

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/30/2024
NAME OF PROVIDER OR SUPPLIER  Hudson Valley Rehabilitation & Extended Care Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 260 Vineyard Ave, Rt 44/55 Highland, NY 12528	
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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>39070</p> <p>Based on observations, interviews, and record reviews during an abbreviated survey (NY00349142), the facility did not ensure the services provided adhered to accepted standards of practice for medication administration (including right time) for 24 (Residents #26 and #18) of 40 residents reviewed. Specifically, 1) on 08/12/2024 at 12:30 PM Licensed Practical Nurse #1 was observed attempting to administer 13 medications to Resident #26, where the physician ordered these medications to be given at 9:00 AM. Licensed Practical Nurse #1 did not notify the physician prior to changing the medication administration time; 2) on 08/13/2024 from 10:05 AM to 10:12 AM Licensed Practical Nurse #4 was observed passing 10 medications for Resident #18 where the physician ordered them to be given at 9:00 AM. Licensed Practical Nurse # 4 did not notify the physician prior to changing the medication administration time. During interviews both nurses stated that they did not have the time to notify the attending physician that they are administering the medication late.</p> <p>The findings are:</p> <p>The facility policy titled Medication Administration dated 08/06/2024 documented that the purpose of the policy was to establish guidelines to promote the health and safety of residents by ensuring the safe assistance and administration of medication and treatments or other necessary procedures. Medications will be administered to residents as prescribed and by persons lawfully authorized to do so. The six rights of medication administration will be observed including #5 Right Time with guidance to check the frequency of the ordered medication; double check the ordered dose is being given at the correct time; confirm when the last dose was given (pay attention to PRNs - as need medications; medications that are specifically ordered must be administered as per physician's order (with meals, before meals, at HS -hour of sleep, etc.); medications are administered one hour before or one hour after scheduled times. Unless otherwise specified by prescriber, routine medications are administered according to the established medication administration schedule.</p> <p>According to the Physician Desk Reference (PDR) and the Institute for Safe Medication Practice, the 6 rights of medication administration include the right patient, right drug, right dosage, right route, right time, and the right documentation. The right time is the time that was intended by the prescriber. Recommendation is for medications to be administered one hour before or after the scheduled time.</p> <p>Resident #26 had diagnoses which include Bipolar Disorder, Major Depressive Disorder and Generalized Anxiety Disorder.</p> <p>(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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 335399
		If continuation sheet Page 1 of 16

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the Physician Order revealed Resident #26 had the following 13 medications ordered to be administered at 9:00 AM: Budesonide-Formoterol HFA(steroid used in the long term management of asthma) 80 micrograms-4.5 microgram/actuation aerosol every day at 9 AM and 5 PM for Chronic Obstructive Pulmonary Disease by inhalation, Cranberry Extract 250 mg every day at 9:00 AM for Urinary Infection by oral route, Duloxetine 30 mg every day at 9 AM for Major Depressive Disorder by oral route, Ferrous Gluconate 324 mg every day at 9 AM for Anemia by oral route, Fluticasone Propionate mcg every day at 9 AM for Allergy by nasal spray, Folic Acid 1 mg every day at 9 AM for Anemia by oral route, Lamictal 100 mg every day at 9 AM for Bipolar Disorder by oral route, Magnesium Oxide 400 mg every day at 9AM and 5 PM for Hypomagnesemia by oral route, Spironolactone 25 mg every day at 9AM and 5 PM for Hypertension by oral route, Sulfasalazine 500 mg every day at 9AM and 5 PM for Ulcerative Colitis by oral route, Vitamin C 500 mg every day at 9 AM for Urinary Infection by oral route, and Vitamin D3 25 mcg every day at 9 AM for Osteoporosis without pathological fracture by oral route.