

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335377	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/18/2026
NAME OF PROVIDER OR SUPPLIER Troy Victorian Rehabilitation & Nursing Care Cntr		STREET ADDRESS, CITY, STATE, ZIP CODE 100 New Turnpike Road Troy, NY 12182	
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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. Based on observations, record review, and interviews the facility failed to ensure residents maintained acceptable parameters of nutritional status for two (2) of three (3) residents (Residents #1 and #6) reviewed. Specifically, Resident #1 was not assisted with their meals as planned, had significant weight loss, their nutritional needs were not reassessed, weights were not obtained as ordered, and there was no documented evidence a medical provider addressed the resident's weight loss; and Resident #6 had was not assisted as their meals as planned and had significant weight loss. Findings include: The facility policy Meal Delivery/Tray Pass dated, last reviewed 10/2025, documented any resident who required assistance with feeding would be assisted when the tray was removed from the food truck. The facility policy Weight Measurement, Monitoring, and Notification Protocol, last reviewed 06/2025, documented: if a resident had a weight change of 3 pounds from the previous recorded weight, a re-weight would be obtained; and the registered Dietitian, attending physician, and family/ representative would be notified within 24 hours if there was an unintended weight change of 5% in 30 days, 7.5% in 90 days, or 10% in 180 days. The facility policy Comprehensive Nutrition Assessment and Care Planning, last reviewed 09/2025 documented: the facility would conduct timely, accurate, and interdisciplinary nutritional assessments for all resident upon admission, quarterly, annually, and upon a significant change in status; significant change in status reassessment would be initiated within 24 hours of any unintended weight change of 5% in 30 days, 7.5% in 90 days, or 10% in 180 days; and assessment components would include current weight, height, body mass index, ideal body weight range, and 30/ 60/ 180-day weight history trends. Assessment would also include estimated calorie, protein, and fluid needs. 1) Resident #6 had diagnoses including stroke with left sided paralysis and pressure ulcers. The 03/08/2026 Minimum Data Set (a resident assessment tool) documented the resident had moderately impaired cognition, functional impairment to one side of the upper extremity, required substantial/maximal assistance with eating, weighed 154 pounds, had a significant weight loss at 1 month or 6 months, and was on a mechanically altered diet. The comprehensive care plan, initiated 11/03/2025, documented the resident had self-care deficits with activities of daily living. Interventions included to provide extensive 1:1 assistance with eating and provide food in separate bowls during meals. The resident was at nutritional risk due to low intakes at meals and a history of significant weight loss. Interventions included provide liberalized diet, supplements, nourishments, and high biological protein food items. Physician orders documented: - on 02/11/2026 provide 240 milliliters of Ensure Plus (oral nutrition supplement) nectar thick. (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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- on 02/17/2026 dietitian consult. - on 02/17/2026 regular pureed diet with nectar thickened liquids. - on 02/24/2026 nurse to monitor intake with every meal. Coordinate with certified nursing assistant to document appropriately. - on 04/01/2026 monthly weights. The resident's weight record documented: - 01/12/2026: 175.0 pounds - 02/05/2026: 160.0 pounds (15-pound loss/8.5% loss at 1 month and no documented reweight obtained - 02/12/2026: 153.8 pounds (21-pound loss/ 12% loss at 1 month) and no documented reweight obtained. The 02/09/2026 Dietetic Technician #28 progress note documented nursing was unable to weigh due to coronavirus disease isolation precautions. The 02/13/2026 Physician #35 progress note documented the 02/12/2026 weight of 153.8 pounds. The 02/16/2026 Dietetic Technician #28 progress note documented a reweight of 153.8 pounds. The resident had a significant 21.2-pound loss/ 12.1% loss from 01/12/2026 and their body mass index was 24.9, which was within normal limits. The resident had a history of COVID-19, poor intakes, dysphagia (difficulty swallowing), pressure ulcers, and required assistance with feeding. Supplements were increased along with nourishment to promote good intakes, wound healing and maintain weight. Nursing, the registered dietitian, nurse practitioner/physician, and speech language pathologist were aware of weight change. Intakes had improved to 50-75%. The plan was to continue weekly weight collection to monitor stability and weight changes. The 02/21/2026 Registered Dietitian #42 progress note documented current diet of pureed solids and nectar thick liquids and daily supplements remained appropriate. There was no documented evidence the resident's significant weight loss was addressed. The resident's weight record documented: - 03/02/2026: 149.8 pounds (10.2- pounds loss/ 6.3% loss at 1 month and 23.6-pound loss/ 13.6% loss at 3 months) and no documented reweight obtained - 03/24/2026: 145.5 pounds no documented reweight obtained - 03/31/2026: 147.0 pounds The 03/09/2026 Dietetic Technician #28 progress note documented the resident's weight was within normal limits. Supplements and nourishment were provided to promote good intakes, wound healing and weight maintenance. (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 03/20/2026 Physician #35 progress note documented resident's weight 149 pounds on 03/02/2026 and 153.8 pounds on 02/12/2026. No change in plan noted. The 04/01/2026 Dietetic Technician #28 progress note documented resident had lost 2.8 pounds from 03/02/2026 to 03/31/2026, had no significant weight change in 4 weeks, and weights could be monitored monthly. The resident's weight record documented: - 04/17/2026: 142.5 pounds (32.5-pound loss/ 18.5% loss at 3 months) and no documented reweight obtained - No weights documented for 05/2026 The 04/17/2026 Physician #35 progress note documented resident's weight as 147 pounds on 03/31/2026, 149 pounds on 03/02/2026 and 153.8 pounds on 02/12/2026. The following observations of Resident #6 were made: -on 05/11/2026 at 12:23 PM lying in bed. Certified Nursing Aide #46 set the resident's lunch tray on the bedside table in front of the resident and left the room. The tray ticket documented regular puree diet with nectar thick liquids, extra meat, no milk, feeding assistance, and aspiration &ndash; no straws. The resident ate their meal unassisted, attempting to use their right hand to spoon food into their mouth. -on 05/12/2026 at 12:40 PM Certified Nursing Aide #52 repositioned resident in bed, placed their lunch tray on the bedside stand and left the room. The tray ticket documented feeding assistance. The resident was leaning to the right side using their right hand to feed themselves. -on 05/13/2026 at 12:40 PM leaning to the right side attempting to eat lunch unassisted. -on 05/14/2026 at 12:30 PM, the lunch tray was on the bedside table. There were no staff assisting the resident with their meal. During an interview on 05/14/2026 at 12:47 PM Certified Nursing Aide #52 stated they set up the resident's food for their meal but did not assist them with eating. When they reviewed the care instructions for Resident #6, they stated the resident required assistance with eating. During an interview on 05/14/2026 at 1:13 PM, Licensed Practical Nurse #9 stated nursing staff should help residents who need assistance at meals. If a resident did not receive assistance as planned, they might not eat well. Resident #6 required extensive assistance with meals. 2) Resident #1 had diagnoses including dysphagia, cognitive communication deficient, and schizophrenia (a serious mental health disorder). The 03/30/2026 Minimum Data Set (a resident assessment tool) documented the resident had severe cognitive impairment, did not reject care, required substantial / maximum assistance with meals, coughed or choked during meals or when swallowing medications, and received a mechanically altered diet. The 08/13/2025 comprehensive care plan, updated 03/30/2026, documented the resident had an (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 02/18/2026 Physician #35 progress note documented they saw the resident for a monthly renewal visit and did not address weight loss. The 03/18/2026 Physician #35 progress note documented the resident's weight was 156.6 pounds on 03/06/2026. They did not address weight loss. The 03/18/2026 Dietetic Technician #28 nutrition assessment documented the resident weighed 159.5 pounds, the resident had a history of weight loss, had no significant weight changes, their intakes were 50-75% at meals, received extra nourishments, and high biological protein foods. The 03/27/2026 Registered Dietitian #42 nutrition assessment documented the resident's estimated daily nutritional needs were 1725 &ndash; 2415 calories, 69 &ndash; 83 grams pf protein, and 1725 - 2415 milliliters of fluid daily. The resident was on 1:1 assistance for feeding assistance and had a 20.9 pound/ 12.9% significant weight loss at 6 months. Nutrition would continue to monitor weights and provide supplements as ordered. Physician orders documented: -03/27/2026, Pureed solids and honey thick liquid diet and 240 milliliters of honey thickened Ensure Plus (oral nutrition supplements) twice daily. -03/31/2026, Resident to receive 1:1 assistance for all meals. The residents' weight record documented: -04/02/2026: 147.2 pounds (12.3 pounds / 7.7% loss at one (1) month and 49.4 pounds loss/ 25.1% loss at six (6) months) and no documented reweight obtained. -04/09/2026: 150.6 pounds -04/14/2026: 150.2 pounds -04/23/2026: 135.6 (14.6 pounds/ 9.7% loss in 9 days) and no documented reweight obtained -04/28/2026: 156 pounds no documented reweight obtained -04/29/2026: 150 pounds (six (6) pound loss in one (1) day) and no documented reweight obtained -05/06/2026: 151 pounds -05/06/2026: 152 pounds. Resident #1 was observed at the following times: -on 05/11/2026 at 11:20 AM, seated upright in their bed with food debris on their clothing protector. Their breakfast meal was on their over bed tray table. The meal ticket documented aspiration precautions, no straws, total feed, pureed scrambled eggs, oatmeal, yogurt, honey thick orange juice, honey thick water, and honey thick coffee. They consumed 100% of the scrambled eggs, 100% hot cereal, and 0-25% of the yogurt. The resident stated they had a difficult time feeding themselves and (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	had lost weight. At 11:33 AM, Diet Technician #28 entered the resident's room and asked if they could remove the meal tray and took it out of the room. -on 05/12/2026 at 12:26 PM &ndash; 1:05 PM, Certified Nurse Aide #29 provided the resident with their meal tray, assisted them to an upright position, pulled the privacy curtain closed, and exited the room. The meal ticket documented aspiration precautions, no straws, and total feed, pureed cottage cheese, pureed fish, applesauce, honey thick apple juice, honey thick water, honey thick Mighty Shake (oral nutrition supplement), honey thick coffee, and chocolate pudding with whipped topping. The resident was not assisted with their meal. At 1:05 PM, Certified Nurse Aide #29 entered the room and removed the resident's meal tray. The resident consumed 100% of their puree items and 0-25% of their drinks. At 1:09 PM, the resident was sipping on their coffee and had two (2) honey thick beverages on their over bed tray table. At 1:38 PM, Licensed Practical Nurse Unit Manger #9 entered the room and spoke to the resident and left the room at 1:40 PM, they did not remove the beverages or assist the resident. -on 05/13/2026 at 12:46 PM, seated upright in bed feeding themselves. Their meal ticket documented aspiration precautions, no straws, and total feed. The resident had pureed beef, pureed corn, pureed taco shell pureed cottage cheese, a honey thick mighty shake, honey thick juice, honey thick water, honey thick coffee, and pudding. At 1:01 PM, the resident had consumed 100% of the puree beef, corn, and pureed taco shell, 0-25% pureed cottage cheese, and their pudding still had the lid on it. They consumed 0-25% of their beverages. No staff assisted the resident with their meal. The May 2026 Medication Record Administration documented the resident was to have 1:1 meal assistance with all meals. -On 05/11/2026, Licensed Practical Nurse #27 signed the order as completed on the 7:00 AM &ndash; 3:00 PM shift. -On 05/12/2026, Licensed Practical Nurse Unit Manager #9 signed the order as completed on the 7:00 AM &ndash; 3:00 PM shift. -On 05/13/2026, Licensed Practical Nuse #14 documented 1:1 assistance at meals was not provided. During an interview on 05/13/2026 at 1:18 PM, Certified Nurse Aide #26 stated they were assigned to Resident #1, and the resident did not require assistance at meals and could feed themselves. If a resident did not receive assistance per their care instructions, they might not eat as well as they could. During an interview on 05/14/2026 at 12:46 PM, Licensed Practical Nurse #14 stated the certified nurse aides should check the care instructions daily as they could change. If they were unable to provide the care per the care instructions, they should tell the nurse. Resident #1 had an order for 1:1 assistance at meals. If the nurse signed the order as completed it meant the resident was assisted with their meals. They were unaware the resident did not receive assistance at their lunch meal on 05/13/2026 and they should have been told. If a resident did not receive assistance at meals as planned it could impact their weight. During an interview on 05/15/2026 at 10:53 AM, the Director of Therapy stated occupational therapy determined the level of assistance a resident required at meals. Resident #1 required substantial/maximal assistance with meals. The resident could feed themselves but would fatigue (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	during meals and staff would have to assist for completion of meals. Resident #6 required extensive assistance at meals due to fatigue. Resident #6 would start off strong eating and needed assistance to complete meals. During an interview on 05/15/2026 at 11:33 AM, Licensed Practical Nurse Unit Manager #9 stated the nursing staff obtained the weights as ordered, Diet Technician #28 notified the nursing administration team if reweights were needed, and weight changes were discussed with the interdisciplinary team in morning report. Both the nurse managers and Diet Technician #28 notified