STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335365	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nyack Ridge Rehabilitation and Nursing Center	476 Christian Herald Road Valley Cottage, NY 10989

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 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** 49372 Based on record review and interviews conducted during an abbreviated survey (NY00339416), the facility did not ensure that for 1 (Resident #1) of 3 residents reviewed, all alleged violations involving abuse, neglect, exploitation or mistreatment are reported immediately but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or serious bodily injury, or no later than 24 hours if the events that cause the allegation do not involve abuse or do not result in serious bodily injury, to the Administrator of the facility and to other officials including to the State Survey Agency and adult protective services where state law provides for jurisdiction. Specifically, on 3/28/2024, the Director of Nursing and the Administrator were informed of an alleged abuse incidence that occurred between Resident #1 and the facility Podiatrist. There was no documented evidence that the incident was reported to the New York State Department of Health. Findings include: Review of the facility abuse, neglect, mistreatment, or misappropriation policy dated 11/2017 and last revised 1/1/2018 documented that the purpose was to protect residents from abuse, neglect, and mistreatment while the resident is under the supervision of the facility. Abuse shall include physical harm, pain, mental anguish, verbal abuse (derogatory terms), sexual abuse or involuntary seclusion from any source. The Facility reporting/response procedure documented that the Facility must immediately report all alleged violations to the Administrator, State Agency, and all other required agencies within specific timeframes. Resident #1 was admitted with diagnoses including but not limited to metabolic encephalopathy, hemiplegia left side and adult failure to thrive. A Quarterly Minimum Data Set assessment dated [DATE] documented that Resident #1's Brief Interview for Mental Status (BIMS, used to determine attention, orientation, and ability to recall information) score of 00/15, associated with severe cognition impairment (00-07 severe impairment, 08-12 moderate impairment and 13-15 cognitively intact). Resident #1's abuse care plan dated 11/2/2022 documented potential for abuse/being abused. Interventions included the resident will not become a victim of abuse/not abuse others. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335365	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER Nyack Ridge Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 476 Christian Herald Road Valley Cottage, NY 10989	

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A behavior care plan dated 4/18/2024 documented that on 3/28/2024 Resident #1 exhibited physical behavioral symptoms directed towards others and kicked at the podiatrist during cares. The intervention documented that Resident #1 had behavior of kicking at Podiatrist during cares, no evidence of trauma and pain noted at the time of occurrence. The facility will continue to monitor. Review of an occurrence report dated 3/29/2024 written by the Director of Nursing documented a brief description of the events along with statements from the wound doctor and the Podiatrist, written statements from the Registered Nurse Wound Care (Staff #4), Registered Nurse Unit Manager(Staff #3), and a telephone statement from Certified Nurse Assistant(Staff #1). The document concluded based on the interviews it is my opinion that there was no abuse substantiated. Also documented, there was no evidence of any injury, discoloration or adverse effects post the event. There was no documented evidence of the incident being reported to the New York State Department of Health in the Aspen Complaint Tracking System. During an interview on 4/22/2024 at 3:05 PM, the Director of Nursing stated they were informed by the Staff #4 about the incident between the Podiatrist and Resident #1. The Director of Nursing stated Staff #4 emailed them and stated the wound doctor was upset because they overheard the exchange between the Podiatrist and Resident #1. The Director of Nursing stated the wound doctor felt the resident was refusing the care from the Podiatrist, but the Podiatrist did not acknowledge it. The Director of Nursing stated they completed an investigation and obtained verbal statements from the Podiatrist and the wound doctor. The Director of Nursing stated they also obtained statements from Staff #1, Staff #4, and Staff #3. The Director of Nursing stated they did not do an incident report, because they did not think it warranted an incident report, it was a complaint. During an interview on 4/23/2024 at 9:10 AM, Staff #4(Registered Nurse Wound Care Nurse) stated while doing their wound rounds with the wound care doctor they were walking by in the hallway by Resident #1's room and heard Resident #1 screaming. Staff #4 stated they looked in the room and saw that the Podiatrist was holding the resident's foot around the ankle with one hand. Staff #4 stated they then heard the certified nurse assistant in the room saying stop it, the resident does not want it. Staff #4 stated the wound team continued their wound rounds and when they were done the wound doctor stated they wanted to speak to the Administrator about the incident with the Podiatrist and the Resident #1. Staff #4 stated the Administrator was not in the office that day, so they texted them and told them to call the wound doctor. Staff #4 stated they gave a statement to the Director of Nursing on the day of the incident and the Director of Nursing told them they were investigating the incident. Staff #4 stated they did not initiate an accident/incident report or report the incident to the State. During an interview on 4/22/2024 at 4:30 PM, the Administrator stated they were informed about the incident with the Podiatrist and Resident #1 on the day of the incident (3/28/2024), but they were not in the facility that day. The Administrator stated they received a message from Staff #4 that the wound doctor had a concern about Resident #1 and was upset. The Administrator stated they spoke with the wound doctor, and they stated they heard Resident #1 say no, no I do not want this, but the Podiatrist continued to provide the services. The Administrator stated they got in touch with the Director of Nursing, and they did an investigation and discovered this was usual behavior for Resident #1. The Administrator stated they do not recall if there was an accident/incident report completed in the facility. The Administrator stated they did not feel like it fit the reportable criteria to report to the State. (continued on next page)