</p> <p>During an observation on 08/12/2024 at 12:25 PM, Licensed Practical Nurse #1 was observed preparing 9:00 AM medications for Resident #26. Licensed Practical Nurse #1 stated they forgot they needed to administer meds to Resident #26, because the resident was not assigned to them. Resident #26 was assigned to Licensed Practical Nurse #2, but the resident does not like Licensed Practical Nurse #2, so they had to administer the meds. Licensed Practical Nurse #1 stated that they were administering 13 medications that were ordered to be administered at 9:00 AM. (The LPN prepared 11 medications that include Spironolactone (Diuretic/Cardiac Med), and Lamictal (Anticonvulsant), 2 meds - nasal spray and inhaler did not need preparation).</p> <p>With surveyor intervention on 08/12/2024 at 12:30 PM, Licensed Practical Nurse #1 did not administer Resident #26's medication. The Director of Nursing was called and immediately counselled Licensed Practical Nurse #1 and Licensed Practical Nurse #2.</p> <p>An Educational Counseling Form dated 08/12/2024 signed by Licensed Practical Nurse #2 revealed that they did not document that Resident #26 was asleep at 9 AM and/or the resident refused their scheduled 9 AM medications. Licensed Practical Nurse #2 did not communicate to Licensed Practical Nurse #1 that they should administer the medications to Resident #26. In addition to documenting reasons for not administering scheduled meds in the resident's medical record, the Licensed Practical Nurse should also notify the physician for late medication administration.</p> <p>During interview on 08/12/2024 at 1:00 PM, the Director of Nursing stated they were made aware by Licensed Practical Nurse #2 that Resident # 26 was asleep and that they were not allowed to administer medications to the resident. Licensed Practical Nurse #2 should have communicated that to Licensed Practical Nurse #1. The Director of Nursing stated Resident #26 had no complaints and was at baseline. The physician was called, and orders received to monitor the resident for any ill effects. The Director of Nursing stated that they counselled Licensed Practical Nurse #1 and Licensed Practical Nurse #2 about communicating with each other and notifying the physician if medications were administered late.</p> <p>On 08/13/2024 at 9:35 PM, surveyor observation revealed that there was no second medication nurse for the 2nd Floor Dementia Unit (North side) to pass meds.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During interview on 08/13/2024 at 9:35 AM, Licensed Practical Nurse #3 stated that it looks like no one was coming and that they will be the only nurse on the unit to administer medications. They stated they needed to administer the 9 AM medications to 20 more residents. Licensed Practical Nurse #3 stated when there is no nurse on the opposite side of the unit, the expectation is to pass all meds by themself without assistance to about 38 to 40 residents on the second floor. Licensed Practical Nurse #3 stated this is usually the case when they are the only nurse to give meds. They stated that since meds must be passed 1 hour before or 1 hour after the scheduled time, it is impossible for them to finish by 10 AM and they usually have to administer the meds late. They stated they do not usually call for help, and they do not have time to call the doctor.</p> <p>Resident #18 had diagnoses which include Dementia, Schizophrenia, and Hypertension.</p> <p>Review of the Physician Order revealed Resident #18 had 10 medications scheduled at 9 AM, as follows: Aspirin 81 milligram every day at 9 AM for Atherosclerotic Heart Disease by oral route, Ativan 1 mg twice a day at 9 AM and 9 PM for Anxiety Disorder by oral route, Cholecalciferol 50 microgram every day at 9 AM for Prophylaxis by oral route, Cozaar 100 mg every day at 9 AM for Hypertension by oral route, Demadex 20 mg every day at 9 AM for Hypertension by oral route, Depakote 500 mg twice a day at 9 AM and 9 PM for Major Depressive Disorder, Docusate Sodium 100 mg twice a day at 9 AM and 9 PM for Constipation by oral route, Perphenazine 8 mg twice a day at 9 AM and 9 PM for Schizophrenia by oral route, Potassium Chloride Extended Release 20 milliequivalent every day at 9 AM for Hypertension by oral route, and Seroquel 25 mg twice a day at 9 AM and 9 PM for Schizophrenia by oral route.</p> <p>During observation on 08/13/2024 between 10:05 AM to 10:12 AM, Licensed Practical Nurse #4 was observed administering 10 medications that were ordered to be administered at 9:00 AM to Resident #18 without notifying the residents' primary care physician.</p> <p>Record Review of Physician Orders and the Administration Documentation History Detail Report (Medication Administration Record) of 40 residents from 08/12/2024 to 08/13/2024 revealed 23 residents from the 2nd Floor Dementia Unit and 1 resident from the 3rd Floor Long Term Care Unit received their medications late with no documentation that the physician was notified.