medical of any significant weight changes. Resident #1, at times refused to weighed, but there was no documented evidence of their refusals, and they had weight loss. Occupational therapy determined the level of assistance a resident required at meals. All staff should review the care instructions daily and follow the instructions. Resident #1 had a medical order for 1:1 with meals. Staff should assist the resident with their meal and stay for the entire meal. If the nurse signed 1:1 at meals order as completed that meant they verified staff was in the room assisting the resident with their meal. If a resident was not assisted with their meals as planned/ ordered it could impact their nutritional status, weight status, and posed a safety risk. They were unaware Resident #1 did not receive assistance as ordered. During an interview on 05/15/2026 at 12:58 PM, Diet Technician #28 stated nursing staff obtained the weight and the facility policy stated if there was a 3 pound weight change from the previous weight, they should notify the nurse managers that a reweight was needed. If the resident refused to be weighed nursing should document any refusals. The registered dietitian should reassess the resident's nutrition needs if there was a significant weight change and complete nutritional assessment. They communicated with the registered dietitian if there were any significant weight changes, as the dietitian worked remotely. Resident #1 had significant weight changes, and they did not see documentation their significant weight change was addressed. During an interview on 05/15/2026 at 1:18 PM, Nurse Practitioner #22 stated the nurse managers and diet technician notified them of significant weight changes. Residents should be assisted with meals as planned. During a telephone interview on 05/15/2026 at 1:44 PM, Registered Dietitian #42 stated the diet technician communicated with nursing staff if there were any outstanding weights and notified nursing if a reweight was needed. They only completed the nutritional assessment for the high risk residents and any significant weight changes triggered by the Minimum Data Set Assessment. Significant weight changes were 3% or more in a week, 5% or more at 30 days, 7.5% at 90 days, and 10% or more at 180 days. They expected the diet technician to complete any significant weight change assessments and reassess the resident's nutritional needs. They worked closely with the diet technician and expected them to reach out if they had concerns. They were not consistently notified of significant weight changes at the facility. They were unaware Resident #1 had significant weight changes and their nutritional needs were not reassessed. They last addressed Resident #6's weight loss in February 2026. They did not notify medical of any significant weight changes. They stated there was no documented evidence the resident's nutritional needs were reassessed after they had significant weight changes. If the resident did not receive assistance as planned at meals it could impact their weight and nutritional status. 10 New York Codes, Rules and Regulations 415.12(i)1		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observations, record review, and interviews, the facility failed to provide pharmaceutical services (including procedures that assure the accurate administering of all drugs and biologicals) for four (4) of nine (9) residents (Residents #2, #47, #97, and #119) reviewed. Specifically, Resident #2's 11:30 AM dose of Renvela (used to lower blood phosphorus levels and taken with meals) was not regularly administered and there was no documented evidence the physician was notified of the missed doses, and no documented evidence the pharmacist reviewed the missed doses during their monthly medication reviews; and Residents #47, #97, and #119 were not provided their carbidopa-levodopa (used to treat Parkinson's disease-a progressive neurological disorder) timely; and Resident #47 had their medications from 5:00 PM and 9:00 PM on 05/12/2026 in the same cup on their bedside table the next morning. Findings include: The facility policy Administering medications/medication errors, last reviewed 06/2025, documented all medications were to be administered in a safe and time manner as prescribed. Staff schedules are arranged to ensure that medications are administered without unnecessary interruptions. Medications are administered in accordance with prescriber orders, including any required timeframes. Medications were administered within 1 hour of their prescribed time unless otherwise specified. The individual administering the medication documents administration after administering the medication.1) Resident #2 had diagnoses including end stage kidney disease. The 02/17/2026 Minimum Data Set documented the resident had intact cognition, had no behaviors, and received dialysis (a process that filters the blood when the kidneys do not work).The 10/24/2024 comprehensive care plan documented the resident was dependent on hemodialysis related to end-stage kidney disease. Interventions include to provide renal diet and follow dietary restrictions as per the provider's order, monitor the shunt for patency, monitor for signs of infection and communicate with the dialysis center any abnormal findings, provide bagged lunch for dialysis, monitor fluid intake and output, vital signs and weight as ordered by the provider, and the resident received hemodialysis three times a week on Monday, Wednesday, and Friday with a pick up time at 10:00 AM.The 04/17/2026 physician order documented Renvela 800 milligrams, give two tablets 3 times daily with food at 11:30 AM, 4:30 PM, and 6:30 AM for end stage kidney disease. The order had a note to vendor Do not send resident has full supply.The May 2026 Medication Administration Record documented Renvela 800 milligram tablet give two (2) tablets by oral route 3 times per day with meals- the 11:30 AM dose on 05/01/2026, 05/04/2026, 05/07/2026, 05/08/2026, 05/11/2026 were marked as the resident being LOA as they were at dialysis and not in the facility (by Licensed Practical Nurse #17 on 05/01/2026, 05/04/2026, and 05/08/2026; and by Licensed Practical Nurse #63 on 05/11/026).There was no documented evidence the provider or the dialysis center was made aware the resident did not receive the 11:30 AM dose of Renvela on dialysis days. There was no documentation the pharmacist was aware of the missed doses and provided a recommendation during their monthly drug regiment review.During an interview on 05/14/2026 at 1:45 PM, Licensed Practical Nurse #17 stated if a resident was not available for their medications and was out of the facility, they marked LOA on the medication administration record. Resident #2's two tablets of 800 milligram Renvela were ordered to be given at 11:30 AM but the resident was at dialysis at that time, so the medication was not given. They did not let the provider know the resident missed the medications because the provider should be aware the resident was at dialysis every other day so they should know the resident was not getting the medication at that time. They had only been marking LOA as that was what everyone else was documenting.During an interview on 05/15/2026 at 9:26 AM, Dialysis Secretary #20 stated the dialysis registered dietitian recommended Resident #2 get 1600 milligrams of Renvela three (3) times a day with meals for their phosphorus levels. The resident did not receive the medication at dialysis, and the dialysis facility expected the resident to receive the medication at the nursing facility.During an interview on 05/15/2026 at 10:10 AM, Licensed (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Practical Nurse Unit Manager #9 stated they reviewed orders when a resident was due for a Minimum Data Set. They were unaware Resident #2 was not receiving their 11:30 AM dose of Renvela from either the facility or dialysis. They were not notified there was a scheduling conflict for the medication on dialysis days. The dialysis center ordered the medication, and they and the provider should be aware the resident was not receiving this dose of medication. During an interview on 05/15/2026 at 1:25 PM Nurse Practitioner #22 stated they believed they were aware Resident #2 was not receiving their 11:30 AM dose of their Renvela on dialysis days but did not recall when they were notified but stated it was probably recently. The medication was only for when the resident was eating. The medication helped reduce phosphorous levels which dialysis treatment did as well. During an interview on 05/15/2026 2:07 PM Pharmacist Consultant #40 stated they did not review the Medication Administration Records during the pharmacy reviews. They did not review whether medications were being given or not, just what the resident was taking. Resident #2 should not miss doses of Renvela. Kidney function was serious and measurable. Missing several doses of the medication would not be good for the resident. 2) Resident #47 had diagnoses including Parkinson's disease (a progressive neurological disease). The 04/21/2026 Minimum Data Set assessment documented the resident had intact cognition and required supervision/ touching assistance for most activities of daily living. The 02/09/2026 physician order documented carbidopa 25 milligrams-levodopa 100 milligram tablet give one tablet 3 times per day at 2:00 PM, 9:00 AM, and 9:00 PM for Parkinson's disease. The 02/12/2025 comprehensive care plan documented a diagnosis of Parkinson's Disease. Interventions included administer medication as ordered. The May 2026 Medication Administration Record documented carbidopa 25 milligrams-levodopa 100 milligram tablet give one tablet 3 times per day at 2:00 PM, 9:00 AM, and 9:00 PM. On 05/12/2026 Licensed Practical Nurse #15 documented they administered the resident one 25 milligram-levodopa 100 milligram tablet at 9:00 PM. During an observation on 05/13/2026 at 10:02 AM, the resident was in bed sleeping. There was a pill cup on their bedside table containing one (1) large white oval pill, two (2) small brownish orange pills, and one (1) small yellow round pill. During an observation and interview on 05/13/2026 at 10:21 AM with Licensed Practical Nurse #14 they stated the pills in the cup included 25 milligram-levodopa 100 milligram tablet from the previous evening. They stated they administered the resident's morning medications in the common area. During an interview on 05/14/2026 at 5:22 PM Licensed Practical Nurse #15 stated medications could be given an hour before and an hour after the scheduled time. Anything outside that required they notify the doctor. They were supposed to stay in the room with the resident to ensure the medications were taken. They provided Resident #47 with their evening medication on 05/12/2026, but the resident became upset, and they left the medication in the room and did not check to ensure the resident took the medication. During an interview on 05/15/2026 at 11:33 AM Licensed Practical Nurse Unit Manager #9 stated carbidopa-levodopa was a time sensitive medication and should be given per the physician order. The nurse should notify the provider if the resident refused medication or was unable to administer the medication as ordered. They were aware Resident #47's evening carbidopa-levodopa was observed in their room the following day and there was no documented evidence the medical provider was made aware the resident missed their evening dose. 3) Resident #97 had diagnoses of Parkinson's disease (progressive neurological disease) and dementia. The 05/17/2026 Minimum Data Set documented the resident had moderately impaired cognition and required moderate assistance or was dependent for most activities of daily living. The 10/30/2024 comprehensive care plan documented the resident had a diagnosis of Parkinson's disease. Interventions included encourage activities of daily living performance by allowing the resident to participate in care, initiate safety precautions to protect the resident from injury, and monitor for complications caused by involuntary movement such as injuries from falls or aspiration. The 12/22/2024 physician order documented carbidopa extended release 25 milligrams-levodopa 100 milligram: give one tablet by oral route 5 times per day. During an observation and interview on 05/14/2026 at 10:44 AM Licensed Practical Nurse #17 entered the resident's room (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with a medication cup to administer medications. Licensed Practical Nurse #17 stated the resident's 9:00 AM dose of carbidopa-levodopa was in the cup. During an interview on 05/14/2026 at 1:45 PM, Licensed Practical Nurse #17 stated carbidopa-levodopa should be given at specific times. If the medication was given late, the provider should be informed so the other doses could be spaced out if needed. They stated they did not inform the provider prior to giving the medication. They stated they informed the provider of any missed, refused, or late medication at the end of their shift in one text message unless it was an emergency. During an interview on 05/15/2026 at 10:10 AM Licensed Practical Nurse Unit Manager #9 stated Resident #97's Carbidopa-Levodopa dose should not be given an hour and 44 minutes past the prescribed time. The nurse should have notified the provider and got directions on how to proceed prior to giving the medication as the dose was very late. 4) Resident #119 had diagnoses including Parkinson's disease. The 04/21/2026 Minimum Data Set assessment documented the resident had intact cognition and required maximum assistance for most activities of daily living. The comprehensive care plan initiated 04/02/2026 documented a diagnosis of Parkinson's Disease. Interventions included administer medication as ordered. The 04/02/2026 Registered Nurse #21 progress note documented the resident went to the neurologist that day and recommendations included increasing the dose of carbidopa-levodopa and to be administered specifically at 8:00 AM, 12:00 PM, 4:00 PM and 8:00 PM. The 04/02/2026 physician order documented two (2) carbidopa 25 milligram-levodopa 100 milligram tablets 4 times a day at 8:00 AM, 12:00 PM, 4:00 PM and 8:00 PM. The May 2026 Medication Administration record documented two (2) carbidopa 25 milligram-levodopa 100 milligram tablets at 8:00 AM, 12:00 PM, 4:00 PM and 8:00 PM. During an observation on 05/14/2026 at 10:34 AM Licensed Practical Nurse #12 administered the resident two (2) carbidopa 25 milligram-levodopa 100 milligram tablets. During an interview on 05/14/2026 at 10:36 AM, Licensed Practical Nurse #12 stated they had an hour before and an hour after the scheduled time to give medication. Anything outside that required they notify the doctor. During a follow up interview at 2:11 PM, Licensed Practical Nurse #12 stated carbidopa-levodopa should be given on time because it was more beneficial to