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	06/04/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observations, record review, and interviews conducted during Abbreviated Surveys, the facility failed to provide necessary care and services to attain or maintain residents' highest practicable physical, mental, and psychosocial well-being in accordance with professional standards of practice for two (Residents #3 and #7) of six residents reviewed for quality of care. Specifically, 1. Resident #3, who had impaired cognition and poor safety awareness was identified as a high risk for falls and required 30-minute monitoring and visual checks. On 04/23/2026 at 1:19PM, Resident #3's 30-minute monitoring form documented monitoring observations through 2:30 PM prior to the required observation times occurring. 2.Resident #7, who required every 30-minute visual checks due to a history of falls, did not have required monitoring observations documented from 7:30 AM through 1:30 PM at the time of surveyor review and the reason for monitoring identified as Other was not specified on the monitoring form.Based on observations, record review, and interviews conducted during Abbreviated Surveys, the facility failed to provide necessary care and services to attain or maintain residents' highest practicable physical, mental, and psychosocial well-being in accordance with professional standards of practice for two (Residents #3 and #7) of six residents reviewed for quality of care. Specifically, 1. Resident #3, who had impaired cognition and poor safety awareness was identified as a high risk for falls and required 30-minute monitoring and visual checks. On 04/23/2026 at 1:19PM, Resident #3's 30-minute monitoring form documented monitoring observations through 2:30 PM prior to the required observation times occurring. 2.Resident #7, who required every 30-minute visual checks due to a history of falls, did not have required monitoring observations documented from 7:30 AM through 1:30 PM at the time of surveyor review and the reason for monitoring identified as Other was not specified on the monitoring form. The Findings include: The facility policy titled Safety and Supervision of Residents, reviewed/revised February 2025, documented the facility strives to provide appropriate supervision and monitoring based on resident needs and identified risk factors. The policy documented residents identified as higher risk may require increased observation, monitoring, or one-to-one supervision and staff are responsible for implementing and documenting required interventions. The facility policy titled Behavior Monitoring and Documentation, reviewed/revised February 2025, documented monitoring observations are to be completed at the time the observation occurs, and documentation is to accurately reflect the resident's status and location. 1. Resident #3 was admitted with diagnoses including but not limited to schizophrenia, Parkinson's disease without dyskinesia, depression, and traumatic subdural hemorrhage with loss of consciousness. The 10/03/2025 Quarterly Minimum Data Set documented Resident #5 had intact cognition. Review of the facility investigative summary dated 12/11/2025 documented Resident #3 slapped another resident in the dayroom. The investigative summary documented the incident was unprovoked and interventions included resident separation, observation, and notification of the physician and family. The falls care plan dated 01/10/2026 documented Resident #3 was at risk for falls related to impaired mobility, history of falls, schizophrenia, psychotropic medication use, and poor safety awareness. The care plan documented interventions included every 30-minute monitoring and visual checks. Review of the facility's 30-minute monitoring form dated 04/23/2026 revealed Resident #3 was identified for monitoring due to behavioral concerns. Further review revealed the (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility monitoring form had been completed in advance of the required observation times. On 04/23/26 at 01:19PM, surveyor review of Resident #3's 30-minute monitoring form revealed monitoring observations had been documented through 2:30 PM prior to the required observation times occurring. During an interview on 04/23/2026 at 2:40 PM, Certified Nurse Aide #2 was asked about the whereabouts of Resident #5 and stated they did not know where the resident was at that time. Certified Nurse Aide #2 stated Resident #3 was their assigned resident and walked back and forth throughout the hallway due to wandering behaviors and became agitated at times. Certified Nurse Aide #2 stated they went to lunch at 1:00 PM and completed the 30-minute monitoring documentation through 2:30 PM because they forgot to complete the monitoring documentation the previous day and did not want to forget again. Certified Nurse Aide #2 stated they were aware staff were not supposed to complete monitoring documentation prior to the actual observation times occurring. On 04/23/2026 at 02:48 PM, the surveyor was unable to locate Resident #3 on Unit 3. When multiple staff members were asked about the whereabouts of Resident #3, staff were unable to identify the resident's location. Resident #3 was subsequently observed walking near the elevator. 