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Nyack Ridge Rehabilitation and Nursing Center	476 Christian Herald Road Valley Cottage, NY 10989

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10 NYCRR 415.4(b)(1)(i)

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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 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** 49372 Based on record review and interview conducted during an abbreviated survey (NY00339416), the facility did not ensure that an allegation of abuse was thoroughly investigated for 1 (Resident #1) out of 3 residents reviewed for abuse. Specifically, on 3/28/2024 the Director of Nursing and the Administrator were informed of an alleged abuse incidence that occurred between Resident #1 and the facility Podiatrist. There was no documented evidence that an accident/incident report was completed, there was no documented skin assessment from the Registered Nurse, there was documented interviews of other residents seen by the Podiatrist on the day of the incident, and the complainant was not interviewed until the next day. Findings include: Review of the Accident/Incidents reporting policy and procedure dated 6/12/08 documented that the supervisor must be notified, and the licensed nurse complete the report documenting the facts. The licensed nurse will document in the nurses notes the facts and the sequence of events as they occurred. Review of the abuse, neglect, mistreatment, or misappropriation of resident property policy dated 11/2017 and last revised 1/1/2018 documented that the purpose was to protect residents from abuse, neglect, and mistreatment, determine the validity of alleged abuse, neglect and mistreatment and comply with New York State Law. A nurse receiving report for all alleged incidents must complete an incident report. Nursing and Social Services will investigate alleged incidents and record all findings within 48 hours. Resident #1was admitted with diagnoses including but not limited to metabolic encephalopathy, hemiplegia left side and adult failure to thrive. A Quarterly Minimum Data Set assessment dated [DATE] documented that Resident #1's Brief Interview for Mental Status (BIMS, used to determine attention, orientation, and ability to recall information) score of 00/15, associated with severe cognition impairment (00-07 severe impairment, 08-12 moderate impairment and 13-15 cognitively intact). An abuse care plan dated 11/2/2022 documented potential for abuse/being abused, resident will not become a victim of abuse/not abuse others. A Podiatry consult dated 3/28/2024 documented the reason for the visit as at-risk foot care (nails. callouses), elongated painful toenails and dry skin with the risk for breakdown. Documented consult findings included: dermatological-trophic changes noted bilaterally, dry skin, scaling skin, thick yellow nails, with subungual hyperkeratosis. The plan/recommendation documented Resident #1's nails were sharply debrided with nail clipper and alcohol was applied. Recommendations stated right 5th nail not debrided due to the resident becoming combative. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Nyack Ridge Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 476 Christian Herald Road Valley Cottage, NY 10989	

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an occurrence document dated 3/29/2024 documented a brief description of the events along with statements from the wound doctor and the Podiatrist. Written statements were attached from Staff #3 and Staff #4, along with a telephone statement from Staff #1. The document stated based on the results of interviews it is in the Director of Nursing's opinion that there was no abuse substantiated. Also stated, there was no evidence of any injury, discoloration or adverse effects post the event. Review of Accident/Incident reports from January to March 2024 revealed no documented evidence of any accident/incident reports for Resident #1. There was no documented evaluation/notes post incident by the social worker in Resident #1's electronic medical record. There was no documented nursing assessment of Resident #1 post incident in the electronic medical record. During an interview on 4/22/2024 at 3:05 PM, the Director of Nursing stated they completed an investigation and obtained verbal statements from the Podiatrist and the wound doctor. The Director of Nursing stated they also obtained statements from Staff #1, Staff #3, and Staff #4. The Director of Nursing stated Registered Nurse Unit Manager-Staff #3) completed a skin assessment of the resident after the podiatry consult but did not document it in the resident's medical record. The Director of Nursing stated they did not do an incident report, because they did not think it warranted an incident report, it was a complaint. During an interview on 4/22/2024 at 4:30 PM, the Administrator stated they were informed about the incident with the Podiatrist and Resident #1, but they were not in the facility that day. The Administrator stated they received a message from Staff #4 that the wound doctor had a concern about a resident and was upset, and to please give them a call. The Administrator stated they spoke with the wound doctor, and they stated they heard the resident say no, no I do not want this, but the Podiatrist continued to provide the services. The Administrator stated they got in touch