

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335380	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/09/2026
NAME OF PROVIDER OR SUPPLIER  Northern Metropolitan Res Health Care Facility Inc		STREET ADDRESS, CITY, STATE, ZIP CODE  225 Maple Avenue Monsey, NY 10952	

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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>Based on observations, record review, and interviews conducted during the Abbreviated Surveys (2663420 and 2700684), the facility did not ensure residents had a right to a safe, clean, comfortable, and homelike environment for 1 (Resident #3) of 3 residents reviewed for resident rights. Specifically, Resident #3, who was assessed by therapy for wheelchair use and whose most recent Minimum Data Set documented wheelchair as the resident's primary mode of locomotion, was observed seated in a wheelchair in the dining room labeled with the name of another resident who no longer resided in the facility. Resident #3 was visibly upset and pointed at the armrest of the wheelchair. The wheelchair was too wide for Resident #3. The right armrest pad was missing, and the left armrest pad was observed frayed. The Director of Rehabilitation stated the wheelchair was not assigned to Resident #3 and observed the wheelchair was damaged and not appropriate for resident use. The findings include: A review of the facility policy titled Resident Seating Recommendations, last revised 10/20/2025, documented that the Rehabilitation Department will identify an appropriate wheelchair, cushion, and positioning device as part of the resident's plan of care. The policy further documented that equipment judged unsafe shall be removed from service until it can be repaired or discarded. Resident #3 was admitted with diagnoses including but not limited to anemia, dementia, and heart failure. The 01/21/2026 Quarterly Minimum Data Set (MDS) documented Resident #3 had severely impaired cognition and required a wheelchair for mobility. On 03/09/2026 at 01:04 PM, Resident #3 was observed seated in a wheelchair in the dining room labeled with the name of another resident who no longer resided in the facility. When approached by the surveyor, Resident #3 appeared visibly upset and pointed to the armrests of the wheelchair. The wheelchair was too wide for Resident #3 and contained damaged armrest padding, including one missing armrest pad and one armrest pad that was frayed. On 03/09/2026 at 01:04 PM, Registered Nurse Unit Manager #1 accompanied the surveyor in the dining room when Resident #3 was observed seated in a wheelchair labeled with the name of another resident who no longer resided in the facility. During an interview at that time, Registered Nurse Unit Manager #1 stated they were unaware how Resident #3 came to be seated in the wheelchair and stated Resident #3 should not have been seated in another resident's wheelchair and the wheelchair was damaged. Registered Nurse Unit Manager #1 stated the assigned Certified Nurse Aide (CNA) was on lunch at the time and they would need to investigate how Resident #3 was placed in the wheelchair. During the observation, Registered Nurse Unit Manager #1 removed the label from the wheelchair using scissors. Registered Nurse Unit Manager #1 stated a referral to therapy would be placed for evaluation of the wheelchair. At that time, a referral had not yet been placed. On 03/09/2026 at 01:24 PM, the Director of Therapy arrived to the unit and observed Resident #3 seated in the wheelchair in the dining room. During an interview at that time, the Director of Therapy stated the wheelchair was not Resident #3's chair and stated the chair was too wide for Resident #3. The Director of Therapy stated therapy would not issue a broken wheelchair to a resident and stated the wheelchair was not suitable for any resident due to the damaged condition. The Director of Therapy stated no resident should be seated in that wheelchair and stated the wheelchair should not have been on the unit. The Director of Therapy stated they were not aware the (continued on next page)</p>

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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>wheelchair was broken and stated therapy should be notified when a wheelchair is damaged. The Director of Therapy stated that when a resident is discharged , the resident's wheelchair should be removed from the unit. The Director of Therapy stated that all wheelchairs should be labeled with the resident's name and stated they were unable to locate Resident #3's wheelchair and would search the unit for it.On 03/09/2026 at 02:37 PM, during an interview, the Director of Rehabilitation stated Resident #3 had been provided with a new wheelchair and stated they were still attempting to locate Resident #3's previous wheelchair.On 03/09/2026 at 02:41 PM, during an interview, Certified Nurse Aide #1 stated they were assigned to Resident #3 for the shift. Certified Nurse Aide #1 stated Resident #3 uses a wheelchair all the time and that when they received Resident #3 at the beginning of the shift at approximately 07:00 AM, Resident #3 was already seated in the wheelchair. Certified Nurse Aide #1 stated they provided care to Resident #3 during the morning, including assisting Resident #3 with a shower, and placed Resident #3 back into the same wheelchair. Certified Nurse Aide #1 stated upon returning from lunch they became aware the wheelchair Resident #3 was seated in did not belong to Resident #3 and stated staff were unable to locate Resident #3's wheelchair. Certified Nurse Aide #1 stated they did not check the name on the wheelchair and were unaware the wheelchair belonged to another resident. Certified Nurse Aide #1 stated they were not aware the wheelchair was damaged and stated if they had known the wheelchair was broken, they would have reported it to the nurse, maintenance, and rehabilitation staff.On 03/09/2026 at 04:27 PM, during an interview, the Director of Rehabilitation stated Resident #3 had been provided with another wheelchair and stated they were still unable to locate the wheelchair that had originally been issued to Resident #3.On 03/11/2026 at 11:02 AM, during an interview, the Director of Maintenance stated they were unaware Resident #3's wheelchair was damaged. The Director of Maintenance stated maintenance does not perform routine inspections of wheelchairs and relies on nursing staff to notify them when equipment is damaged. The Director of Maintenance stated there is no system in place to routinely identify damaged wheelchairs.10 NYCRR 415.5</p>		

