STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335377	A. Building B. Wing	05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Victorian Rehabilitation & Nursing Care Cntr	100 New Turnpike Road Troy, NY 12182

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observations, record review, and interviews (iQIES intake 2626678) the facility failed to ensure a clean, comfortable, and homelike environment for two (2) of five (5) resident halls (South Wing and [NAME] Wing halls) and the Second Floor common area. Specifically, the South Wing and [NAME] Wing resident halls and the Second Floor common area had unclean floors. Findings include:The facility policy Environmental Services - Floor Maintenance, last reviewed 05/2025, documented there was to be daily routine cleaning in corridors and common areas, as well a spot cleaning as needed. The facility policy Resident Right-Safe/Clean/Comfortable/Homelike Environment, last reviewed 06/2025, documented the facility was to provide a safe, clean, comfortable homelike environment to respect resident rights. Resident care areas including but not limited to passageways, resident rooms, and common areas will be kept free from obstacles, debris, and soil. The following observations were made in the [NAME] Wing resident hall:-on 05/11/2026 at 10:36 AM the hallway floor was dirty with dried, light brown liquid spill spots three doors down from the double doors to end of the hallway. The floor outside resident room [ROOM NUMBER] had debris and paper wrappers.-on 05/13/2026 at 10:00 AM the floor outside locked door and resident room [ROOM NUMBER] had dirt and food crumb debris. Resident room [ROOM NUMBER] had food crumbs and dirt smashed into the floor outside the room. At 10:01 AM, the doorway entrance where the hall floor meets the room floor tiles were stained. There was caked brown, tan, and black crumbs and debris on the floors in rooms 326, 338, 328, and 340. At 10:53 AM the floor in front of the crash cart was dirty with food crumbs and black and brown dirt debris. The following observations were made in the South Wing resident hall:-on 05/13/2026 at 11:31 AM the floor under the fire extinguisher from the doorway of resident room [ROOM NUMBER] to the utility room had crumbs, dirt debris, and brown stains. At 11:33 AM the hallway between resident room [ROOM NUMBER] across to resident room [ROOM NUMBER] had orange and light brown smears. There were stuck on brown and black spots and food crumbs.-on 05/14/2026 at 10:13 AM the floor under the fire extinguisher from doorway 310 to the utility room had visible crumbs, dirt debris, and brown and black spots. At 10:21 AM the wall between resident room [ROOM NUMBER] and the mechanical room was speckled with brown and black spots. During an observation on 05/14/2026 at 1:01 PM the Second Floor common area floorin front of the old nurses' station next to the couch had dried on sticky stains, dried brown smears, and food crumbs and dirt. During an interview on 05/15/2026 at 9:56 AM Certified Nurse Aide #29 stated the floors were cleaned every day. The facility used a heavy scrubber on the floor a couple of times a week, but they had to block off parts of the floor to do it. Housekeeping was responsible for taking care of the dried spills in the common area. During an interview on 05/15/2026 at 11:37 AM Housekeeper #60 stated their responsibilities included making sure the rooms were clean, and the garbage was emptied. The hallways were cleaned every day. Any stuck-on food or grime in the hallways was treated with chemicals and scraped up if needed. During an interview on 05/15/2026 at 1:09 PM, Housekeeping Supervisor #61 stated the housekeepers were responsible for cleaning the rooms, sweeping and mopping the bathrooms, cleaning up any spills or tracks on the floor, and making sure the hallways and common areas were clean. Hallways were (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	done with the auto scrubber every morning before the residents were active for the day and in the evening. Spot mopping was done midday. Any stuck-on spots were supposed to be soaked, then scraped to get the spot up and then spot mop the area. At 1:13 PM the Housekeeping Supervisor observed the South Wing resident hallway spilled dried liquid and dried food spots. They stated some of the spots the auto scrubber did not touch but some of the spots would have easily come up and should have been cleaned. 