with the Director of Nursing, and they did an investigation and discovered this was usual behavior for Resident #1. The Administrator stated they do not recall if there was an accident/incident report completed in the facility. The Administrator stated they did not feel like it fit the reportable criteria to report to the State. There was no documented evidence of the incident being reported to the New York State Department of Health (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/23/24 at 3:30 PM, the Wound care doctor stated they were on the unit on the day of the incident doing wound rounds with Staff #4. The Wound Care Doctor stated the Podiatrist was also doing their rounds and were in a few rooms ahead of them. The Wound Care Doctor stated they heard someone screaming and saying stop. The Wound Care Doctor stated they went to the room where they heard the screaming coming from and the Podiatrist was in there at Resident #1's bedside. The Wound Care Doctor stated the Podiatrist then walked out of the room within a few minutes. The Wound Care Doctor stated they were concerned because of the screaming of stop from the resident. The Wound Care Doctor stated they went to the Administrator's office to inform them, but the Administrator was not there. The Wound Care Doctor stated they did not realize the Director of Nursing was in the building and so they asked Staff #4 to send an urgent message to the Administrator and the Director of Nursing to call. The Administrator and the director of Nursing did not return the call until the following day in the afternoon. The Wound Care Doctor stated when they were called by the Administrator and the Director of Nursing, they were asked to repeat and confirm what they had seen or heard, and they were told the information will be investigated and report back to them. The Wound Care Doctor stated the following week while doing wound rounds they saw the Director of Nursing, and the Director of Nursing stated when asked about the incident with resident #1 and the Podiatrist the Director of Nursing responded they were handling it, whatever that meant. During an interview on 4/25/2024 at 10:20 AM the Director of Social Services stated they were informed about the alleged incident of mis-apropriateness of care for Resident #1 with the Podiatrist last week by the Director of Nursing. The Director of Social Services stated they spoke with Resident #1 after they were informed but Resident #1's orientation is severely impaired, so they were unable to dialogue. The Director of Social Services stated they did not write any note in Resident #1's chart regarding the incident. The Director of Social Services stated they do not complete a psychological evaluation for residents after an incident. If the resident is not interview able, they will determine if there are signs of trauma related to the event and if there is, a referral is made to psychiatry or psychology. For Resident #1, they did not make any referrals as they did not see any signs of trauma. Resident #1 was not even aware anything occurred. 10 NYCRR 415.4(b)(ii)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48849 Based on record review and interviews conducted during an abbreviated survey (NY00339416), the facility did not ensure in accordance with accepted professional standards and practices that a resident's medical records was accurately completed and contained a record of the assessment performed for 1(Resident #1) of 3 residents reviewed. Specifically, on 3/28/2024, Resident #1 had an incident of alleged abuse during a podiatry toenail trimming consult overheard by staff (the Wound Doctor and the Registered Nurse Wound Care Nurse-Staff #4 and the Certified Nurse Aide-Staff #1). There was no documented assessment in the electronic medical record of Resident #1. Findings include: Review of the Accident/Incidents reporting policy and procedure dated 6/12/08 documented that the supervisor must be notified, and the licensed nurse complete the report documenting the facts. The licensed nurse will document in the nurses notes the facts and the sequence of events as they occurred. Resident #1 was admitted with diagnoses that included but not limited to metabolic encephalopathy, hemiplegia left side and adult failure to thrive. A Quarterly Minimum Data Set assessment dated [DATE] documented that Resident #1's Brief Interview for Mental Status (BIMS, used to determine attention, orientation, and ability to recall information) score of 00/15, associated with severe cognition impairment (00-07 severe impairment, 08-12 moderate impairment and 13-15 cognitively intact). Resident #1's abuse care plan dated 11/2/2022 documented potential for abuse/being abused. Interventions included the resident will not become a victim of abuse/not abuse others. A Podiatry consult dated 3/28/2024 documented the reason for the visit as at-risk foot care (nails. callouses), elongated painful toenails and dry skin with the risk for breakdown. Documented findings included: dermatological-trophic changes noted bilaterally, dry skin, scaling skin, thick yellow nails, with subungual hyperkeratosis. The plan/recommendation documented Resident #1's nails were sharply debrided with nail clipper and alcohol was applied. Recommendations stated right 5th nail not debrided due to the resident became combative. Review of an occurrence document dated 3/29/2024 documented a brief description of the events along with statements from the wound doctor and the Podiatrist. Written statements are attached from Staff #4 and Staff #3, along with a telephone statement from Staff #1. The document stated based on the results of interviews it is in the Director of Nursing opinion that there was no abuse substantiated. Also stated, there was no evidence of any injury, discoloration or adverse effects post the event. Review of Accident/Incident reports from January to March 2024 revealed no documented evidence of any accident or incident reports for Resident #1. