wanted to have their shirt changed more frequently because the dressing on their back was leaky and itchy. They pulled up their shirt and a dressing to left lower back was observed with date 1/15/26 and a small amount of drainage coming from the lower edge of dressing. During an observation on 01/21/2026 at 11:30AM, the same dressing to the lower left back was in place with dried brown drainage on the bandage dated 01/15/2026. The Treatment Administration Record documented nurses changed the left lower back dressing on 01/17/26, 01/18/26, 1/19/26, 1/20/26 ,1/21/26, 1/22/26 during the 7-3 shift. During an observation and interview on 01/23/2026 at 09:58 AM Resident#158 stated their dressing needed to be changed and had not been changed in a long time. They stated it was itchy and leaked on the bed sheets. The resident rolled over and same dressing dated 1/15/26 was observed still in place now with black dried blood and old drainage on dressing. During a wound dressing observation on 01/23/2026 at 10:12 AM Licensed Practical Nurse Unit Manager #2 prepared to perform the dressing change. They donned a gown and gloves, gathered supplies and explained the procedure to the resident. The resident was positioned; the old dressing was removed. Dirty gloves were removed, hand hygiene was performed, and clean gloves were donned. The wound was pink in color and cleansed with normal saline, gloves were removed, hand (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hygiene was performed, and clean gloves were donned. Licensed Practical Nurse Unit Manager #2 opened a package of Bacitracin ointment, squeezed it on to a piece of gauze and an island dressing (absorbent, nonstick pad surrounded by a breathable, adhesive border) was applied. During an interview on 01/23/2026 at 10:38 AM Licensed Practical Nurse #2 stated the dressing was dated 01/15/2026 which meant nurses were not changing the dressing daily as ordered. They stated it was important it be changed according to orders because nurses need to provide the care and to prevent infection. They stated nurses signed for it on the Treatment Administration Record but did not do it. During a second interview on 01/23/2026 at 01:10 PM, Licensed Practical Nurse Unit Manager#2 was made aware the treatment they provided was not as the physician ordered. They stated they did not check the orders prior to starting the dressing change but should have done that as the resident had a lot of wounds and all the wounds had different treatments. During an interview on 01/23/2026 at 1:56 PM, the Director of Nursing stated nurses needed to read the physician orders before doing the treatment. They stated they had educated nurses about following the orders. They stated they were not aware nurses were signing for treatments they did not do. 2) Resident #51 had diagnoses including right hip dislocation of prosthesis, 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 daily activities of living, including transfers with the assistance of two people. An Occupational Therapy progress notes dated 01/28/2025 at 11:26 AM documented that the resident had been seen by the physician on 01/17/2025 for lethargy and tenderness of the right thigh. An X-ray of the right hip/pelvis had been conducted, which revealed a dislocation of the right femoral head prosthesis with inward rotation of the right hip and pain upon movement. The resident required a Hoyer lift with two staff for transfers and remained non-weight bearing on the right lower extremity with right hip precautions until cleared by Orthopedics. The nursing note dated 01/31/2026 at 11:02 AM, documented the resident went out to an orthopedic appointment accompanied by an aide and was sent to the hospital for further evaluation. The nursing note dated 02/01/2026 at 7:48 AM documented the resident returned from the hospital emergency department visit at 5:15 AM. The diagnosis was right hip dislocation, and the resident was weight bearing as tolerated for transfers only. The 02/01/2025 Hospital Discharge Summary documented the resident was seen in the emergency room on [DATE] and to follow-up with Orthopedic in one (1) week. A review of Resident #51's electronic medical records revealed no documented evidence the resident followed up with orthopedics or any attempts to schedule an orthopedic appointment. During an interview on 1/27/2026 at 1:20 PM, Physician #1 stated that after the resident's right hip was dislocated, the plan had been for the resident to follow up with orthopedics for possible hip replacement or other recommendations. They stated they were not informed by the staff if the Orthopedic appointments were made and did not get any feedback from the staff. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/28/2026 at 11:54 AM, the Director of Nursing stated the resident's orthopedic consultation was not done as the Orthopedic facility could not accommodate the resident in the Geri-chair. The Director of Nursing stated they were in the process of finding an orthopedic office that could accommodate the resident for their orthopedic appointments. 10 NYCRR 415.12

