STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335365	A. Building B. Wing	11/04/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews conducted during the Abbreviated Survey (#2583624), the facility did not ensure that the residents' environment remained as free of accident hazards as possible for one (1) of three (3) residents (Resident #1) reviewed for accidents. Specifically, Resident #1 was transferred by Certified Nurse Aides #1 and #2 with a new mechanical lift they had not received training on. The lift tilted during the transfer, hitting Resident #1 on the head. Resident #1 sustained a laceration to the head and was transferred to the hospital for emergency care and received staples for the laceration. This resulted in actual harm to Resident #1 that was not Immediate Jeopardy.The findings include: The policy titled 'Mechanical Lift (Hoyer Lift) Use and Safety' revised on 01/2025, documented the Hoyer lift was to be used in accordance with manufacturer guidelines and facility protocols to safely transfer non-weight-bearing residents or those needing assistance. Staff requirements to use the mechanical lift include two (2) trained staff members be present, one to operate the lift and another to guide and stabilize the resident throughout the transfer; both staff members must have documented training on the use of the mechanical lift. The manufacture's user guide, provided by the facility, version 2021.09, page 5, Safety Instructions, documents before attempting to lift anyone, please practice operating the lift. Resident #1 was admitted with diagnoses including amyotrophic lateral sclerosis (a degenerative neurological disease), muscle weakness, and chronic obstructive pulmonary disease (lung and airway disease that restricts breathing). The annual Minimum Data Set (a resident assessment tool) dated 05/23/2025 documented Resident #1 had intact cognition, impaired range of motion in both lower extremities, and was dependent on staff for transfers. The care plan for Activities of Daily Living initiated 12/01/2022 documented interventions included two (2) or more persons physically assisting the resident with a mechanical lift out of bed to a high-back wheelchair. The Certified Nurse Aide Accountability Record and Plan of Care (care instructions) dated August 2025, documented Resident #1 transferred with a mechanical lift and assistance of two (2) staff. The Accident and Incident form dated 08/04/2025 at 10:00 PM completed by Registered Nurse #7 documented Resident #1 was hit on the head by the mechanical lift during transfer and sustained a laceration to the head. The resident was transferred to the hospital Emergency Department for a computed tomography scan and further evaluation. Certified Nurse Aide #1's written statement dated 08/04/2025, documented while transferring the resident back to bed, and after ensuring the lift was secure, they started to lift the resident when the lift began tilting to one side which caused the collision between the lift and the front area of the resident's head. Certified Nurse Aide #2's written statement dated 08/04/2025, documented they were about to lift the resident, and the lift slid down on the resident's head. The resident was cut and was bleeding from their head. The Emergency Department After Visit Summary dated 08/05/2025, documented Resident #1 was seen for a head laceration and had computed tomography scans of the head and neck. Discharge instructions included following up with primary care physician and returning to the Emergency Department in seven (7) days for staple removal. The nursing progress note dated 08/05/2025 at 6:33 AM, documented Resident #1 returned from the hospital with three (3) staples on top of their head. The facility Incident Report submitted on 08/06/2025 to New York State Department of Health documented on 08/04/2025, during a transfer from the wheelchair to the bed, using the mechanical lift, Resident #1's head came into contact with the mechanical lift's metal hook and the resident sustained a laceration to the scalp. Resident #1 was transferred to the Emergency Department and was kept for observation and treatment and returned to the facility on [DATE]. Resident #1 required three (3) staples to the scalp to close the laceration. Interviews and reenactment determined two (2) staff set up and planned the mechanical lift transfer, but while the transfer was being done, the device unexpectedly tilted forward causing the impact. The plan was to in-service on the proper techniques for setting up the mechanical lift for transfers and ensuring the base of the device was appropriately expanded. During an interview on 10/23/2025 at 10:07 AM, Resident #1 used their iPad to communicate and stated that on 08/04/2025 Certified Nurse Aides #1 and #2 were putting them to bed from the wheelchair. Resident #1 stated they put them on the mechanical lift and one (1) of the Certified Nurse Aides did not know how to operate the mechanical lift. The resident stated the bar that the sling was hooked to hit and cut them in the head. The resident stated they were bleeding, went to the hospital, and staples were put in their head. During an interview on 10/23/2025 at 10:42 AM, the Nurse Educator stated they got new mechanical lifts in the summer. They stated when the mechanical lifts came in, they did an in-service along with the Maintenance Director with a video and a