2. Resident #7 was admitted with diagnoses including but not limited to dementia with mood disturbance, major depressive disorder, and anxiety disorder. The 04/24/2026 Quarterly Minimum Data Set documented Resident #7 had moderately impaired cognition. Review of the falls care plan dated 12/27/2022, last reviewed 03/08/2026, documented Resident #7 was at risk for falls and required visual checks every 30 minutes. On 04/23/2026 at 01:38 PM, the surveyor requested documentation for residents on monitoring checks and residents on one-to-one supervision from Registered Nurse Unit Manager #1. Review of the facility 30-minute monitoring form dated 04/23/2026 revealed no documentation for Resident #7's monitoring form from 7:30 AM through 1:30 PM Further review of the monitoring form revealed no specified reason for the intervention to monitor every 30minutes. The specified reason was left blank. Resident #7's required 30-minute monitoring documentation was not completed and the reason for monitoring identified as Other was not specified on the monitoring form. Review of the legend located at the bottom of the monitoring form revealed the O designation required staff to specify the reason for the monitoring intervention; however, the specified reason was left blank. During an interview on 04/23/2026 at 02:51 PM, Certified Nurse Aide #3 stated Resident #7 was assigned to them and they did not complete the 30-minute monitoring documentation because they were busy. Certified Nurse Aide #3 stated they had recently started working at the facility and were not aware why Resident #7 was on monitoring checks. Certified Nurse Aide #3 further stated they did not know what the O designation on the monitoring form meant. During an interview on 04/23/2026 at 02:53 PM, Certified Nurse Aide #4 stated they did not know what the O designation on the 30-minute monitoring form meant and stated the reason for the monitoring designation should have been specified on the form. Certified Nurse Aide #4 further stated they were not aware of why Resident #7 was on monitoring checks. During an interview on 04/23/2026 at 02:59 PM, Certified Nurse Aide #5 stated they were not aware what the O designation on the 30-minute monitoring form meant and were not aware of why Resident #7 was on monitoring checks. During a follow-up interview on 04/23/2026 at 03:01 PM, Registered Nurse Unit Manager #1 stated the O designation on the 30-minute monitoring form should have specified the reason for the monitoring intervention so staff would know why the resident was on monitoring checks. During an interview on 04/27/2026 at 12:55 PM, the Director of Nursing stated staff should document monitoring checks in real time as the monitoring occurs and staff should not pre-document monitoring sheets or wait until the end of the shift to complete documentation. The Director of Nursing further stated the current monitoring system was problematic because multiple residents are listed on the same monitoring form, which creates confusion for staff. The Director of Nursing stated each resident should have a separate monitoring documentation form to ensure accurate monitoring and documentation by staff. 10 NYCRR 415.12(a)(1)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations, record review, and interviews, the facility did not ensure the resident environment remained as free from accident hazards as possible and did not ensure residents received adequate supervision to prevent accidents for 4 (Residents #1, #3, #5, and #6) of 6 residents reviewed for accidents. Specifically, 1. Resident #1, who had a history of behavioral symptoms including refusal of care and agitation during care, sustained a 4 centimeter by 1 centimeter laceration to the head when Certified Nurse Aide #6 shaved the resident's head while providing care. Resident #1 was transferred to the emergency room and required four staples. This resulted in actual harm to Resident #1 that was not immediate jeopardyThe Findings include: The facility policy titled Accident/Incident Prevention and Reporting Policy, reviewed/revised April 2025, documented the facility shall maintain practices designed to promote resident safety, reduce the risk of accidents and incidents, and ensure timely reporting, assessment, documentation, and follow-up of events involving residents. The policy further documented preventive interventions shall be implemented based on resident needs, identified risk factors, and professional judgment.The facility policy titled Activities of Daily Living (ADL) and Personal Care Policy, reviewed/revised April 2025, documented the facility shall provide assistance with activities of daily living in accordance with each resident's assessed needs, dignity, safety, and individualized plan of care. The policy further documented staff assisting with shaving shall utilize appropriate equipment, follow standard safety practices, observe for cuts or bleeding during grooming, and report significant findings to the nurse supervisor/charge nurse. 