the resident. Resident #119 had a history of falls and had stiffness that improved after receiving their carbidopa-levodopa. That day, the resident's carbidopa-levodopa was administered late because they were busy with other residents. They notified the physician about the late administration of medications that day. They should have called prior to giving it late to get approval but did not because they knew the provider well and they thought it would be okay if they gave it. During an interview on 05/14/2026 at 11:16 AM, Resident #119 stated they were supposed to get their carbidopa-levodopa at certain times and when they were home, they were diligent about taking it on time. Carbidopa-levodopa helped manage their motor skills and if administered late it affected their speech, caused them to stutter, and caused leg tremors which made them unable to move their legs, making them more likely to fall. Earlier that morning, they were having leg tremors that improved since receiving the carbidopa-levodopa. During an interview on 05/14/2026 at 4:38 PM, Registered Nurse Unit Manager #5 stated medications could be given as early as an hour before and as late as an hour after the scheduled time. If beyond those parameters, the supervisor and the provider should be notified prior to administration because the timeline of future administrations could be affected. Parkinsonian medications needed to be given on time, and nurses should prioritize the medication pass to make sure that happened. Resident #119 had some stuttering and a fine hand tremor and was unsure of the impact the carbidopa-levodopa had on those symptoms. During an interview on 05/15/2026 at 1:25 PM Nurse Practitioner #22 stated the instant release carbidopa-levodopa was a time sensitive medication and should be given as close to the ordered time as possible. If it was going to be given late, the nurses should let them know and depending on how late they would decide whether the medication should be held or not. They stated they were unsure if they were notified Resident #47 did not take their 9:00 PM dose of carbidopa-levodopa that was left in a medicine cup at their bedside. They did not see why the resident's 5:00 PM and 9:00 PM medications could not be given at the same time, but they should be (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	notified if medications were going to be given early or late. Resident #97's medication being given an hour and 44 minutes past the ordered time should not be a habit but likely would not cause harm. They were unsure if they had been notified it was late prior to the nurse giving the medication. They were unsure if they were notified prior to Resident #119's carbidopa-levodopa being given 2 1/2 hours after the scheduled time. During an interview on 05/15/2026 2:07 PM Pharmacist Consultant #40 stated they could not answer if carbidopa-levodopa was a significant medication or if there could be effects if the medication was missed but a resident should not skip a dose. The medication was sometimes time sensitive. 10 New York Codes, Rules and Regulations 415.18(a)(1)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, record review, and interviews, the facility failed to ensure food was stored, prepared, distributed, and served in accordance with professional standards for food service safety for one (1) of one (1) main kitchen and one (1) of two (2) kitchenettes (2nd Floor kitchenette). Specifically, in the main kitchen food was not labelled, the walk-cooler floor was unclean with food debris, the walk-in freezer floor was unclean with food debris on the floor and reach in cooler wire racks were sticky and had a pink substance on them; and the 2nd floor kitchenette was unclean. Finding included: The facility policy Food Receiving and Storage, last reviewed 03/11/2024, documented, food services or other designated staff would maintain clean food storage areas at all times; all foods stored in the refrigerators and freezers would be covered, labeled and dated with a use by date; and beverages would be dated when opened and discarded after 24 hours. The undated facility policy Sanitation, documented, all kitchens, kitchen areas and dining areas shall be kept clean, free from litter and rubbish; all utensils, counters, shelves, and equipment would be kept clean, maintained in good repair and would be free from breaks, corruptions, open seams, cracks, and chipped areas that may affect their use or proper cleaning; kitchen and dining room surfaces not in contact with food would be cleaned on a regular schedule and frequently enough to prevent the accumulation of grime; the Food Service Director would be responsible for the scheduling of regular cleaning of the kitchen; and food service staff would be trained to maintain cleanliness. The following observations were made in the main kitchen: -On 05/11/2026 at 10:37 AM, in the walk-in cooler there was one undated opened carton of cranberry juice with a best used by date 03/02/2027. There was one 8-ounce carton of milk, several 4-ounce plastic cartons of thicken juice, and several creamer cups on the floor under the shelves. At 10:39 AM, the walk-in freezer had one metal pan of sliced pizza. Underneath the shelves on the floor were straws and one frozen nutrition supplement. -On 05/11/2026 at 10:41 AM the left reach in cooler wire racks were chipped and had a pink sticky substance. -On 05/11/2026 at 10:52 AM, there was various paper debris and two cartons of thickened juice on the floor under the shelves. -On 05/13/2026 at 11:18 AM, the 2nd Floor Kitchenette freezer had a layer of ice buildup. -On 05/13/2025 at 11:20 AM, the 2nd Floor Kitchenette cabinet had a spilled sticky substance with two cartons of prune juice laying in it. The floor was stained with brown spots and was sticky. During an interview on 05/14/2026 at 10:36 AM, the Food Service Director stated the dietary aides were supposed to clean up any spills in the kitchenettes. During a follow up interview on 05/15/2026 at 09:16 AM, the Food Service Director stated all food items should be labeled and dated when opened. Food and beverage items were good for 3 days unless they were in the original container with a best used by date. If there was a best used by date the item would be discarded on that date. Food should be labeled and dated to ensure food quality and prevent any foodborne illnesses. The Chefs/ Supervisors should ensure all areas of the kitchen were swept and mopped daily. There was no official cleaning schedule, but they had a paper in the office that staff signed when the cleaning was completed. The wire racks in coolers should be cleaned when soiled. They stated they asked for new wire racks in the past but had not received any at this time. 10 New York Codes, Rules and Regulations 415.14(h)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations, record review, and interviews, the facility failed to ensure residents had the right to a dignified existence in a manner and an environment that promoted the maintenance or enhancement of quality of life for two (2) of two (2) residents (Residents #1 and #132) reviewed. Specifically, Residents #1 and #132 had bright colored signage hung prominently in their room that disclosed personal information regarding the resident's care. Findings include: The facility policy Resident Rights, Dignity, and Respect, last reviewed 03/2026, documented residents had the right to be treated with dignity and respect. Residents had the right to be informed, make their own decisions, and have their personal information kept private. 1) Resident #1 had diagnoses including dysphagia (difficulty swallowing). The 03/30/2026 Minimum Data Set assessment documented the resident had severe cognitive impairment, required substantial assistance with meals, coughed or choked during meals or when swallowing medications, and received a mechanically altered diet. The comprehensive care plan initiated 03/31/2026, documented the resident had dysphagia. Interventions included assistance as per occupational therapy recommendations, small bites/sips, slow rate and to be upright for all oral intake. During an observation on 05/11/2026 at 11:20 AM, a bright orange sign dated 05/03/2026 was posted on the bulletin board in the resident's room. The sign stated puree, honey, upright for all meals, assist with feeding as per occupational therapy/care plan, small bites/ sips, and slow rate. The sign was prominent and able to be seen by all staff and visitors. During an interview on 05/14/2026 at 1:08 PM, Certified Nurse Aide #26 stated they were unsure but thought speech therapy put the orange sign up in Resident #1's room. They stated the sign was not violating Health Insurance Portability and Accountability Act because it did not post anything about the resident's diagnosis or medications. 2) Resident #132 had diagnoses including dysphagia (difficulty swallowing) and need for assistance with personal care. The 04/05/2026 Minimum Data Set assessment documented the resident had moderately impaired cognition, required set-up or clean up assistance with eating, oral hygiene, and personal hygiene, had complaints of difficulty or pain with swallowing, coughed or choked during meals or when swallowing medications, and a diagnosis of dysphagia. The comprehensive care plan, initiated 03/31/2026, documented the resident had dysphagia. Interventions included diet per physician order and take small bites and sips at a slow rate. During observations on 05/11/2026 at 1:26 PM and 05/12/2026 at 8:34 AM Resident #132's room had a bright orange sign with black lettering on the wall behind the head of the bed. The sign documented the residents first name and first letter of their last name and mechanical diet, thin liquids, pills crushed in applesauce or pudding. During an observation and interview on 05/13/2026 at 12:06 PM, Resident #132 was sitting on the edge of the bed eating lunch. They stated the sign was taken down because they had their diet advanced to regular. They stated staff told them the sign was hung up, so they did not receive the wrong diet and choke. During an interview on 05/14/2026 at 1:43 PM, Licensed Practical Nurse #36 stated they were familiar with signs being hung in resident rooms and recalled Resident #132 having a sign behind their bed with their diet, consistency, and how they took their medications listed on it. They were unsure who was responsible for the signs or why the signs were hung up because every resident had a copy of their care plan inside their closet door that contained the same information. They stated the sign was not dignified because the resident's personal information was posted for other residents and visitors to see. During an interview on 05/14/2026 at 2:07 PM, Certified Nurse Aide #37 stated they could not recall a sign being posted in Resident #132's room. Personal information should not be posted for everyone to see. During an interview on 05/15/2026 at 10:14 AM, Registered Nurse Unit Manager #5 stated speech therapy initiated signs in resident rooms, so all staff were aware of any changes that were made to the resident's diet or consistency. The information was also updated in the resident care instructions. Therapy or the nurse managers were responsible for hanging the care instructions inside the residents' closet doors when changes were made. (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #132 had a sign in their room that was removed by speech therapy when their diet was upgraded. Having medical information posted on a sign for other residents and visitors to see was not dignified. During an interview on 05/15/2026 at 10:54 AM, the Director of Therapy stated speech therapy initiated eye-catching signs in resident rooms that had important information for staff to know like diet consistency or if the resident was on aspiration precautions. They were also responsible for updating the information in the resident's care plan and care instructions. Care instructions were kept inside residents' closets for dignity reasons so they could understand how an eye-catching sign with the residents' medical information on it could be a dignity issue. They thought the eye-catching signs could go below the care instructions inside the closets so it would be more of a homelike environment for the residents. 10 New York Codes, Rules and Regulations 415.3(c)(1)(i)		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observations, interviews, and record review the facility failed to ensure the interdisciplinary team determined a resident's ability to safely administer their own medications, if clinically appropriate, for one (1) of one (1) resident (Resident #47) reviewed. Specifically, Resident #47 had one (1) plastic bottle of over-the-counter calcium carbonate (antacid medication), an inhaler (for lung disease), and a medication cup with several unidentified pills on their nightstand. There was no documented evidence of assessments and/or physician orders for the resident to safely self-administer medications. Findings included: The facility policy Resident Self-Administration of Medication, last reviewed 09/2025, documented if a resident requested to self-administer medications an assessment would be completed and reviewed by the interdisciplinary team. The interdisciplinary team determines if self-administration was clinically appropriate for the resident and would document it in the medical record and on the resident's care plan. A physician's order was needed prior to the initiation of a self-administration program specifying the specific medications the resident was to be self-administering. The interdisciplinary team will re-evaluate the self-administration program on a quarterly basis, with any significant changes and as needed to ensure it is clinically appropriate. The facility policy Administering Medications/ Medication Errors, revised 06/2025, documented medications would be administered in accordance with prescriber orders, including required time frame. Residents may self-administer medications only if the attending physician, in conjunction with the interdisciplinary care planning team, had determined they had the decision making capacity to do so safely, and medications could be stored safely in the resident's room. Resident #47 had diagnoses including Parkinson's disease (a progressive neurological disease), chronic obstructive pulmonary disease (lung disease), and paranoid schizophrenia (mental disorder). The 03/17/2026 Minimum Data Set documented the resident had intact cognition and required supervision/ touching assistance with for most activities of daily living. Physician orders documented:-01/20/2025 Breyna 80 microgram- 4.5 microgram/actuation HFA aerosol inhaler (for lung disease) two puffs by inhalation 2 times daily.-02/09/2026 carbidopa 25 milligram-levodopa 100 tablet (for Parkinson's disease) give one tablet 3 times daily.