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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. 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	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 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 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview during the recertification survey from 01/20/2026 to 01/28/2026, the facility did not ensure residents received necessary treatment and services consistent with professional standards of practice, to prevent new pressure ulcers from developing and/or promote healing of pressure ulcers for two (2) of eight (8) Residents (Resident #125 and #94) reviewed for pressure ulcers. 1) Specifically, Resident #125 who had Stage 4 pressure ulcers to their right hip and sacrum and was at high risk for further development of pressure ulcers, was observed on multiple occasions without physician-ordered bilateral heel boots in place and/or their heels were not offloaded while in bed. Additionally, during a wound treatment observation for the two Stage 4 pressure ulcers, the resident was left with a saturated brief and bed liner contaminating the wound after it had been cleansed. 2) Resident #94 did not have their heels offloaded/floating while in bed and the comprehensive care plan was updated to include a physician order to offload Resident #94 heels while in bed. The findings included:A facility policy titled Pressure Injury-Prevention and Care dated 04/25/2025 documented: The facility commits to preserve the skin integrity of Residents by identifying all Residents at risk for skin breakdown upon admission, re-admission and during their stay the facility. Certified Nurse Aides will observe resident's skin every shift and report changes to the nurse. Prevention and treatment included pressure reducing surface as per protocol (special mattress, heels pads, overhanging heels on pillow).1) Resident #125 had diagnoses including Parkinson's disease, and Stage 4 pressure ulcers of sacral region and right hip. The annual Minimum Data Set (a resident assessment tool) dated 10/29/25 documented Resident #125 had severe cognitive impairment, was dependent on staff for all cares and mobility. They were always incontinent of bowel and bladder and at risk of pressure ulcers/Injuries. Resident #125 had two (2) Stage 4 pressure ulcers present on admission or reentry and had applications of ointments/medications other than to feet, and pressure reducing devices for chair and bed. A resident care plan titled Skin Integrity/ Risk for Skin Breakdown updated 03/25/2025 documented the resident had potential for new areas of skin breakdown and skin lesions. Interventions included daily skin inspection, floating heels while resting in bed, and heel booties when in chair as tolerated if not ambulating.The resident care plans, updated 03/25/2025, for the Stage 4 right hip ulcer and Stage 4 sacral ulcer had interventions including to apply local treatments as ordered by physician and monitor for signs and symptoms of infection (increased redness, warmth, drainage, foul odor, etc.), to assess for pain, effectiveness of pain medications per physician order, off-load wound, perform wound care rounds weekly, pressure reduction mattress, pressure reduction wheelchair cushion and refer for follow-up with the wound care team. Physician orders dated 11/14/2025 documented the treatments for both Stage 4 pressure ulcers, to the sacrum and right hip, included to cleanse the area with Dakins solution (wound cleanser), pat dry, apply calcium alginate and collagen particles (wound treatment) to wound bed, apply zinc paste (barrier cream) to peri-wound (surrounding skin), cover with silicone superabsorbent bordered dressing, daily and as needed.Physician orders dated 11/12/2025 documented heel booties while in chair as tolerated and to check skin integrity before placement and after removal; to float heels in bed; and enhanced barrier precautions. A physician order dated 12/05/2025 documented to off-load heels with pillows. During observations on 01/20/2026 at 11:31 AM, 01/20/26 at 3:32 PM, 01/21/2026 at 10:59 AM, and 01/21/2026 at 3:45 PM, Resident #125 was in their room seated in their Geri chair reclined at 45 degrees. They had socks on their feet, and their heels were observed resting on leg rests. The heel booties were not in place.During an observation on 01/23/2026 at 9:05 AM, Resident #125 was in bed, on their back, with their bare heels directly on the mattress.During an observation and interview