10 New York Codes, Rules and Regulations 415.5(h)(4)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observations, record review, and interviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident to include services provided to maintain the resident's highest practicable physical well-being for one (1) of one (1) resident (Resident #97) reviewed. Specifically, Resident #97 did not have their fall mat (a cushioned floor mat placed next to the bed) in place while in bed as planned. Findings include:The facility policy Comprehensive Care Plans, last reviewed 04/2026, documented each resident was to have an interdisciplinary care plan that was initiated within 24 hours of admission. The care plan would be consistent with the medical plan of care for the resident and identify priority problems and needs addressed for the resident along with strengths, limitations, and goals. Care plans were updated as needed to meet the residents' needs and preferences. Resident #97 had diagnoses including Parkinson's disease (a progressive neurological disease) and dementia with agitation. The 05/17/2026 Minimum Data Set documented the resident had moderately impaired cognition, had two or more falls, and required moderate assistance or was dependent for most activities of daily living. The 10/30/2024 comprehensive care plan documented the resident was at medium to high risk for falls with an actual fall on 09/30/2025, had Parkinson's disease, and was on psychotropic medication. The resident was non-compliant with safety measures and frequently tried to transfer themselves. Interventions included a floor mat on the door side of bed, ensure the head of the bed was lowered at hours of sleep to prevent from leaning and falling out of bed, and do hourly checks while in bed to ensure proper positioning and they were centered in bed. The following observations of the resident were made:-on 05/12/2026 at 8:42 AM in bed with the head of the bed raised, their sheets were twisted and hanging off the bed on the floor and the bare over bed table was raised across their lap. The floor mat was folded up and not in place next to the bed-on 05/14/2026 at 10:02 AM in bed with the head of the bed slightly elevated. They were slumped to the right side with their head to their shoulder at the edge of the bed. The fall mat was not placed next to the bed and was folded up vertically next to the nightstand. During an interview on 05/15/2026 at 10:06 AM Certified Nurse Aide #1 stated if a resident was supposed to have a fall mat in place it should be on their care plan. Resident #97 was care planned to have a fall mat in place while in bed. The resident was usually up for breakfast but if they were still in bed during or after breakfast the fall mat should still be in place. During an interview on 05/15/2026 at 11:09 AM Licensed Practical Nurse #17 stated Resident #97 was care planned to have a fall mat in place when they were in bed. The staff knew to put the fall mat in place while the resident was in bed as the resident would roll out of bed. If the fall mat was moved for the tray table for breakfast it should be put back in place when the tray was removed. During an interview on 05/15/2026 at 11:33 AM Licensed Practical Nurse Unit Manager #9 stated Resident #97 should have a fall mat in place on one side while in bed. If the fall mat was in the way of the tray table for a meal, the fall mat should be put back in place once the tray was removed. 10 New York Codes, Rules and Regulations 415.11(c)(1)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observations, record review, and interviews (iQIES Intakes 2626678, 2727573, and 2970379) the facility failed to ensure that residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for one (1) of six (6) residents (Resident #9) reviewed. Specifically Resident #9 did not receive showers as planned.Findings include:The facility policy AM/PM/ Activity of Daily Living Care, last reviewed 07/2025, documented residents would receive hygienic care at routine intervals. Hygienic care was in addition to any regular scheduled bathing. Shaving, nail hygiene, and oral care were considered parts of AM / PM/ activity of daily living care. Any refusal of care would be immediately reported to the nurse.Resident #1 had diagnoses including muscle weakness and need for assistance with personal care. The 04/13/2026 Minimum Data Set assessment documented the resident had intact cognition, did not reject care, required setup or clean-up assistance with bathing and was independent with personal hygiene.The comprehensive care plan, initiated 10/21/2024 and revised 02/24/2026, documented the resident had a self-care deficit. Interventions included the resident was independent with bathing after set-up and independent with personal hygiene.The undated care instructions documented the resident was independent with bathing after set-up.The 2nd floor shower schedule documented Resident #9 was scheduled to receive a shower on Friday evenings (3:00 PM-11:00 PM).Certified Nurse Aide Documentation Records documented the following;-March 2026 the resident received a shower on 03/19/2026.