-04/03/2026 senna 8.6 milligram tablet (laxative) give two tablets once daily. The following observations of Resident #47 were made:-on 05/11/2026 at 11:43 AM, lying in their bed. There was one plastic bottle of over-the-counter calcium carbonate (antacid) and an inhaler on the bedside table.-on 05/13/2026 at 10:02 AM, lying in their bed sleeping. There was a small plastic medication cup on their bedside table containing one large white oval pill, two brownish/ orange smaller round pills, and one yellow small round pill. There was no documented evidence of a medication self-administration assessment, a physician order for self-medication, or a comprehensive care plan related to self-administration or storage of medication in the resident's room. During an interview on 05/13/2026 at 10:21 AM, Licensed Practical Nurse #14 stated the medications in the resident's room must have been from the previous evening as they provided the resident their medications in the common area that morning. The resident did not have an order to self-administer medications and the nurse who provided the residents with their medications should ensure the resident took all their medications. They stated it was a safety issue if medications were left unattended in the resident's room. During an interview on 05/14/2026 at 5:22 PM, Licensed Practical Nurse #15 stated when they provided the residents with medication, they should stay with them to ensure they took their medications. Resident #47 did not have an order to self-administer medications and sometimes they left the inhalers in the residents' rooms if they requested. They attempted to provide Resident #47 with their evening medications last night, but the resident did not want to take the medications at that time, so they left the medications in the room. They forgot to go back and check to see if the resident took their medications. During an interview on 05/15/2026 at 11:33 AM, Licensed Practical Nurse Unit Manager #9 stated if a resident was able to self-administer medications there should be a physician order and their care plan would document their ability to (continued on next page)		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	self-administer medications. Resident #47 was forgetful at times and was unable to self-administer their own medications. The nurse providing the residents with their medications should always stay with the residents to ensure they took their medication. Leaving medications in a resident's room posed a safety risk as there were other residents who wandered on the unit. 10 New York Codes, Rules and Regulations 415.23(f)(1)(vi)		

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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 unclear 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 floor in 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 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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NAME OF PROVIDER OR SUPPLIER Troy Victorian Rehabilitation & Nursing Care Cntr		STREET ADDRESS, CITY, STATE, ZIP CODE 100 New Turnpike Road Troy, NY 12182	
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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observations, record review, and interviews, the facility failed to ensure services provided met professional standards of clinical practice for two (2) of six (6) residents (Residents #2 and #5) reviewed. Specifically, Resident #2 had multiple medications not documented as administered; and Resident #5 had multiple medications not documented as administered and units of insulin administered per sliding scale coverage were not consistently documented. Findings include: The facility policy Administering Medications/Medication Errors, last reviewed 06/2025, documented all medications were to be administered in a safe and timely manner as prescribed. Staff schedules are arranged to ensure that medications are administered without unnecessary interruptions. Medications are administered in accordance with prescriber orders, including any required timeframes. Medications were administered within 1 hour of their prescribed time unless otherwise specified. The individual administering the medication documents administration after administering the medication. 1) Resident #2 had diagnoses including end stage kidney disease, diabetes, and low blood pressure. The 02/17/2026 Minimum Data Set documented the resident had intact cognition and received hemodialysis (process that filters blood when the kidney does not function adequately). Physician orders documented the following medications:- Depakote (seizure medication) 125 milligram tablet, delayed release: give one tablet two (2) times per day- Eliquis (blood thinner) 2.5 milligram tablet: give one (1) tablet two (2) times per day- midodrine (low blood pressure) 10 milligram tablet: give one tablet three (3) times per day; hold for systolic (upper number) blood pressure more than 120- levetiracetam (seizure medication) 250 milligram tablet: give one (1) tablet by oral route two (2) times per day- metoprolol tartrate (high blood pressure) 25 milligram tablet: give one (1) tablet two (2) times per day- Juven (protein supplement) 7 gram-7 gram-1.5-gram oral powder packet: give one (1) packet two (2) times per day- sevelamer carbonate (Renvela) (phosphate binder) 800 milligram tablet: give two (2) tablets (1600 mg) three (3) times per day with meals.- insulin lispro (fast acting insulin) inject 4 units subcutaneously before meals 4 days per week. The May 2026 Medication Administration Record documented:- on 05/02/2026 and 05/07/2026 at 4:00 PM insulin lispro subcutaneous inject 4 units before meals were not documented as given. - on 05/02/2026 and 05/07/2026 at 4:30 PM sevelamer carbonate was not documented as given. - on 05/02/2026 and 05/07/2026 at 5:00 PM midodrine and Juven were not documented as given.- on 05/02/2026, 05/07/2026, and 05/09/2026 at 9:00 PM Depakote, midodrine, levetiracetam, and metoprolol tartrate were not documented as given by an unidentified nurse. There were no documented nursing progress notes addressing the medications not being administered. 2) Resident #5 had diagnoses including diabetes, polyneuropathy (nerve damage) and heart disease. The 02/25/2026 Minimum Data Set documented the resident had intact cognition and received insulin injections. The May 2026 Medication Administration Record documented:- the 05/01/2026 at 5:30 AM, 05/06/2026 at 4:30 PM, and 05/06/2026 at 9:00 PM doses of Novolog U-100 insulin aspart 100 unit/milliliters subcutaneous solution: inject by subcutaneous route per prescriber's instructions. Insulin dosing requires individualization and did not have the number of units administered per the sliding scale insulin order.- the 05/03/2026 and 05/08/2026 at 5:00 PM dose of carvedilol (for high blood pressure) 12.5 milligram tablet: give one tablet by mouth twice daily; and acetaminophen 500 milligram tablet give 2 tablets (1000 milligrams) by oral route three (3) times per day were not documented as administered.- the 05/05/2026 at 5:30 AM dose of Novolog U-100 Insulin aspart 100 unit/milliliters subcutaneous solution: inject by subcutaneous route per prescriber's instructions. Insulin dosing requires individualization was not documented as administered and the blood sugar was not documented as checked.- the 05/10/2026 at 9:00 PM dose of Novolog U-100 Insulin aspart 100 unit/milliliters subcutaneous solution: inject by subcutaneous route per prescriber's instructions. The blood sugar documented was 341. Per the order the resident was to receive 8 units of insulin. Licensed Practical Nurse #14 documented the resident received 10 units of insulin.- the 05/08/2026 at 4:30 PM and 9:00 PM dose of Novolog U-100 Insulin aspart 100 (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unit/milliliters subcutaneous solution: inject by subcutaneous route per prescriber's instructions. Insulin dosing requires individualization was not documented as administered and the blood sugar was not documented as checked- the 05/08/2026 at 9:00 PM dose of quetiapine (an antipsychotic) 25 milligram tablet: give one tablet once daily at bedtime; melatonin (hormone for sleep) 5 milligram tablet: give one (1) tablet by oral route once daily; insulin glargine (U-100) inject 16 units by subcutaneous route 2 times per day; gabapentin (an anticonvulsant used for nerve pain) 100 milligram: one (1) capsule by mouth at bedtime; Eliquis (a blood thinner) 5 milligram tablet: and ranolazine (a medication for chest pain) 12 hour extended release 500 milligram tablet: daily were not documented as administered.- the 05/13/2026 at 9:00 PM dose of Novolog U-100 Insulin 100 unit/milliliters subcutaneous solution: inject by subcutaneous route per prescriber's instructions. Insulin dosing requires individualization was not documented as administered and the blood sugar was not documented as checked. During an interview on 05/14/2026 at 2:21 PM Licensed Practical Nurse #14 stated they knew how many units of insulin to give when a resident was on sliding scale insulin by the scale in the order. Resident #5's blood sugar on 05/10/2026 at 9:00 PM was 341 so they gave 8 units of insulin per the sliding scale. They must have made an error when documenting in the comment section as they gave 8 units, not 10. The number of units given was supposed to be documented in the dose box, not the comment box. During an interview on 05/14/2026 at 5:51 PM Licensed Practical Nurse #38 stated they followed the physician order on how many units of insulin to give based on the resident's blood sugar for a sliding scale insulin. The number of units given should be documented on the Medication Administration Record. They put ok in the comments on Resident #5's 4:30 PM and 9:00 PM sliding scale insulin doses as the Medication Administration Record would not let them document. They did not let anyone know the record would not let them document the units. During an interview on 05/15/2026 at 10:10 AM, Licensed Practical Nurse Unit Manager #9 stated they go through the orders when a resident was due for a Minimum Data Set assessment and reviewed the medications. The amount of insulin given should be entered for a sliding scale insulin order in the dose box that comes up on the Medication Administration Record. They documented how much insulin was given and the physician reviewing the documentation knew the doses the resident received. They were aware there were times the nurses did not document in the Medication Administration Record; consistency was a problem. If a nurse could not complete their documentation during their shift, they should report it or stay and complete it. There should never be an entire shift of medications not signed for. During an interview on 05/15/2026 at 1:25 PM, Nurse Practitioner # stated they expected the nursing staff to sign off on the medications they administered in the Medication Administration Record. They expected the nurses to document the number of units given for a sliding scale insulin order as there needed to be a record of the amount of insulin given. During an interview on 05/15/2026 2:07 PM Pharmacist Consultant #40 stated they did not review the Medication Administration Records during the pharmacy reviews. They did not review whether medications were being given or not, just what the resident was taking. They were only in the facility once a month for a short visit and they did not have any clinical interactions with the residents. 10 New York Codes, Rules, and Regulations 415.11(c)(3)(i)		

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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 unclear 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 unclear 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 unclear. 10 New York Codes Rules Regulations 415.12(a)(3)		

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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, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for one (1) of one (1) resident (Resident #19) reviewed. Specifically, Resident #19 had leg wounds, and their dressings were not changed as ordered or as scheduled. Findings include: Resident #19 had diagnoses including cellulitis (a skin infection) of both legs. The 03/16/2026 Minimum Data Set assessment documented the resident had intact cognition, required moderate assistance with most activities of daily living, and received application of nonsurgical dressings (with or without topical medications) other than to feet. The 12/09/2025 comprehensive care plan documented the resident had cellulitis of both legs and a risk for skin breakdown related to impaired mobility, weakness and lymphedema (swelling). Interventions included application of local treatments as ordered, off-load extremities and elevating both legs. The 05/08/2026 physician order documented cellulitis to left and right lower leg wounds: Cleanse with Dakin's solution (a cleanser used to prevent infection). Apply methylene blue (an antimicrobial wound dressing) to the wound bed only. Wet methylene blue prior to applying. Apply abdominal pads (thick, absorbent dressing) then wrap the extremity with Coban (a type of compression wrap) starting at the toes to the knees 3 times a week on Monday, Wednesday and Friday, and as needed. The 05/11/2026 Registered Nurse #34 progress note documented 3+ edema (a measurement that indicates a moderate to severe amount of swelling) to their legs. The May 2026 Treatment Administration Record documented the leg dressings were not changed on 05/13/2026. The 05/15/2026 Physician #35 History and Physical note documented the resident had 2+ pitting edema (a measurement that indicates a moderate amount of swelling) of their extremities. The following observations of the resident's legs and leg dressings were made: -On 05/11/2026 at 11:27 AM the resident had kerlix (a type of gauze wrap) wrapped around both lower legs just above their feet. The resident was barefoot, their legs were not wrapped with Coban, and both feet and lower legs were very swollen. -On 05/12/2026 at 3:58 PM the resident was lying in bed with kerlix dressings on their lower legs just above their feet. The right leg dressing had a date of 05/11/2026 written on a piece of tape holding the dressing in place. Their legs were not wrapped with Coban and both legs and feet were swollen. -On 05/14/2026 at 9:51 AM the resident was sitting in their wheelchair with kerlix dressings on their lower legs just above their feet. The right leg dressing had a date of 05/11/2026 written on a piece of tape holding the dressing in place, and the left leg dressing had a large amount of yellow drainage covering about 30% of the dressing. The resident was barefoot, their legs were not wrapped with Coban, and their legs and feet were swollen. During an interview on 05/11/2026 at 11:27 AM, the resident stated they had wounds on their