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's electronic medical record revealed no documented evidence of a skin assessment being completed on or after 3/28/2024. During an interview on 4/22/2024 at 12:25 PM, Registered Nurse Unit manager(Staff #3) stated that about a day or two after the incident, the director of nursing told them to examine Resident #1's toes and they found the nails were cut but did not observe any injuries. Staff #3 stated that they did not interview any staff about the incident or do an accident or incident report, and they did not document their findings of the examination because there was no injury. Staff #3 stated that they reported to the Director of Nursing that there were no injuries. During an interview on 4/22/2024 at 3:05 PM, the Director of Nursing stated Staff #3 completed a skin assessment of the resident after the podiatry consult. It was stated that Staff #3 did not write a note about the skin assessment completed after the podiatry consult. They stated they did not do an incident report, because they did not think it warranted an incident report, it was a complaint. During an interview on 4/22/2024 at 3:05 PM, the Director of Nursing stated they were informed by the wound nurse about the incident. The Director of Nursing stated the wound nurse emailed them and stated the wound doctor was upset because they overheard the exchange between the podiatrist and Resident #1. The Director of Nursing stated the wound doctor felt the resident was refusing the podiatrist's care, but they were not acknowledging it. The Director of Nursing stated they had completed an investigation and obtained verbal statements from the podiatrist and the wound doctor. Also, obtained statements from the primary certified nurse assistant, wound nurse, and staff #3(the registered nurse unit manager). The Director of Nursing stated Staff #3 completed a skin assessment of the resident after the podiatry consult and did not write a note about the skin assessment. The Director of Nursing stated they did not do an incident report because they did not think it warranted an incident report, it was a complaint. The Director of Nursing stated the podiatrist had no prior complaints. The investigation concluded that the Resident #1 exhibited some behaviors such as resisting medications and cares. The Director of Nursing stated that Resident #1 will agree with cares after coaxing and reapproach. The Podiatrist approached Resident #1 and they were agitated and kicked at them. The Podiatrist then tried to reapproach, but the resident became more agitated and the Podiatrist stopped. The Director of Nursing stated that the family was not notified about the occurrence because there was no incident. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/22/2024 at 4:30 PM, the Administrator stated they were informed about the incident, but they were not in the facility that day. The Administrator stated they received a message from the wound nurse that the wound doctor had a concern about a resident and was upset, and to please give them a call. The Administrator stated they spoke with the wound doctor, and they stated that when they were doing wound rounds and they passed by, the room in question, they heard the resident say no, no, I do not want this. But the Podiatrist continued to provide the services. The Administrator stated they got in touch with the Director of Nursing, and they did an investigation and discovered this was usual behavior for Resident #1. The Administrator stated the wound doctor was not aware of Resident #1's behaviors, because they do not treat them. Stated from the wound doctor's vantage point it was concerning. The Administrator stated Resident #1 does refuse and say things when she does not want a shower or to take their medications. stated that the investigation revealed no wrongdoing on the part of the podiatrist. Stated they spoke with the regular staff on the unit, the wound doctor with the Director of Nursing, and the Podiatrist. The Administrator stated podiatrist told them they were in the middle of a procedure, and they could not just stop there. Stated they stopped after that toe due to the resident being upset. The Administrator stated they do not recall if there was an accident/incident report completed in the facility. Stated they did not feel like it fit the reportable criteria to report to the State. The Administrator stated they have not had any other complaints from residents regarding the Podiatrist and come every two weeks. During an interview on 4/23/2024 at 9:10 AM, Staff #4(the Registered Nurse Wound Care nurse), they stated they were doing their wound rounds with the wound care doctor on the second floor B wing on 3/28/2024. Staff #4 stated they were passing by the room and heard Resident #1 screaming, so they looked into the room and saw that the podiatrist was holding the resident's foot around the ankle with one hand. Staff #4 stated they heard the certified nurse assistant in the room (but could not see them) saying stop it; the resident does not want it. Staff #4 stated they continued doing their wound rounds, and when they were done, the wound doctor stated they wanted to speak to the administrator about the incident involving the podiatrist and Resident #1. The administrator was not in the office that day, so they texted them and told the administrator to call the wound doctor. Staff #4 stated they gave a statement to the Director of Nursing on the same day, and the Director of Nursing stated they will investigate the incident. Staff #4 stated they did not initiate an accident or incident report. As stated in their experience, they do not believe Resident #1 was abused, because Resident #1 they have worked with resident #1 in the past and during treatment for blisters on their feet, Resident #1 will moan, when the certified nurse assistants perform care on Resident #1, the resident will sometimes scream out. Staff #4 stated that this is a normal behavior for Resident #1. Staff #4 stated they were unsure if the podiatrist kept providing the treatment for the Resident #1 when they left the residents' room. Staff #4 stated that they have never heard anyone scream during podiatry care. The podiatrist is friendly with the residents. 10 NYCRR 483.70