on 01/23/2026 at 10:03 AM with Certified Nurse Aide #3, Resident #125 was in bed, lying on their back with bare heels resting on the mattress. Resident #125's mid left heel had a dime-sized white scab-like area of skin impairment and redness was (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	observed on the right heel. Certified Nurse Aide #3 stated they did not know why Resident #125's heels were not offloaded. They stated they had not seen the skin impairments on Resident #125's heels and had not reported them to unit nursing staff. Certified Nurse Aide #3 stated they knew Resident #125's care included wearing heel booties when in the Geri chair. Certified Nurse Aide #3 located Resident #125's heel booties in closet. During a wound care observation and interview on 01/23/2026 at 11:01 AM with Wound Care Registered Nurse #4 and Registered Nurse Supervisor #7, wound care supplies were assembled by Wound Care Registered Nurse #4. During positioning, a saturated adult brief and wet disposable bed liner were observed, and when the brief was opened, Resident #125's right hip wound was exposed without a bandage/treatment in place. Registered Nurse Supervisor #7 and Wound Care Registered Nurse #4 stated they did not know why there was no bandage in place on the right hip. Registered Nurse Supervisor #7 pushed the wet adult brief and wet disposable bed liner under Resident #125's buttock and it remained there throughout the wound care treatment. Wound Care Registered Nurse #4 applied the treatment to Resident #125's right hip as ordered and proceeded to the sacral wound. During wound care for Resident 125's sacral wound, Nurse Supervisor #7 rested the lower edges of Resident 125's cleaned sacral wound area against the wet, soiled disposable bed liner while awaiting Wound Care Registered Nurse #4 to prepare calcium particles and calcium alginate. When interviewed at the time, Nurse Supervisor #7 stated they should not have allowed the cleaned wound to touch the soiled, wet disposable bed liner. Wound Care Registered Nurse #4 recleaned the wound and proceeded to complete sacral wound care as ordered. When interviewed at the end of the dressing change, Wound Care Registered Nurse #4 and Registered Nurse Supervisor #7 were unable to explain why the heavily saturated adult brief and soiled disposable bed liner remained in place throughout the care. Wound Care Registered Nurse #4 then observed Resident #125's heels and was interviewed at the time of observation. They stated there was a dime-sized white scab-like area of skin impairment on the left heel surrounded by some redness, and the right heel had redness. Wound Care Registered Nurse #4 stated they had not observed the skin impairments to the heels during recent wound rounds and that Resident #125 had a history of a left heel skin impairment which they stated was resolved. They stated they had not received a report of skin impairment on Resident #125's left or right foot from unit staff and that Resident #125's heels should have been offloaded/floated while in bed and they should have had bilateral heel booties in place while in Geri chair to prevent skin breakdown.During a follow-up interview on 01/27/2026 at 11:11 AM, Registered Nurse Supervisor #7 stated unit staff had not reported concerns with skin impairment on Resident #125's left or right heel prior to the wound observation on 01/23/2026. They stated certified nurse aides were expected to observe Resident #125's skin, including heels, during cares and when applying socks and heel booties. Registered Nurse Supervisor #7 stated they were not aware Resident #125 did not have bilateral heel booties in place while in the Geri chair or why their heels were not offloaded while in bed. They stated they were responsible for supervising certified nurse aide task completion on the unit and they did not perform rounds on 01/20/2026 through 01/23/2026 due to their workload of administering medications and treatments. They stated certified nurse aides should check the accountability binder to review tasks each shift. During an interview on 01/28/2026 at 1:00 PM, the Director of Nursing stated incontinence cares should have been completed prior to wound care treatments. During an interview on 01/28/2026 at 2:20 PM, Physician #1 stated medical orders should be followed and completed as ordered. They stated they were aware that Resident #125 had a history of heel pressure ulcers and that the order for heels booties while in Geri chair and floating heels while in bed was important in the prevention of further skin breakdown. They stated they were first made aware of concern with Resident #125's left heel by the Assistant Director of Nursing on 01/26/2026. Physician #1 stated they observed Resident #125's left heel and there was no redness observed, and a small-callused area of skin was observed. Physician #1 stated the callous could have been caused by friction with the resident's mattress or Geri chair. They stated floating the heels in bed and applying heel booties while in the Geri chair could (continued on next page)