legs because of poor fluid flow up and down their legs. They stated compression stockings were discussed last week but talk was as far as it went. During an interview on 05/15/2026 9:21 AM, Registered Nurse Unit Manager #5 stated whichever nurse was assigned to the medication cart completed those residents' treatments. Most treatment orders could also be done as needed in case the dressing fell off or became soiled. Nurses should be checking the integrity of the dressing and change accordingly. If a nurse was unable to complete a treatment it should be relayed during shift report so the next shift could do it. If the treatment was still unable to be done, the provider should be notified for further directives and that should be documented. Resident #19 was admitted with leg cellulitis and an extreme case of edema which was an issue with their legs healing. They received a diuretic (water pill) and Coban wraps. It has not been reported to them the resident had not been getting the Coban wraps. During an interview on 05/15/2026 at 10:07 AM, Registered Nurse #34 stated treatment orders were on the treatment administration record and should be followed as ordered; if a treatment was not done, the nurse should write a note as to why and notify the provide. Dressing integrity should be checked even if the dressing was not due to be changed. They stated they changed Resident #19's dressing on 05/11/2026 at 3:00 PM. There was not any Coban on the unit and they planned to go upstairs and get (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	some but never got around to it. On 05/13/2026, they were assigned to the resident but did not do their dressing because they only worked until 1:00 PM and it was supposed to be passed on to the evening shift for them to do the dressing. During an observation and interview on 05/15/2026 at 12:14 PM the resident's left leg dressing had a large amount of yellow drainage extending from the lateral to posterior aspect and the right dressing had a date of 05/11/2026 written on a piece of tape holding the dressing in place. Wound Care Registered Nurse #21 removed the dressings and stated the date on the right dressing was dated 05/11/2026. They should not have a dressing on that was dated 05/11/2026 and the amount of drainage on the left dressing should have prompted it to be changed. The legs were not wrapped with Coban but should have been. The Coban treated the edema, promoted healing, and decreased pain. During an interview on 05/15/2026 at 1:40 PM Nurse Practitioner #22 stated they expected treatments be completed as ordered and they should be notified if they were not. Resident #19 had chronic lymphedema (fluid buildup) and vascular disease (a disease that affects blood flow). Coban was ordered to help with compression which could help with healing. The resident should be getting those wraps, and they expected to be notified if they were not. 10 New York Codes Rules and Regulations 415.12		

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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)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 failed to ensure that each resident received adequate supervision to prevent accidents for four (4) of six (6) residents (Residents #1, #6, #115, and #119) reviewed. Specifically, Residents #1 and #6, were at risk for aspiration (inhaling food or liquids into the lungs) and were not supervised or monitored when eating; Residents #115 and #119 had mattresses that were not adequately fitted to the bed frame and their beds tilted laterally causing a downward slope; and Resident #119 had a loose enabler bar on their bed. Findings include: The facility policy Aspiration Precautions, last reviewed 04/2026 documented no resident on aspiration precautions would use a straw for the delivery of nutrition or fluids, unless otherwise specified by the Speech Language Pathologist; no resident on a thickened liquid diet shall use straws; and residents on aspiration precautions would receive frequent monitoring by nursing staff. The facility Maintenance Policy, updated 05/2026, documented routine preventative maintenance schedules included weekly bed/siderail/mattress inspections. The undated facility policy Restraints, Safety Devices, Enabler Bars/Side Rails Policy, documented it was the responsibility of the maintenance department to ensure the enabler bar/side rail was securely placed and it was the responsibility of all departments to report any safety concerns regarding equipment to maintenance. Aspiration Precautions 1) Resident #6 had diagnoses including stroke with left sided paralysis. The 02/26/2026 Minimum Data Set (a resident assessment tool) documented the resident had mild to moderately impaired cognition; functional impairment to one side of the upper extremities, and to both lower extremities; required substantial/maximal assistance with eating and was on a mechanically altered diet. The 10/31/2025 hospital discharge instructions documented the resident was to receive a dysphagia 5 diet with mildly thick liquids (used for swallowing difficulties). The 11/03/2025 comprehensive care plan documented the resident had a self-care deficit and dysphagia. Interventions included extensive assistance of one with eating, provide food in separate bowls during meals, control rate and amount of oral intake, and place in an upright position for all oral intake. The 02/03/2026 Speech Language Pathologist #53 progress note documented the resident continued to tolerate ordered diet well without overt signs or symptoms of aspiration or other reported difficulty. Baseline dysphagia continues without candidacy for further advancement. No further evaluation or treatment indicated. Physician orders documented:- on 02/17/2026 regular pureed diet with nectar thickened liquids.- on 02/24/2026 nurse to monitor intake with every meal. Coordinate with certified nursing assistant to document appropriately. The 02/26/2026 comprehensive care plan documented the resident had a respiratory disorder of wheezing. The resident had a frequent, congested cough and wheezing. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident was observed at the following times: -on 05/11/2026 at 12:23 PM lying in bed. Certified Nurse Aides #46 and #47 boosted the resident up in bed into a sitting position. Certified Nurse Aide #46 set the lunch tray on the bedside table in front of the resident and left the room. The resident's meal ticket documented regular puree diet with nectar thick liquids, extra meat, no milk, feeding assistance, and aspiration-no straws. The resident ate unsupervised and was unassisted during the meal. The resident attempted to use their right hand to spoon food into their mouth. -on 05/12/2026 at 12:40 PM Certified Nursing Assistant #52 repositioned the resident into a sitting position, placed the lunch tray on the bedside table in front of the resident and left the room. The meal tray ticket documented the resident required total assistance. The resident was leaning to the right side using their right hand to feed themselves. -on 05/13/2026 at 12:40 PM in their room leaning to the right side attempting to eat lunch unassisted and unsupervised. -on 05/14/2026 at 12:30 PM in their room with their lunch tray in front of them. The resident was not assisted or supervised. During an interview on 05/14/2026 at 1:13 PM Licensed Practical Nurse Unit Manager #9 stated the certified nurse aides, or the nurses were responsible for assisting residents who needed help with eating. If residents did not receive the assistance they needed, they could choke, or they may not eat. They stated the resident's care plan documented the resident required extensive assistance of one with eating. During an interview on 05/15/2026 at 11:33 AM, Licensed Practical Nurse Unit Manager #9 stated aspiration precautions meant the resident was at risk for choking, they needed to be monitored closely at meals. Monitoring could include staff circulating the unit and checking in periodically with the residents. During an interview on 05/15/2026 at 10:53 AM, the Director of Therapy stated the facility's aspiration policy documented the residents should be seated upright, staff should conduct frequent monitoring, and if the residents were on a thickened liquid diet they should not be provided with straws. Occupational Therapy determined the level of assistance a resident required at meals. Resident #6 required extensive assistance with meals due to fatigue, they started off strong and needed assistance to complete meals. Staff should have set up the resident's meal and checked to ensure the resident was completing meals. They stated speech language pathology communicated to nursing and dietary regarding aspiration precautions and instructions would have been added to the meal ticket. 2) Resident #1 had diagnoses including dysphagia (difficulty swallowing) and Schizophrenia (a serious mental health disorder). The 03/30/2026 Minimum Data Set documented the resident had severe cognitive impairment, did not reject care, required substantial / maximum assistance with meals, coughed or choked during meals or when swallowing medications, and received a mechanically altered diet. Resident #1's Comprehensive Care Plan documented: (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-08/13/2025 and updated 03/30/2026, the resident had an activity of daily living deficit. The resident required extensive assistance of one at meals. -03/27/2026 the resident was at nutrition risk related to advanced age, fair intakes, and a history of weight loss. Interventions included provide a liberalized modified diet and supplements. -03/31/2026 the resident had dysphagia. The goal was to safely manage the restrictive diet without signs/ symptoms of aspiration. Interventions included to provide the diet as ordered, remain upright for all intakes, assist with meals per occupational therapy recommendations and small bites/ sips at a slow rate. Physician orders documented:-03/27/2026, pureed solids and honey thick liquid diet and 240 milliliters of honey thickened Ensure Plus (oral nutrition supplements) twice daily.-03/31/2026, resident on 1:1 assistance with staff for all meals. The 03/30/2026 Occupational Therapist #24 Occupational Therapy Plan of Treatment documented moderate assistance with feeding. The 03/31/2026-04/29/2026 Speech Language Pathologist #23 Evaluation and Plan of Treatment documented puree solids, honey thick liquids, and close supervision for oral intakes. Strategies included upright for all meals, small bites/ sips, slow rate, and assist per occupational therapy recommendations. The current care instructions documented the resident required extensive assistance of one with meals, was on a pureed solids and honey thickened liquid diet and was 1:1 assistance with meals. The following observations of Resident #1 were made: -on 05/11/2026 at 11:20 AM, seated upright in their bed with food debris on their clothing protector. Their breakfast meal was on their over bed tray table. The meal ticket documented aspiration precautions, no straws, total feed, pureed scrambled eggs, oatmeal, yogurt, honey thick orange juice, honey thick water, and honey thick coffee. The resident stated they were on thickened liquids because they were easier to swallow, and they had a hard time feeding themselves. At 11:33 AM, Diet Technician #28 entered the resident's room and asked if they could remove the meal tray and removed the tray from the room. There was a bright orange sign in the room that read Puree honey, upright for all meals, assist with feeding per occupational therapy/ care plan. -on 05/12/2026 from 12:26 PM-1:05 PM, Certified Nurse Aide #29 provided the resident with their meal tray, assisted them to an upright position, pulled the privacy curtain closed, and exited the room. The meal ticket documented aspiration precautions, no straws, and total feed puree cottage cheese, puree fish, applesauce, honey thick apple juice, honey thick water, honey thick Mighty Shake (oral nutrition supplement), honey thick coffee, and chocolate pudding with whipped topping. The resident was in their bed and staff did not monitor or assist the resident. At 1:05 PM, Certified Nurse Aide #29 entered the room and removed the resident's meal tray. At 1:09 PM, the resident was sipping on their coffee and had two honey thick beverages on their over bed tray table. At 1:38 PM, Licensed Practical Nurse Unit Manger #9 entered the room and spoke to the resident and left the room at 1:40 PM, they did not remove the beverages or assist the resident. -on 05/13/2026 at 12:46 PM, the resident was seated upright in bed feeding themselves without staff (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assistance or supervision. Their meal ticket documented aspiration precautions, no straws, and total feed. The resident had pureed beef, pureed corn, pureed taco shell, pureed cottage cheese, a honey thick mighty shake, honey thick juice, honey thick water, honey thick coffee, and pudding. The May 2026 Medication Record Administration documented the resident was on 1:1 meal assistance with staff at all meals.-On 05/11/2026, Licensed Practical Nurse #27 signed the order as completed on the 7:00 AM &ndash; 3:00 PM shift.-On 05/12/2026, Licensed Practical Nurse Unit Manager #9 signed the order as completed on the 7:00 AM &ndash; 3:00 PM shift.