1. Resident #1 was admitted with diagnoses including but not limited to dementia, Alzheimer's disease, and anxiety disorder.A physician's order dated 02/02/2026 documented Resident #1 was to receive Aspirin 81 milligram chewable tablet by mouth once daily at 9:00 AM for prophylactic measures The 02/06/2026 Annual Minimum Data Set documented Resident #1 had severely impaired cognition and required supervision or touching assistance for personal hygiene. The Anticoagulation Care Plan reviewed 04/27/2026 documented Resident #1 was at risk for signs and symptoms of bleeding related to anticoagulation/antiplatelet therapy including Aspirin 81 milligrams daily. The Investigative Summary dated 03/08/2026 documented Resident #1 sustained a laceration to the head while being shaved with a disposable razor by Certified Nursing Assistant #6. when Resident #1 became physically aggressive and combative during shaving care, causing the razor to come into contact with the resident's head. The investigation documented Resident #1 sustained a four by one centimeter laceration to the top of the head, was transferred to the emergency room for evaluation and treatment and required four staples to the head. Staff re-education and in-servicing were initiated regarding razor use and resident safety during care. The Incident/Accident Employee Statement dated 03/08/2026 documented Certified Nursing Assistant #6 was shaving Resident #1 with a manual razor when the resident became physically aggressive and began moving around, resulting in the razor cutting the top of the resident's head. The statement further documented Resident #1 sustained a laceration to the top of the head and nursing staff were notified immediately.The 03/08/2026 at 12:13 PM nurses progress note by Registered Nurse #3 documented staff notified nursing that Resident #1 sustained a cut to the head with a razor while being shaved. The note further documented Resident #1 moved his head while staff was shaving him, the area was assessed and cleaned, and the nurse practitioner recommended transfer to the hospital for further evaluation and treatment. The 03/08/2026 at 5:52 PM nurses progress note by Registered Nurse #3 documented Resident #1 returned from the hospital after evaluating a razor cut to the head and four staples were placed to the head laceration. The note further documented Resident #1 returned to the facility in stable condition. Review of the behavioral symptoms care plan dated 04/16/2025 documented Resident #1 exhibited behavioral symptoms including refusal of medication and morning care, becoming agitated during care, refusing vital signs at times, and wandering. During an interview on 04/27/2026 at 5:55 PM, the (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Director of Nursing stated Certified Nursing Aide #6 shaved Resident #1's head and Resident #1 became agitated and combative during shaving care, resulting in Resident #1 sustaining a laceration to the head requiring hospital evaluation and four staples. The Director of Nursing further stated staff are not supposed to shave residents' heads and if staff are unable to perform requested care or services, staff are expected to notify the nursing supervisor. The Director of Nursing additionally stated staff were subsequently in-serviced regarding shaving practices and resident safety.During an interview on 05/15/2026 at 12:21 PM, the Medical Director stated residents generally go to the barber to have their heads shaved and shaving a resident's head by Certified Nursing Assistant staff was a very unusual situation. The Medical Director further stated residents may become agitated and aggressive during care and if residents are combative or moving around, they should not be shaved because it is not safe.During an interview on 05/18/2026 at 2:19 PM, Certified Nursing Assistant #6 stated Resident #1 sustained a cut to the head while they were shaving Resident #1's head with a disposable razor. Certified Nursing Assistant #6 stated during care Resident #1 became agitated, and began swatting hands, and moved while the razor was being used, resulting in the cut. Certified Nursing Assistant #6 stated shaving Resident #1's head was performed at the request of the resident's wife as a barber appointment could not be scheduled. Certified Nursing Assistant #6 stated they were aware staff were not supposed to shave residents' heads and acknowledged they should have notified the nursing supervisor regarding the request rather than performing the task. They were not directed by nursing to shave Resident #1's head. Certified Nursing Assistant #6 stated residents can become agitated unexpectedly during care and next time they would notify the supervisor immediately if family requests for staff to perform tasks outside what they are required to do. 10 NYCRR 415.12(h)(1)(2)