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<p>F 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies.</p> <p>Based on observations, record review and interviews conducted during the Abbreviated Surveys (2663420 and 2700684), the facility did not ensure that the facility-wide assessment determined the required resources to provide the care and services to its residents during day-to-day operations, did not address what is considered sufficient, particularly on weekends, and did not include behavioral health services necessary to meet resident needs for three (3) of three (3) units reviewed. Specifically, the Facility Assessment provided during the onsite survey did not include minimum staffing requirements for weekends for certified nurse aides and licensed practical nurses, did not identify the number of staff needed to provide behavioral health care and services, and listed zero registered nurses on the day, evening, and night shifts for all three resident units. The findings are: Review of the Facility policy titled Facility Assessment revised 11/19/2025, documented that a facility assessment is conducted at least annually and as needed to determine and update the facility's capacity to meet the needs of and competently care for residents during day-to-day operations (including nights and weekends) and emergencies. Review of the Facility Assessment received from the Administrator on 03/09/2026 at 3:51 PM documented that the Facility Assessment included a staffing breakdown identifying staffing levels by unit. The Facility Assessment provided during the onsite visit documented that the resident population included residents with behavioral health needs, substance use disorders, IV medications, dialysis, oxygen therapy, and residents requiring assistance with activities of daily living. However, the Facility Assessment did not determine staffing resources necessary to meet the care needs of these residents. The Facility Assessment documented facility resources necessary to provide care during emergencies; however, the Facility Assessment did not determine staffing levels necessary to provide care during emergencies. The Facility Assessment did not identify minimum staffing requirements specific to weekends and did not determine how staffing needs on weekend shifts differ from staffing needs on other shifts and did not identify the number of staff needed to provide behavioral health care and services. Review of the Facility Assessment staffing breakdown provided by the facility revealed the following: the Facility Assessment did not determine Registered Nurse staffing levels for the resident units and listed zero Registered Nurses on the day, evening, and night shifts for all three resident units in the facility. For 1 West, the staffing breakdown documented two Licensed Practical Nurses on the day shift, two Licensed Practical Nurses on the evening shift, and one Licensed Practical Nurse on the night shift. For 2 West, the staffing breakdown documented two Licensed Practical Nurses on the day shift, one Licensed Practical Nurse on the evening shift, and one Licensed Practical Nurse on the night shift. For 2 East, the staffing breakdown documented two Licensed Practical Nurses on the day shift, one Licensed Practical Nurse on the evening shift, and one Licensed Practical Nurse on the night shift. The staffing breakdown further documented three certified nurse aides on the day shift, three certified nurse aides on the evening shift, and two certified nurse aides on the night shift for 1 West, 2 West, and 2 East. The surveyor observed that the facility census was approximately one hundred twenty residents at the time of the survey, with approximately forty residents residing on each of the three units. During an interview on 03/09/2026 at 02:29 PM, the staffing coordinator stated that weekends are generally less staffed. The staffing coordinator stated that staff call out and aides are moved between units to balance staffing levels. The staffing coordinator further stated that staffing concerns have been discussed with nursing administration and that the facility attempts to hire additional staff. During an interview on 03/09/2026 at 3:40 PM, when the surveyor requested staffing information upon review of the Facility Assessment received on 03/06/2026, the Administrator stated that the staffing breakdown was an attachment that had not been included with the Facility Assessment provided to the surveyor and (continued on next page)</p>		

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<p>F 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>stated that it would be provided. Upon receipt and review of the staffing breakdown, the document listed zero Registered Nurses on the day, evening, and night shifts for the resident units. When asked about the Registered Nurse staffing identified as zero across shifts, the Administrator stated that the supervisors are Registered Nurses. When asked where the Facility Assessment identified staffing for weekends and staffing needed to meet behavioral health care and service needs, the Administrator stated that they were not sure and would get back to the surveyor. During an interview on 03/09/2026 at 4:18 PM, the Administrator stated that the minimum staffing levels identified on the staffing breakdown within the Facility Assessment represent the facility's minimum staffing levels and are not separated by weekday or weekend shifts and do not identify staffing specific to behavioral health care and service needs.10 NYCRR 415.19</p>