-On 05/13/2026, Licensed Practical Nurse #14 documented 1:1 assistance at meal was not provided. During an interview on 05/13/2026 at 1:18 PM, Certified Nurse Aide #26 stated they were assigned to Resident #1. Each resident had care instructions that were supposed to be checked daily, and the certified aides were to follow the care instructions. Aspiration precautions meant the resident had a risk for choking and staff were supposed to check on them throughout the meal. Extensive assistance with meals meant the certified nurse aide was supposed to assist the resident with their meal. They stated Resident #1 did not need assistance with meals but just needed to be set-up and was able to feed themselves. During an observation on 05/14/2026 at 5:22 PM, the resident was in bed seated upright drinking their Ensure Plus with a straw. Licensed Practical Nurse #15 stated the resident was on a puree honey thick diet. They thickened their Ensure Plus supplement and provided them with a straw and then continued with their medication pass. They stated there was no order for the resident not to have straws or they were on aspiration precautions. They stated they were unaware the resident should not have straws. The resident was supposed to receive 1:1 assistance with meals per their orders. On 5/14/2026 at 5:54 PM, Licensed Practical Nurse Unit Manager #9 was alerted by the surveyor the resident was drinking their Ensure Plus supplement with a straw. They reviewed the resident's orders and stated there was not an order for no straws. They called the Director of Therapy via telephone, who told them there was no documentation in the speech pathologist notes regarding straws. During an interview on 05/15/2026 at 10:53 AM, the Director of Therapy on 05/15/2026, stated the facility's aspiration policy documented the residents should be seated upright, staff should conduct frequent monitoring, and if the residents were on a thickened liquid diet they should not be provided with straws. Resident #1 should not have a straw as it posed a safety risk, as they received honey thick liquids. The speech pathologist recommendations were to provide close supervision for oral intakes and strategies included upright for all meals, small bites/ sips, slow rate, and assist per occupational therapy recommendations. During an interview on 05/15/2026 at 11:33 AM, Licensed Practical Nurse Unit Manager #9 stated aspiration precautions meant the resident was at risk for choking and needed to be monitored closely at meals. Monitoring could include staff circulating the unit and checking in periodically with the residents. The speech language pathologist determined who could have straws. If there was a medical order for 1:1 assistance at meals staff should be in the room assisting the resident. If the nurse signed that the order was completed it meant someone was in the room when the resident was eating. They were unaware staff were not assisting the resident with their meal or when they received their nutritional supplements between meals. Resident mattresses/beds/side rails (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1)Resident #115 had diagnoses including polyneuropathy (nerve damage), chronic obstructive pulmonary disease (lung disease), and congestive heart failure. The 03/17/2026 Minimum Data Set documented the resident was cognitively intact, had moderate depression, had no behaviors, and required maximum assistance for rolling side to side in bed. The 10/24/2024 comprehensive care plan documented the resident had a self-care deficit in bed mobility. Interventions included extensive assistance of two for bed mobility and dependence with a mechanical lift of three for transfers. The 03/28/2025 comprehensive care plan documented the resident had chronic obstructive pulmonary disease and was at risk for inadequate oxygenated blood circulation and respiratory distress. Interventions include to maintain the head of the bed 30 degrees elevation or higher to tolerance to prevent shortness of breath while lying flat. The resident was observed at the following times: -on 05/11/2026 at 11:07 AM lying in bed. There was a mobility bar on the left side of the bed, and the bed tilted right at the head of the bed approximately 20 degrees resulting in a downward slope. The mattress was hanging over the left side of the bed frame at the foot of the bed approximately six inches. The bed was also slightly hanging over the frame on the right-side foot of the bed. The resident stated their right shoulder hurt from leaning on it due to the slope of the bed and they also could not assist with bed mobility as much as the staff wanted because they were not able to roll up a hill at their size. -on 05/12/2026 at 12:07 PM lying on the right side of bed with the bed sloped approximately 20 degrees to the right side. The mattress was slightly hanging over on the right side and approximately six inches on the left side of the bed. The resident stated they were tired of being crooked in the bed.-on 05/13/2026 at 10:38 AM lying on the right side of bed with the bed sloped approximately 20 degrees to the right side. The mattress was slightly hanging over on the right side and approximately six inches on the left side of the bed. They stated their right arm was painful and numb this morning when they woke up and thought it was due to the weight on their right shoulder due to the slope of the bed.-on 05/14/2026 at 1:09 PM lying on the right side of bed with the bed sloped approximately 20 degrees to the right side. The mattress was slightly hanging over on the right side and approximately six inches on the left side of the bed. There were no documented Maintenance Requests for Resident #115's bed from 01/16/2026 to 05/15/2026.During an interview on 05/14/2026 at 2:26 PM Certified Nurse Aide #55 stated some of the resident mattresses in the facility did not fit the frames. When they moved resident rooms, they moved the mattresses but did not always take the frames. They stated if you make Resident #115's mattress fit the bottom of the bed, it pops out on the top. They reported the mattress not fitting to both the nurses and maintenance. They did not believe the frame tilted at the head of the bed was reported. The resident complained of pain on their right side from the way they slept in the bed and leaning onto the right side. During an interview on 05/14/2026 at 2:11 PM, Licensed Practical Nurse #14 stated they would let maintenance know if a resident's mattress was not fitting their bed or if the bed frame was tilted. They were unaware Resident #115's mattress was hanging over the side of their bed or the frame was tilted. At 2:14 PM Licensed Practical Nurse #14 observed the resident in their bed with the mattress hanging over the left side and inquired if the top of the bed was stuck in the tilt. The resident stated the mattress did not do it so much when the bed was flat, but the mattress slid when they were repositioned in bed. During an interview on 05/15/2026 at 10:10 AM Licensed Practical Nurse Unit Manager #9 stated mattresses were applied by housekeeping and maintenance. Maintenance and housekeeping should be notified if a resident's mattress was hanging over the bed frame as that meant the resident needed a new mattress. They stated they should also be notified as the unit manager. If the top of the bed frame was sloped maintenance should be notified as soon as possible as the resident should not be in a bed that was broken. They were not informed Resident #115 had any issues with their mattress or bed. 4) Resident #119 had diagnoses including Parkinson's Disease (a progressive neurological disease). The 04/21/2026 Minimum Data Set (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment documented the resident had intact cognition and required maximum assistance for bed mobility. The comprehensive care plan initiated 10/28/2024 and revised 06/23/2025, documented the resident was at risk for falls. Interventions included provide hourly visual checks to ensure they were centered properly in bed and to reposition if not. The comprehensive care plan initiated 11/25/2024 documented the resident used a left quarter rail as an enabler for bed mobility. Interventions included the resident understood and signed enabler bar consent form. The following observations of Resident #119's bed were made on 05/11/2026 at 11:05 AM, 05/12/2026 at 1:55 PM, and 05/14/2026 at 1:30 PM: the right side of the mattress was extending approximately 6 inches beyond the bed frame resulting in that section of the mattress being suspended and not supported; the bed as a unit was leaning to the left (towards the door) approximately 20 degrees resulting in a downward slope; and the enabler bar on the left side of the bed was very loose in all directions. During an observation on 05/13/2026 at 10:01 AM, the resident was in bed lying diagonally on their left side facing the door. Their upper body was positioned on the right upper quadrant of the mattress and their legs dangled off the left lower quadrant resulting in the right lower mattress lifting creating a space of approximately 3 inches between the frame and mattress. There was no documented evidence of maintenance performed on the resident's bed in 2026. During an interview on 05/11/2026 at 11:05 AM, Resident #119 stated the bed rail was loose for a couple of weeks. It loosened up a couple times in the past and had to be tightened. They used the rail to pull themselves from lying to the side of the bed and to help them roll to their side. During an interview on 05/14/2026 at 1:30 PM, Certified Nurse Aide #13 stated housekeeping brought up beds and mattresses. Mattresses should be the same size as the bed frame and not extend beyond the frame. Side rails were applied by maintenance and were used to help residents move around and should be secure and tight and if not, should be reported right away. Resident #119 was a big person and had a wide mattress and a bed rail that made it easier for them to sit up and move around in bed. Upon looking at the bed, they stated the mattress was not squarely on the frame; the mattress should be squarely on the frame; and the bed rail was loose and seemed to be bent. During an interview on 05/14/2026 at 2:11 PM, Licensed Practical Nurse #12 stated maintenance obtained and set up the beds. Beds should be level, and the mattress should fit the bed frames. Any issues with an ill-fitting mattress should be reported to the supervisor or maintenance. Side rails were used for positioning and should not be loose or wobbly and if they were, it should be reported. Resident #119 had a bariatric bed and a bed rail used for mobility. They stated the bed was leaning in the direction of the door and the mattress did not fit the frame because the frame had not been extended. They were unsure why the bed was like that, and no one had reported any of those issues to them. During an interview on 05/14/2026 at 4:38 PM, Registered Nurse Unit Manager #5 stated the facility had bariatric beds and bariatric mattresses. Housekeeping or maintenance set those beds up. Visualizing mattresses would show whether a mattress fit the frame properly. Beds should not lean (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and if it did, they would question if the control was faulty or the bed was bent. Side rail/enabler bars were used for mobility and should be snug to not cause an entrapment risk. They expected any of those issues to be reported to them and to the maintenance department. Resident #119 had a bariatric bed and an enabler bar. Upon looking at the bed, they stated the mattress was hanging past the bed frame and the bed appeared to be leaning. No one had reported any of these issues to them. During an interview on 05/15/2026 at 10:52 AM, the Assistant Director of Maintenance stated they or housekeeping set up beds when requested from nursing. Preventative maintenance checks involved only the electrical component of the beds; bariatric bed frames had extenders on either side that needed to be extended to accommodate a bariatric mattress; mattresses should fit the bed frame and not extend over the bed frame; and beds should not tilt to one side because that could cause a tipping issue. They installed and removed side rails based on directives from nursing or therapy and side rails should be snug, not loose. Once on, they did not do anything with the rails unless notified there was a problem. They were called regarding Resident #119's bed on 05/14/2026. They noticed the bed was tilted in the direction of the door and a piece was missing from the side rail. They thought maybe the bed was bent from the resident positioning themselves on that side of the bed. They moved the mattress around and thought they resolved the issue. They had to take the side rail to the maintenance shop to fix it before reinstalling it on the bed. They had not received any recent work orders involving Resident #115's mattress or sloping of their bed. 10 New York Codes, Rules and Regulations 415.12(h)(1)		

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NAME OF PROVIDER OR SUPPLIER Troy Victorian Rehabilitation & Nursing Care Cntr		STREET ADDRESS, CITY, STATE, ZIP CODE 100 New Turnpike Road Troy, NY 12182	
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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observations, record review, and interviews, the facility failed to provide the necessary care and services to prevent urinary tract infections, to the extent possible, for one (1) of one (1) resident (Resident #26) reviewed. Specifically, Resident #26 had an indwelling urinary catheter (a tube that removes urine from the bladder), wore a urinary collection leg bag (a small, wearable, and discreet bag) and was not provided with a large capacity urinary collection bag. The urinary collection leg bag was not positioned below the level of the bladder to prevent backward urine flow. Findings include: The facility policy Catheter, Foley Insertion, Removal and Care, last reviewed 07/18/2022, documented the facility would provide catheter care during morning and evening care to residents that had indwelling catheters to prevent infection and reduce irritation. When using a leg bag, they should be checked and emptied every 2 hours. Resident #26 had diagnoses including obstructive uropathy (a condition that blocks the flow of urine), urine retention, and urinary tract infections. The 02/09/2026 Minimum Data Set assessment documented the resident had moderately impaired cognition, required supervision/touching assistance with personal hygiene and showering/bathing, independence with toileting hygiene, and had an indwelling catheter. The comprehensive care plan, revised 04/23/2026, documented the resident had an indwelling urinary catheter related to an enlarged prostate. Interventions included maintaining catheter and urology appointments, providing resident with risk benefit and understanding and agreement for catheter maintenance. There was no documented evidence of the resident's ability to empty or change their urinary collection bag. Physician orders documented: -on 03/10/2026, change 16 French (catheter size) urinary catheter on 03/12/2026 and every 4 weeks thereafter. -on 04/23/2026, may change urinary catheter if plugged, leaking or out. -on 04/25/2026, Augmentin (antibiotic) oral tablet 500-125 milligram give one tablet by mouth 2 times a day for 7 days for urinary tract infection. -on 04/29/2026, monitor indwelling catheter to leg bag/bedside drainage bag and ensure privacy bag was in place. -on 05/01/2026, change leg bag and obtain a urine specimen and send it to the lab for processing. The 05/10/2026 Registered Nurse #21 progress note documented a urine specimen was obtained and was awaiting pick up by the lab. During an observation and interview on 05/12/2026 at 8:29 AM, the resident was sitting in a chair with their urinary collection leg bag attached to their lower right thigh extending from just above the knee to just below the knee. A large, overnight collection bag was in an unopened package on the resident's dresser. No collections bags were observed in the bathroom. The resident stated they wore (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the leg bag all the time because they did not know how to switch it to the overnight collection bag. During an observation and interview on 05/13/2026 at 8:02 AM, the resident was sitting on their bed, and their