-April 2026 no showers were provided.-May 2026 no showers were provided.Resident #9 was observed at the following times:-on 05/11/2026 at 11:53 AM, in the dining room. They were eating and licking their fingers, their fingernails were long and unclean with a dark substance underneath. At 1:11 PM, the resident was walking down the hallway, their hair was long, greasy, had white specs in it, and their nails were long and unclean with a dark substance underneath them. The resident stated they would like their nails cut, they had not had a shower in a month, and wanted their hair washed.-on 05/12/2026 at 9:10 AM, seated in the common area. Their hair was long, greasy, and had white specs in it. Their nails were long and had a dark substance underneath them. At 12:42 PM, the resident was walking down the hallway. Their hair was long, greasy, and had white specs in it. Their nails were long and had a dark substance underneath them.-on 05/13/2026 at 9:58 AM, the resident was walking in the hallway. Their hair was long, greasy, and had white specs in it. They stated their nails were cut.During a telephone interview on 05/14/2026 at 12:06 PM Certified Nurse Aide #54 stated showers were completed Monday through Fridays on the day or evening shifts. There was a shower schedule posted behind the nurse's station and each aide completed the provided showers as scheduled based on their assignment. If a resident refused to be showered the aide should tell the nurse and provide a bed bath, if the resident was agreeable. They documented the shower was provided in the certified nurse aide documentation. If it was not documented, that meant it was not done. The nurse aides could document any refusals, and the nurse was supposed to document the refusals as well. Resident #9 was on their assignment last Friday evening, the resident refused to be showered, and they told Licensed Practical Nurse #15. They were unsure if they documented the refusal. During an interview on 05/14/2026 at 5:22 PM, Licensed Practical Nurse #15 stated showers were provided by the certified nurse aides according to the schedule at the nurse's station. If a resident refused their shower the certified nurse aide should notify the nurse of the refusal and both the nurse and certified nurse aide should document the refusal. They did not recall being told that Resident #9 refused their shower on Friday evening. They stated if they were made aware they would have documented it.During an interview on 05/15/2026 at 11:33 AM, Licensed Practical Nurse Unit Manager #9 stated the certified nurse aides showered the residents per the shower schedule based on their assignments. Both the nurse and the certified nurse should document any refusals. Resident #9 at times refused showers, but if they were reapproached, they would typically be agreeable to a shower. Residents should be showered at least weekly, nail (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care should be done on shower days, and as needed. Resident #9 was not a diabetic and the nursing staff could cut and clean their nails. They were unaware the resident had not had a documented shower since March 2026, but their hair looked greasy, and they had staff cut the resident's nails this week as they were long and unclean. 10 New York Codes Rules Regulations 415.12(a)(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. Based on observations, record review, and interviews (iQIES intake 2727573), the facility failed to ensure a resident with pressure ulcers received the necessary treatment and services consistent with professional standards of practice, to promote wound healing, prevent infection and prevent new ulcers from developing for one (1) of one (1) resident (Resident #17) reviewed. Specifically, Resident #16 had an existing Stage 4 (full thickness tissue loss with exposed bone, tendon, or muscle) pressure ulcer on the sacrum (large bone at the base of the spine) and treatments were not administered as ordered and the wound was not monitored consistently. Findings include: The facility policy Pressure Ulcer Prevention and Managing Skin Integrity, last reviewed 12/2025, documented care and interventions regarding pressure ulcers included implementation of appropriate evidence-based care, and close monitoring of the responses to treatment.Resident #16 had diagnoses including a Stage 4 pressure ulcer to the sacrum, impaired circulation and urinary incontinence (loss of bladder control). The 02/09/2026 Minimum Data Set (a resident assessment