</p> <p>During an interview on 08/13/2024 at 12:15 PM, the Director of Nursing stated that Licensed Practical Nurse #3 has been the assigned nurse on the 2nd Floor for a long time and they are used to passing meds to 40 residents by themselves. The Director of Nursing stated, I was surprised when she was saying she needed help when she came down with you this morning. Surveyor informed the Director of Nursing that Licensed Practical Nurse #3 and Licensed Practical Nurse #4 completed the 9 AM med pass after 10 AM for at least 20 residents without calling the physician. The Director of Nursing stated that they will have all the residents who received their medications late assessed and have their primary physicians notified, they will re-educate and write up Licensed Practical Nurse #3 and #4. The Director of Nursing stated that all residents on the 2nd floor unit were stable, and no acute changes were noted.</p> <p>(continued on next page)</p>		

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F 0658  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	<p>During an interview on 08/14/2024 at 3:30 PM, the Director of Nursing stated they review the dashboard for medications not documented in the Sigma. They do not run a report to check the time the medications were administered. It is not unreasonable for one medication nurse to pass meds to twenty residents. The facility uses agency nurses to staff the building. The facility has a contract with 9 different staffing agencies to staff the building. The agency nurses used by the facility have been with them for at least 6 months or longer. All nurses are aware of the medication administration policy and know they need to notify the medical provider if the medications are administered late. Agency nurses receive the same training as the facility employed nurses. Director of Nursing stated they were only aware of one weekend when there were issues in the building. The weekend of 07/20/2024-07/21/2024 was a rough weekend for the facility and they were in constant communication with the facility staff and the Ombudsman.</p> <p>10NYRCC 415.11(c)</p>		

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<p>F 0711</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit.</p> <p>39070</p> <p>Based on record reviews, and interviews during an abbreviated survey (NY00349142), the facility did not ensure Resident Primary Care Physicians (Attending Physician) comprehensively reviewed the resident's total program of care, including the Residents' medications and treatments for 24 of 40 residents reviewed. Specifically, a review of the medication administration detailed report from 07/01/2024 to 08/13/2024 revealed residents received their medications late including 19 Residents with significant medications (Antianxiety, Antidiabetic (Insulin), Anticoagulant, Antihypertensive, Antipsychotic, Anti-Parkinson's, and Antiseizure). During an interview with the Medical Director, they stated they were unaware of the consistent late medication administration in the facility. There was no documented evidence that facility staff communicated to the Resident' Primary Care Physician and/or the Medical Director that significant medications were not administered as prescribed by the physician.</p> <p>The Findings are:</p> <p>The facility policy titled By-Laws, Rules and Regulations of the Medical Staff dated 01/2020 documented that the medical staff are responsible for the quality of medical care in the facility and must accept and assume this responsibility subject to the authority of the Governing Body and that the best interests of the residents are protected by concerted effort, physicians practicing in the facility agree to conform and abide with the By-Laws, Rules and Regulations.</p> <p>The facility policy titled Pharmacy Drug Regimen Reviews dated 10/02/2018 documented that the Consultant Pharmacist shall review the medical record of each resident and perform a Drug Regimen Review at least once each calendar month. The Consultant Pharmacist shall identify document and report possible medication irregularities for review and action by the attending physician when appropriate. Any identified irregularities of an urgent nature shall be communicated to the Director of Nursing and/or Nursing Supervisor for immediate follow up and action by the Attending Physician and/or licensed designee.