leg bag was on their right thigh with the distal portion above the knee area, and not below the level of the bladder. The bag contained a scant amount of dark yellow urine. The resident stated they kept the same leg bag on their right upper thigh when they sat in the chair and while lying in bed. They slept with the leg bag and sometimes woke up at night to find the bag very full, requiring them to empty it. During an observation on 05/13/2026 from 11:23 AM &ndash; 11:52 AM, the resident was sitting in a chair in their room. Their leg bag was on their right thigh with the distal portion level with the resident's upper knee, not below the level of bladder. During an observation on 05/14/2026 at 08:51 AM, the resident was sitting on the edge of their bed. Their leg bag was on their right thigh, and the distal portion of the bag was at their knee, and not below the level of the bladder. During an observation and interview on 05/14/2026 at 11:53 AM, the resident was sitting on the edge of their bed. The leg bag was on their right lower leg below the knee extending to their calf. The resident stated staff recently told them the drainage bag should be kept on their lower leg so it could drain. Staff never explained that to them before. During an interview on 05/14/2026 at 1:52 PM, Licensed Practical Nurse #36 stated nursing was responsible for monitoring catheter output, placement, and were to report any related issues. The certified nurse aides should switch the collection bags from a leg bag to an overnight collection bag at night and switch back over to a leg bag in the morning. They were unsure if Resident #26 was allowed to change their collection bags themselves. They were not aware the resident was using a leg bag all the time and was not notified by the aides the resident used the leg bag even when in bed. The resident should not wear a leg bag on their thigh if they were sitting down or even lying down because it could have disrupted the urine flow, causing backup and a urinary tract infection. During an interview on 05/14/2026 at 2:14 PM, Certified Nurse Aide #13 stated the certified nurse aides were supposed to change the leg bag to the overnight collection bag at bedtime and back over in the morning. Resident #26 had used a large overnight collection bag but switched over a few weeks ago to wearing a leg bag all the time so they could get used to it before they went home. They had not changed it over for them in a long time because they were letting the resident manage the collection bag so they could do it when they went home. They were aware the resident was sleeping with the leg bag and kept it on their thigh, but they just realized it was not being kept below the level of the bladder when they were sitting or lying down so it could have caused the urine to back up and not flow freely. During an interview on 05/15/2026 at 10:02 AM, Registered Nurse Unit Manager #5 stated in the mornings the certified nurse aides should assist the resident with changing over from an overnight collection bag to a leg bag if the resident agreed to it and it should have been monitored to ensure it was kept below the level of the bladder. They were not aware Resident #26 was sleeping with a leg bag and not using an overnight collection bag. The resident had a history of bladder infections, and the bag needed to be kept lower than the bladder. 10 New York Codes, Rules and Regulations 415.12(d)(1)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observations, record review, and interviews, the facility failed to ensure residents who required dialysis services (filtration of blood when the kidneys do not work) received such services consistent with professional standards of practice for one (1) of one (1) resident (Resident #2) reviewed. Specifically, Resident #2 received hemodialysis treatments at a community-based dialysis center and did not have consistent on-going assessments or oversight before and after dialysis treatments; there was no documented evidence the resident's dialysis access site was routinely assessed; and the resident did not receive a bagged lunch for missed meal during their dialysis treatment. Findings include: The facility policy Care of Resident Receiving Hemodialysis, last reviewed 10/2025, documented the staff were to enter the pre-treatment information per the form fields in the dialysis communication book and enter the resident's departure into the clinical record. When a resident returns from dialysis the staff were to obtain vital signs, observe the access site for bleeding or redness, check for bruit (audible whooshing sound indicating blood flow) and thrill (palpable vibration indicating blood flow), and any alterations in the resident's status. A meal tray was to be ordered if a meal was missed. Record any recommendations and communications from dialysis and the post-treatment data per the form fields. Resident #2 had diagnoses including end stage kidney disease, diabetes, and low blood pressure. The 02/17/2026 Minimum Data Set documented the resident had intact cognition and received dialysis. The 10/24/2024 comprehensive care plan documented the resident was dependent on hemodialysis related to end-stage kidney disease. Interventions included: provide renal diet and follow dietary restrictions as per the provider's order; monitor the shunt for patency; monitor for signs of infection and communicate with the dialysis center any abnormal findings; provide bagged lunch for dialysis; monitor fluid intake and output; and vital signs and weight as ordered by the provider. The resident received hemodialysis three times a week on Monday, Wednesday, and Friday with a pickup time of 10:00 AM. The 12/23/2025 physician order documented collect and document vital signs pre-treatment, complete dialysis communication book, and write progress note. Monitor hemodialysis access site for bruising, bleeding, symptoms of infections, and the presence of thrill and bruit (if applicable) every shift. There was no documented order to check the resident's vitals or to complete an assessment upon the resident's return from dialysis. The May 2026 Treatment Administration Record documented the resident's hemodialysis access site was not documented as monitored on: the 7:00 AM to 3:00 PM shift: 05/07/2026 by Licensed Practical Nurse #14, and 05/12/2026 by Licensed Practical Nurse #14. - the 3:00 PM to 11:00 PM shift: 05/02/26 by Licensed Practical Nurse #15, 05/05/2026 by Licensed Practical Nurse #14, 05/07/2026 by Licensed Practical Nurse #14, 05/08/2026 by Licensed Practical Nurse #17, and 05/12/2026 by Licensed Practical Nurse #18. - the 11:00 PM to 7:00 AM shift: 05/03/2026 by Licensed Practical Nurse #15, 05/04/2026 by Licensed Practical Nurse #16, 05/16/2026 by unidentified licensed practical nurse and 05/17/2026 by unidentified licensed practical nurse. There were no documented pre-dialysis assessments, and the nurse progress notes only documented the resident was out of the facility for dialysis. There were no documented post-dialysis assessments. The resident did not have their dialysis communication form filled out with necessary information on 05/01/2026, 05/04/2026, and 05/08/2026. The 05/01/2026 dialysis communication form documented dialysis recommended to Please Limit fluid as [resident] is gaining a lot and unable to tolerate the high goal was reviewed by the nurse and communicated to the provider. The resident was observed on 05/13/2026 at 11:26 AM leaving on a stretcher to dialysis and was not sent with a meal. During an interview on 05/14/2026 at 1:03 PM Resident #2 stated the facility did not give them lunch on dialysis days; they gave them a glass of water and sent them on their way. They stated the facility did not do bagged lunches. During an interview on 05/14/2026 at 1:45 PM, Licensed Practical Nurse #17 stated the resident sometimes received a lunch tray that was held until they got back from dialysis. The facility used to make lunches and then keep them at the front desk for the residents to take when (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	they left but they did not think that was happening anymore. They only documented when the resident came and went from dialysis in their notes because there were already a lot of other orders for dialysis in the resident's chart. There used to be a whole specific set of things they had to write in the notes but not anymore. They had to complete the resident's dialysis book before they left for dialysis to include their vitals and if anything happened prior to dialysis. They were also supposed to check the resident's dialysis access site every shift and sign off it was completed; if it was not signed off as completed, it was not done. During an interview on 05/15/2026 at 9:04 AM Food Services Supervisor #19 stated they did not make to-go lunches for dialysis. They used to send bagged lunches, but dialysis stated the residents could no longer bring food with them. Resident #2 has their lunch tray held for them until they get back from dialysis. During an interview on 05/15/2026 at 9:26 AM Dialysis Center Secretary #20 stated they allowed residents to bring food to dialysis. They provided Resident #2 with a protein bar at dialysis as the resident did not bring any food with them. During an interview on 05/15/2026 at 10:10 AM Licensed Practical Nurse Unit Manager #9 stated residents who missed lunch because they were at dialysis were supposed to have a bagged lunch sent with them. They stated Resident #2 would not take a bagged lunch and would say they did not need it. But lunch should always be offered and documented as refused and a snack offered. They were unaware Resident #2 was not provided with a bagged lunch. The resident's dialysis access site should be monitored every shift and signed off. The licensed practical nurses were responsible for filling out the dialysis communication sheets. The nurse who reviewed the dialysis communication sheets when the resident returned from dialysis should put any outcomes, refusals, or information that was included on the communication sheet in their note. It did not appear the recommendation on the 05/01/2026 dialysis communication sheet to limit fluids was communicated to the provider and they were unaware of it. The notes the staff were supposed to document prior to dialysis should include more than just the resident went out to dialysis. There should also be a post-dialysis assessment and note but the resident did not have orders for that. 10 New York Codes, Rules and Regulations 415.12(k)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, record review, and interviews, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for two (2) of five (5) residents (Resident #12 and #101) reviewed and for legionella (a bacteria causing Legionnaires' disease-a respiratory disease) testing. Specifically, Residents #12's and #101's transmission-based precaution orders were not followed; and the facility did not perform legionella testing as required based on positivity rate and a legionella positivity rate greater than 30% was not reported to the Department of Health as required. Findings include: Isolation Precautions: The facility policy Infection Control, Transmission-Based Precautions, dated 11/2025, documented transmission-based precautions were used for residents known or suspected to be infected with highly transmissible or epidemiologically important pathogens for which additional precautions beyond standard precautions were needed to interrupt its transmission. The facility Special Droplet/Contact Precautions signage documented that in addition to standard precautions everyone must clean their hands when entering and leaving the room, wear eye protection (face shield or goggles), a mask (fit tested N-95 or higher when performing aerosol-generating procedures), a gown and gloves. 1) Resident #12 had diagnoses including methicillin resistant staphylococcus aureus (a resistant bacteria) infection of an unspecified site and osteomyelitis (a bone infection) of the lower leg bones. The 05/04/2026 Minimum Data Set assessment documented the resident had intact cognition and had a multidrug-resistant organism. A 04/24/2026 wound culture report documented the resident tested positive for methicillin resistant staphylococcus aureus. The 04/30/2026 comprehensive care plan documented an infection of the right knee. Interventions included maintain precautions as ordered. The 05/01/2026 Nurse Practitioner #22 medical order documented the resident was on contact precautions for methicillin resistant staphylococcus aureus wound infection. During an observation on 05/11/2026 at 12:42 PM, Resident #12's room had a Special Droplet/Contact Precautions sign outside the door above their name placet. There was a bin containing personal protective equipment outside the door and there were no hampers near the doorway in the room. Certified Nurse Aide #48 entered the room without putting on any personal protective equipment, picked up the resident's meal tray, exited the room, placed the tray on the cart, then entered another resident's room. The following observations were made of staff entering the resident's room not wearing any personal protective equipment on 05/12/2026: -At 11:56 AM Certified Nurse Aide #6 entered room to deliver a lunch tray, exited the room without performing hand hygiene, then entered another resident's room. -At 12:16 PM Certified Nurse Aide #44 entered the room, picked up the lunch tray, exited the room without performing hand hygiene, put the tray on the cart, then entered another resident's room. -At 12:19 PM Registered Nurse Unit Manager #5 entered the room and was looking at the resident's right hip area. Registered Nurse Unit Manager #5 did not put gloves on and picked up the resident's partially full urinal, entered the bathroom, exited the bathroom with an empty urinal, returned the urinal to the resident then washed their hands. They touched the resident's bedside table and left the room without performing hand hygiene. -At 12:49 PM Physical Therapy Assistant #45, utilized hand sanitizer before entering the resident's room. At 12:50 PM they exited the room without performing hand hygiene, entered the code in the Nursing Supplies room door's keypad, entered that room, exited seconds later then reentered the resident's room. During an interview on 05/12/2026 at 2:06 PM Certified Nurse Aide #6 stated residents on precautions had a sign and a bin containing personal protective equipment outside their room. The signs directed what precautions had to be followed and applied to all staff members. Personal protective equipment should be put on prior to entering the room and removed in the doorway before exiting the room and placed in the trash can. There were not designated hampers. They thought Resident #12 was on enhanced barrier precautions but after looking at their sign stated they were on droplet precautions. All the things that were on the sign should be followed every time (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	someone entered the room, including when delivering and picking up meal trays. They delivered the resident's lunch tray that day and did not follow the sign but should have. During an interview on 05/12/2026 2:24 PM, Physical Therapist Assistant #45 stated residents on precautions had a sign outside the room indicating the type of precaution and what staff needed to wear. The signs applied to all employees. Personal protective equipment should be put on before entering the room, removed and disposed of in a regular garbage can before exiting the room, and hands should be washed before entering and exiting the room. Resident #12 was on contact precautions due to an infection in their knee. A gown and gloves should be worn anytime they go in the room. They did not follow the sign because they did not see the sign. They should have followed the precautions. During an observation on 05/12/2026 at 3:55 PM the droplet/contact sign was no longer outside the resident's room. There was an enhanced barrier precaution posted outside the room. 2) Resident #101 had diagnoses including acute and chronic respiratory failure with hypoxia (low oxygen levels). The 04/22/2026 physician order documented the resident was on contact/droplet precautions. There was no documented evidence the comprehensive care plan included transmission-based precautions. During an observation on 05/11/2026 at 12:48 PM, Resident #101 was in their room. There were enhanced barrier and special droplet/contact precaution signs on their door. There was a bin outside the door, no hampers next to the door, and the door was open. The following observations were made of staff entering the resident's room not wearing any personal protective equipment on 05/12/2026:-At 11:49 AM Certified Nurse Aide #6 entered the room carrying a lunch tray. They exited the room seconds later without performing hand hygiene then delivered a lunch tray to another room.