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have prevented an area of callousness/skin impairment on Resident #125's left heel. 2) Resident #94's diagnoses included Stage 4 pressure ulcer of the sacral region, muscle wasting and Alzheimer's disease.The Quarterly Minimum Data Set, dated [DATE] documented Resident #94 had severe cognitive impairment, was dependent on staff for all activities of daily living and mobility and was at risk for pressure ulcers. A physician order dated 12/05/2025 documented to float heels while in bed. A resident care plan titled Skin Integrity/Risk for Breakdown, dated 03/08/2024, documented the potential for skin breakdown and skin lesions due to limited mobility and needs assistance in toileting and bed mobility. Interventions included to avoid skin to surface sheering contact during care and transfer, daily staff skin inspection and monitor for skin breakdown/lesions, pressure relief air mattress in bed and turn and position of body in bed and in the wheelchair. The care plan did not include an intervention to offload/float heels while in bed, as ordered by the physician. During observations on 01/21/2026 at 11:00 AM and 01/23/2026 at 9:12 AM, Resident #94 heels were resting directly on the mattress and not offloaded/floated. During an observation and interview on 01/27/2026 at 10:41 AM, Registered Nurse Supervisor #7 stated Resident #94's heels were not offloaded while lying in bed. They stated the certified nurse aide who provided care for Resident #94 should have floated the heels on a wedge or pillows after completion of morning care. During an interview on 01/27/2026 at 10:47 AM, Certified Nurse Aide #3 stated they provided cares for Resident #94 about 7:30 AM. They stated they forgot to offload/float Resident #94's heels on wedge after care completed. During an interview and observation on 01/28/2026 at 9:59 AM, Registered Nurse Supervisor #11 stated there was a physician order dated 12/05/2025 to float Resident #94's heels while in bed. After review of Resident #94's care plans on the electronic medical record, Registered Nurse Supervisor #11 stated they were unable to locate a care plan intervention to float Resident #94's heels while in bed. They stated the unit manager registered nurse or any nurse on the unit would have been responsible for entering a care plan intervention after reviewing the physician order, preferably under the skin integrity care plan. 10 NYCRR 415.12(c)(1)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, record review, and interviews during the recertification survey from 01/20/2026 to 01/28/2026, the facility did not ensure that needed services, care, and equipment were provided to ensure that a resident with limited range of motion and mobility maintained or improved function based on the resident's clinical condition for one (1) of three (3) residents (Resident #125) reviewed for position and mobility. Specifically, Resident #125 had a contracted left hand and was observed on multiple occasions without a physician ordered left-hand hand roll device in place.The findings included: Resident #125 diagnoses included Parkinson's disease, and Stage 4 pressure ulcers of sacral region and right hip.The annual Minimum Data Set (a resident assessment tool) dated 10/29/2025 documented Resident #125 had severe cognitive impairment, no rejection of cares and was dependent on staff for all cares and mobility. A resident care plan titled Activities of Daily Living updated 01/31/2025, documented interventions including a left-hand roll to be worn when out of bed as tolerated. Remove for hygiene, skin checks and as needed. Check skin prior to application and upon removal.A physician order dated 11/12/2025 documented a left-hand roll to be worn when out of bed as tolerated. Remove for hygiene, skin checks and as needed. Check skin prior to application and upon removal. The January 2026 Certified Nurse Aide accountability record documented a left handroll/left upper extremity. Perform skin check before/after application. Report to nurse any skin changes observed. During observations on 01/20/2026 at 11:31 AM, 01/20/2026 at 3:32 PM, and 01/21/2026 at 3:45 PM, Resident #125 was seated in a Geri chair in their room. A left-hand contracture was observed and there was not a device/hand roll in place.During an observation an interview on 01/27/2026 at 10:29 AM with Certified Nurse Aide #6, Resident #125 was observed in Geri chair in their room. Left hand contracture was observed with no device/hand roll in place. Certified Nurse Aide #6 