</p> <p>Review of 40 facility residents Physician Orders and the Administration Documentation History Detail Report (Medication Administration Record) from 08/12/2024 to 08/13/2024 revealed 24 Residents received their medications late with no documented evidence that the physician was notified. Out of the 24 Residents, 19 Residents had significant (Antianxiety, Antidiabetic (Insulin), Anticoagulant, Antihypertensive, Antipsychotic, Anti-Parkinson's, and Antiseizure) medication not administered as per prescriber's' order outside the physician ordered scheduled time frame. Out of the 19 residents, 6 Resident (Residents #4, #14, #18, #19, #24, #26) Medication Administration Record was reviewed from 07/01/2024 to 08/13/2024 (Refer to citation text at tag F760 for further information).</p> <p>There was no documented evidence that facility staff communicated to the Resident Attending Physician (Primary Care Physician), and/or Medical Director that there was consistent delay in medication administration from 07/01/2024 to 08/13/2024 until surveyor intervention on 08/12/2024 on the third-floor long term unit and 08/13/2024 on the second-floor dementia unit. This failure to keep the physician informed could directly impact the resident's health outcomes and falls under the physician's oversight responsibilities.</p> <p>(continued on next page)</p>		

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<p>F 0711</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 08/14/2024 at around 4:30 PM, the Medical Director stated they only became aware that medications were being administered late when they were informed by the Director of Nursing on 08/13/2024. Since they were informed, the residents on the second floor have been monitored and no residents have been identified with any acute concerns or discharges to the hospital for medication related issues. The Medical Director stated they will continue to monitor and complete a medical evaluation of all the residents who had their medications administered late on the second floor and third floor. The Medical Director stated that in their opinion the following drug classes are time sensitive such as Hypertensives like the Beta Blockers, Antibiotics, Insulin, Psych Meds, and Short Acting medications like Ativan, including Anticoagulants, Anticonvulsants, and some Controlled Pain Medications.</p> <p>During a telephone interview on 08/21/2024 at 3:04 PM, the Attending Physician stated they have been the attending physician in the facility since June of last year and they have residents assigned to them on the second and third floors. The Attending Physician stated they have been notified of their resident's medications had been given late, but this does not happen often. The Attending Physician stated they were notified within the last couple of weeks. The Attending Physician stated they have not had any concerns related to any medications being late that would have an adverse outcome related to missed medications. The Attending Physician stated none of their resident have been transferred out to the hospital related to late medications. The Attending Physician stated they do not remember the times being changed on the medication's charts on the second floor. The Attending Physician stated they do not believe the time change could adversely affect their residents.</p> <p>During a telephone interview on 08/30/2024 at 2:52 PM, the Administrator stated that staffing has been the root cause of the issue, and they continue to work on the issue with the help of the physicians. The Administrator stated that they are very aware of the seriousness of the late medication administration, and they are addressing the situation now with collaboration with the physicians and physician review of resident care plans.</p> <p>10NYRCC 415.12(b)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>39070</p> <p>F725 - Sufficient Nursing Staff</p> <p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>Based on observation, interviews and record review conducted during an abbreviated survey (NY00349142), the facility did not provide sufficient numbers of personnel to meet the care needs of all residents on the Second Floor Dementia Unit. Specifically, an observation conducted on 08/13/2024 at 9:35 AM revealed that there was no additional medication nurse to pass medications on the north side of the unit. Consequently, 23 residents received their physician ordered 9 AM medications (see associated tag F760) late. Further review of the Medication Administration History Detailed Report from 07/01/2024 to 08/13/2024 revealed consistent pattern of late medication administration on the second floor. Facility daily shift schedule and Director of Nursing interview revealed one medication nurse assigned to pass meds to all forty residents on the second-floor dementia unit.