-At 11:53 AM Physical Therapy Assistant #43 entered the room, moved the resident's tray table around, prepared lunch drinks, and touched the resident's reaching tool. At 12:06, while still in the room, they put on a pair of gloves, set up the resident's lunch tray, removed the gloves, exited the room, then used hand sanitizer from a dispenser located in the hall.-At 12:02 PM Certified Nurse Aide #44 entered the room and began making the bed then exited room without first washing hands and dragged a bag of dirty linen down the hall. During an observation on 05/12/2026 at 2:34 PM the droplet/contact sign was removed and only an enhanced barrier precaution was posted. During an interview on 05/12/2026 at 1:50 PM, Certified Nurse Aide #44 stated if a resident was on precautions there should be a sign and a bin outside their room. The precautions applied to everyone and directed what needed to be worn. Everyone must follow the sign, and the precautions were mainly for care delivery and did not apply to dropping off trays. They were not sure why the resident was on precautions. They should have followed the sign's instructions, including washing their hands when entering and exiting the room, but had not noticed the sign until just then. During an interview on 05/12/2026 at 6 2:34 PM, Physical Therapist Assistant #43 stated their understanding, and assumption was the resident had been cleared by the nurse practitioner at least a week ago to not be on both precautions. They asked Registered Nurse Manager #5 about the signs on 05/12/2026 at 2:00 PM and Registered Nurse Manager #5 took the droplet/contact sign down. They did not think they should have followed the droplet/contact precaution sign earlier that day because of that prior conversation they had with the nurse practitioner. During an interview on 05/13/2026 at 1:18 PM, Licensed Practical Nurse #59 stated precautions signs direct what should be worn and they should be followed. They were trained in the hospital, not the facility, about precautions and followed that knowledge and their nursing judgement; not necessarily what the precaution sign said. Their responsibility was to make sure precautions were followed. Resident #101 had an order for droplet/contact precautions, but the order did not say why. They expected staff to follow the signage. Resident #12 had a chronic infected right knee that drained and an active order for contact precautions. During an interview on 05/13/2026 at 1:42 PM, Registered Nurse Unit Manager #5 stated precautions signs were posted at the door and directed staff to what equipment had to be worn for what activity. Precautions should have an order and a care plan. They or the infection control nurse was responsible for putting the signs up and taking them down. If there was an order for precautions that order should be followed. If the order and (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the signage did not match, the provider should be contacted for clarification. There should always be an order to discontinue precautions prior to taking a sign down. Resident #12 had a chronic problem with an infected right knee and was on enhanced barrier precautions. They did not know if the resident was on contact/droplet precaution earlier that week and no one told them that signage was removed. After referring to the orders they stated there was an order for contact precautions due to methicillin resistant staphylococcus aureus and that should be followed. Resident #101 had enhanced barrier precautions for a pressure ulcer. They were not aware the resident had a droplet/contact precaution sign on their door earlier that week. They did not recall removing any signs but had been redoing the enhanced barrier precaution signs that week and may have taken those signs down without realizing what they were taking down. They expected to be notified if a precautions sign was taken down and no one had notified them of any signs being removed that week. During an interview on 05/15/2026 at 1:25 PM, Nurse Practitioner #22 stated they expected precaution orders were followed and if the precaution order was active the sign should be posted. Resident #101 was admitted on precautions due to pneumonia. The pneumonia had been resolved, and they thought they had talked to the manager earlier that week about discontinuing the precautions. Resident #12 was on contact precautions due to infection in their wound and if there was an active wound, they should still be on precautions. During an interview on 05/15/2026 at 12:56 PM, Registered Nurse Educator/Infection Preventionist #57 stated residents on precautions had a sign outside their door that directed what personal protective equipment was needed to enter the room. Precautions should have a physician order, and signs should not be removed unless the order was discontinued. The nurse manager was responsible for putting up the signs. They expected all staff to follow the ordered precautions or whatever the sign said that was outside the room. If a sign was taken down, they expected to be notified. Resident #101 was admitted on an antibiotic. They were unsure why they were on contact/droplet precautions but if the sign was posted it should be followed. Resident #12 had an order for contact precautions due to methicillin resistant staphylococcus aureus in their wound. Staff should follow the precaution sign to protect themselves and the resident from spreading the infection. They were not aware the signs were removed. Legionella: The undated Water Management Plan documented no less than 10 potable water dispensing locations within the facility would be checked at intervals not to exceed 90 days for the 12-month period beginning June 2018, and annually thereafter. If the percentage of positive Legionella tests were greater than or equal to 30% the water system would be re-sampled no sooner than 7 days and no later than 4 weeks after disinfection to determine the efficacy of the treatment. The 08/08/2024 legionella testing results documented 10 tests were obtained and three (3) had positive results. The 02/25/2026 legionella testing results documented 16 tests were obtained and nine (9) had positive results. There was no documented evidence of legionella test results obtained between 08/08/2024 and 02/25/2026. During an interview on 05/14/2026 at 1:15 PM, the Director of Maintenance stated they conducted legionella tests with an outside vendor and if there was a positive result it was escalated to the administrator. The facility had to test quarterly. The last test was about 2 months ago, and they thought there were 4-5 positives out of about 12 to 15 tests. They were unsure what the positivity percentage was but believed it was higher than acceptable. They did not report the results. When they started in their position approximately 3 months ago an outside water treatment company was working in the facility because of prior positive results. After the vendor's water treatments were completed, they retested, and the number of positive results was higher than prior to the vendor treating the water. They had a treatment scheduled for last week, but the vendor did not show up. During an interview on 05/15/2026 at 12:45 PM, the Administrator stated an outside vendor came in February 2026 to work on their water tank and valves and testing was performed on 02/24/2026. Sixteen sites were tested, and more than half were positive. When the vendor was at the facility in February 2026 more valves had broken, and it was not until April 2026 that the vendor came back to fix them. All the valves were fixed approximately 3 weeks ago. No further testing was done since 02/24/2026. They did not report the (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	positivity rate to the Department of Health because they assumed the results were not accurate due to their valve problem. Reporting it could have created a lot of work if based on faulty results. The vendor was supposed to come back a week ago and put an automatic backflow and flushing system in. They planned to retest the water a week after that work was completed but the vendor did not show up. They were unsure when the next testing would happen. They were on an annual testing schedule but thought they would have to go to quarterly. 10 New York Codes, Rules and Regulations 415.19 (a) (1-3)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335377	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/18/2026
NAME OF PROVIDER OR SUPPLIER Troy Victorian Rehabilitation & Nursing Care Cntr		STREET ADDRESS, CITY, STATE, ZIP CODE 100 New Turnpike Road Troy, NY 12182	
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 0836 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. Based on record review and interviews, the facility failed to operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. Specifically, the facility did not provide the Medicare/Medicaid Application (CMS-671), Civil Rights Questionnaire (DOH-1506), Facility Assessment, Equipment Inventory Form, Legionella policies and procedures, menus for the duration of the survey, admission packet, and documentation of the Infection Preventionist's specialized training in infection prevention and control in a timely manner as required. Findings include: The Centers for Medicare and Medicaid Services survey form Entrance Conference Worksheet, provided to the Administrator upon survey entrance documented the following items were required during the recertification survey: -menus including therapeutic menus for the duration of the survey within 1 hour of entrance. -documentation of the Infection Preventionist's specialized training in infection prevention and control within 1 hour of entrance. -admission packet within 4 hours of entrance -Facility Assessment within 4 hours of entrance. -completed Medicare/Medicaid Application (CMS-671) within 24 hours of entrance. The New York State Addendum form Entrance Conference Worksheet, provided to the Administrator upon survey entrance documented the following items were required during the recertification survey: - Equipment Inventory Form within 24 hours of entrance. - Legionella policies and procedures within 24 hours of entrance. - completed Civil Rights Questionnaire (DOH-1506) within 24 hours of entrance. The New York State Department of Health surveillance team entered the facility on 05/11/2026 at 10:00 AM. The Team Coordinator met with the facility's Administrator and Director of Nursing at 10:42 AM to review the documents required for the survey as outlined on the entrance conference worksheets. The Administrator was provided with a hard copy of the entrance conference worksheets. The worksheets included the time frame for providing the Medicare/Medicaid Application (CMS-671), Civil Rights Questionnaire (DOH-1506), Facility Assessment, Equipment Inventory Form, Legionella policies and procedures, menus for the duration of the survey, admission packet, and documentation of the Infection Preventionist's specialized training in infection prevention and control. On 05/12/2026 at 9:35 AM, the Administrator sent the admission packet that was required within 4 hours of entrance. On 05/12/2026 at 12:44 PM, The Team Coordinator met with the Administrator and notified them they had sent an email at 12:41 PM with blank copies of the Medicare/Medicaid Application (CMS-671), Civil Rights Questionnaire (DOH-1506), and Equipment Inventory Form that were required within 24 hours of entrance. On 05/12/2026 at 2:25 PM, the Team Coordinator sent an email to the Administrator requesting all food menus that would be served for the duration of the survey that was required within 1 hour of entrance. On 05/12/2026 at 2:37 PM, the Administrator sent the food menus that would be served for the duration of the survey. On 05/13/2026 at 9:45 AM, the Team Coordinator met with the Administrator to review all missing documents that were required from the Entrance Conference Worksheets. The Administrator stated they were doing their best to get things completed and sent. On 05/13/2026 at 1:05 PM, the Administrator sent the Civil Rights Questionnaire (DOH-1506), Equipment Inventory Form, and Legionella policies and procedures that were required within 24 hours of entrance. On 05/14/2026 at 10:15 AM, the Administrator sent documentation of the Infection Preventionist's specialized training in infection prevention and control that was required within 1 hour of entrance. On 05/18/2026 at 12:44 PM, the Team Coordinator sent an email to the Administrator requesting the Medicare/Medicaid Application (CMS-671) that was required within 24 hours of entrance. On 05/18/2026 at 1:03 PM, the Administrator sent the Medicare/Medicaid Application (CMS-671). The Facility Assessment that was required within 4 hours of entrance was never received. 10 New York Codes, Rules, and Regulations 483.70 (i)		