tool) documented the resident had moderately impaired cognition; was dependent on staff for all personal hygiene and mobility; had unhealed pressure ulcers present on admission; was at risk for developing new pressure ulcers; had pressure reducing devices for bed; and received application of nonsurgical dressings and ointments/medications.The 03/02/2025 comprehensive care plan documented the resident was at risk for skin breakdown related to impaired mobility, refusals to reposition in bed, refusals to get out of bed, urinary incontinence, and diabetes. The resident had a Stage 4 sacral pressure ulcer. Interventions dated included provide urinary incontinence care; perform wound care rounds weekly; monitor for changes in pressure ulcer daily and documenting findings weekly; provide a pressure reducing mattress; maintain turning and positioning schedule as recommended; prevent skin friction during transfers and positioning; use skin protectant ointment when performing perineal care; promote optimal hydration and nutrition; apply local treatments as ordered by the physician; and wound care consult as needed.The 04/13/2026 Physician #30 order documented fill sacrum wound cavity with gauze moistened with Dakin's solution 25% (a strong antiseptic used to treat and prevent infections), soak for 20 to 30 minutes. Gently cleanse with normal saline after soak, use collagen dressing and cover with blue antibacterial foam dressing followed by a dry dressing every Monday, Wednesday, and Friday during 7:00 AM - 3:00 PM shift.The 04/14/2026 consulting Wound Physician #33 documented the sacrum wound was improved with no overt infection. Recommendations included cleansing the wound with normal saline, applying skin protectant ointment around the edges of the wound; soaking with Dakin's solution 20 to 30 minutes prior to dressing changes, gentle cleansing with normal saline after the soak, applying collagen dressing to wound bed, then covering with an antibacterial foam dressing. Change dressing 3 times a week and as needed.There was no documented evidence of facility-documented wound assessments in the electronic health record from 03/27/2026 through 05/12/2026.The April 2026 and May 2026 Treatment Administration Record documented fill sacrum wound cavity with gauze moistened with Dakin's solution 25%, soak for 20 to 30 minutes. Gently cleanse with normal saline after soak, use collagen dressing and cover with blue antibacterial foam dressing followed by dry dressing with a start date of 04/13/2026. There was no documented evidence the treatment was administered on 04/13/2026, 04/15/2026, 04/17/2026, 04/22/2026, 04/24/2026, 04/27/2026, and 05/15/2026. During an observation on 05/13/2026 at 1:00 PM Licensed Practical Nurse #31 performed wound care to Resident #17's sacral wound with the assistance of Assistant Nurse Manager #32. The sacrum wound dressing was intact without visible drainage. The dressing was removed by Assistant Nurse Manager #32. The wound was 3.0 centimeters x 1.0 centimeter x 1.0 centimeter with granulation (new healthy tissue), no signs or symptoms of infection, and surrounded by pink intact skin. Licensed Practical Nurse #31 sprayed the wound with wound cleanser, wiped the wound with a sterile gauze, packed the wound with collagen dressing, and covered the wound with an antibacterial foam dressing followed by a dry sterile dressing. There was (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	no evidence the wound was filled with Dakin's solution gauze for 20-30 minutes as ordered.During an interview on 05/14/2026 at 1:46 PM Licensed Practical Nurse #31 stated they did not perform the Dakin's solution soak for 20 to 30 minutes prior to completing the dressing change as ordered. During an interview on 05/15/2026 at 11:30 AM Wound Care Registered Nurse #21 stated they assess all pressure ulcers weekly with the facility physician, the physical therapy director, a registered dietitian, and a unit nurse manager. They state the resident had an outside consultant for pressure ulcer care. They stated they still assessed Resident #17's pressure ulcer weekly but had not completed any documentation of the assessments since starting in the position in late March of 2026. They stated the last time they saw the resident's wound was Thursday, 05/07/2026, but they did not document the assessment in the medical record. They stated the medication nurse was responsible for completing pressure ulcer dressing changes, and they documented in the Treatment Administration Record. They stated if dressing were not performed as ordered this could have led to infection, delayed healing, and pain.10 New York Codes, Rules and Regulations 415.12 (c)(1)