stated Resident #125 should have had a left-hand roll device in place and did not know why the resident did not have one in place. During observation, the left-hand roll was observed under tray table on the floor at bottom of Resident #125's bed. Certified Nurse Aide #6 stated the hand roll should have been in Resident #125's left hand and not on the floor. During an interview on 01/27/2026 at 11:11 AM Registered Nurse Supervisor #7 stated Resident #125 should have had a left-hand roll device in place at least during the day hours. They stated they applied hand roll device to Resident #125 at about 8:00 AM while Resident #125 was in bed. They stated they did not know why it was not re-applied after cares were completed or why the hand roll device was not in place during observations 01/20/2026 to 01/27/2026. They stated certified nurse aides should be checking task accountability sheets to make sure they are aware of tasks for each resident assigned to them. They stated they were responsible for supervising certified nurse aide task completion on the unit and that they did not perform rounds 01/20/2025 through 01/23/2025 due to workload of administering medications and treatments to unit Residents.During an interview on 01/28/2026 at 1:00 PM, the Director of Nursing stated for residents with a physician order for hand roll devices or braces, the expectation was the resident would have device in place as ordered. 10NYCRR: 415.12(e)(2)

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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. Based on observations, interviews, and record review conducted during the Recertification Survey 01/20/2026-01/28/2026 it was determined for 1 of 2 residents (Resident #8) the facility did not ensure that residents who need respiratory care are provided such care, consistent with professional standards of practice, Specifically, Resident #8, who had a tracheostomy, (an surgical opening into the trachea to provide an airway for easier breathing) did not have an Ambu bag (and a self-inflating bag resuscitator) and an extra tracheostomy replacement provided in the resident room to be used in the event of accidental extubation.The findings are: Based on observations, interviews, and record review conducted during the Recertification Survey from 01/20/2026-01/28/2026 the facility did not ensure residents who needed respiratory care were provided with such care, consistent with professional standards of practice, for 1 of 2 residents (Resident #8) reviewed for respiratory care. Specifically, Resident #8 had a tracheostomy, (a surgical opening into the trachea to provide an airway for easier breathing) and did not have an Ambu bag (and a self-inflating bag resuscitator) and an extra tracheostomy replacement provided in the resident room to be used in the event of accidental extubation.The findings include:Resident #8 had diagnoses of acute hypoxic respiratory failure, bilateral above the knee amputations, and tracheostomy.The admission Minimum Data Set assessment tool dated 09/24/2025 documented the resident was cognitively intact and was dependent on staff for all activities of daily living and received oxygen through a tracheostomy.The current physician orders dated 12/5/25 documented cuffless tracheostomy set size 6.5, oxygen at three liters as needed, and tracheal suctioning every shift and as needed. During an observation and interview on 01/23/2026 at 11:07 AM Registered Nurse Unit Manager#1 was asked to locate emergency equipment in the resident's room in the event of accidental extubation namely, an Ambu bag and an extra tracheostomy set. Registered Nurse Unit Manager#1 opened all drawers in the resident's supply cart and closet and stated there were no supplies in the resident's room. They stated they thought there was a spare tracheostomy set at the nurse's station locked in a cabinet and there was an Ambu bag in the dining room on a cart. They left the resident's room and went to the nursing station and observed a tracheostomy set size 6.0 and were unable to locate a 6.5 size as ordered by the physician. They stated if the resident needed a quick replacement the supply on hand would not be the correct size or fit. They stated they should have the right size. They stated it was good practice to check supplies at the beginning of the shift, and they did not. They stated that the Ambu bag was essential equipment for tracheostomy residents and needed to be accessible in case of emergency. During an interview on 01/23/2026 at 1:45 PM the Director of Nursing stated all residents with tracheostomies should have emergency supplies including Ambu bags, replacement sets, suction and oxygen at the bedside. They stated managers and nurses were supposed to check every shift to ensure supplies were accessible. 10 NYCRR 415.12