</p> <p>The findings include but are not limited to:</p> <p>Review of the facility assessment last updated 08/01/2024 and last reviewed by the Quality Assurance and Performance committee on 08/06/2024 for preliminary discussion, documented the facility staffing PAR (Periodic Automatic Replacement) level as follows: Registered Nurses 1 per unit during day shift, 1 Registered Nurse Supervisor to supervise the 3 units during the evening and night shifts. 2 Licensed Practical Nurses providing direct care per unit during day shifts; 1-2 Licensed Practical Nurses per unit during the evening shift; 1 Licensed Practical Nurse or a Registered Nurse per unit during the night shift.</p> <p>The facility policy titled Medication Administration dated 08/06/2024 documented that the purpose of the policy was to establish guidelines to promote the health and safety of residents by ensuring the safe assistance and administration of medication and treatments or other necessary procedures. Medications will be administered to residents as prescribed and by persons lawfully authorized to do so. The six rights of medication administration will be observed including #5 Right Time. Unless otherwise specified by prescriber, routine medications are administered according to the established medication administration schedule.</p> <p>Review of facility resident Physician Orders and the Administration Documentation History Detail Report (Medication Administration Record) for 40 residents from 08/12/2024 to 08/13/2024 revealed 24 Residents received their medications late. There was no documentation that the physician was notified of late medication administration. 19 out of the 24 Residents had significant (Antianxiety, Antidiabetic (Insulin), Anticoagulant, Antihypertensive, Antipsychotic, Anti-Parkinson's, and Antiseizure) medication not administered according to the physician ordered scheduled time frame. Review of the Medication Administration History Detailed Report for 6 of the 19 residents (Residents #4, #14, #18, #19, #24, 26) from 07/01/2024 to 08/21/2024 revealed a pattern of late medication administrations.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Facility Daily Shift Schedule from 07/01/2024 to 08/13/2024 revealed that the second floor Dementia Unit consistently had two Licensed Practical Nurses, one nurse assigned to provide treatments and perform desk work (care planning, schedule appointments, and follow ups) and one nurse assigned to pass medications with a full bed capacity of 40 residents. On 07/01/2024, 07/02/2024, 07/03/2024, 07/07/2024, and 07/08/2024 there was only one Licensed Practical Nurse to do both treatment, desk work, and medication administration to 38 to 40 residents on the second floor Dementia Unit.</p> <p>During an interview on 08/13/2024 at 9:35 AM, Licensed Practical Nurse #3 stated it looks like no one is coming and that they will be the only medication nurse on the unit. They stated they still must administer the 9 AM medications to around 20 residents. They stated when they are short, they need to pass all meds themselves without assistance. They stated that this is usually the case when they are the only nurse to give meds to about 38 to 40 residents on the second floor. They stated since meds must be passed 1 hour before and 1 hour after the scheduled time, it is impossible for them to finish by 10 AM and they usually had to administer them late. They stated they do not usually call for help, and it is not as if they did not try before, but nothing came of it, and they do not have time to call the doctor.</p> <p>During interview on 08/12/2024 at 10:58 AM, the Director of Nursing stated that they have a census of 91 and they have 3 units, First Floor (1-East) is the Rehab Unit, Second Floor (2-East) is the Dementia Unit, and Third Floor (3-East) is the Long-Term Unit. The Director of Nursing stated that on the First Floor (1-East) there are 2-3 nurses and 2-3 CNAs during the Day Shift (7-3), there is 1 nurse (2 nurses only on Thursdays) and 2 CNAs during the Evening Shift (3-11), there is 1 nurse and 1-2 CNAs during the Night Shift (11-7); on the Second Floor (2-East) there are 2-3 nurses, 3-4 CNAs, and 1 Geri Aide to do 1 to 1 during the Day Shift (7-3), there is 1 1/2 nurse (1 nurse from the day shift stays until 7 PM) and 3-4 nurses during the Evening Shift (3-11), and 1 nurse and 1-2 CNAs during the Night Shift (11-7); on the Third Floor (3-East) there are 2-3 nurses, 3-4 CNAs during the Day Shift (7-3), there is 1 1/2 nurse (1 nurse from the day shift stays until 7 PM) and 3-4 nurses during the Evening Shift (3-11), and there is 1 nurse and 1-2 CNAs during the Night Shift (11-7).</p> <p>During interview on 08/13/2024 at 11:40 AM, the Administrator stated that they were aware on what was going on the second floor. The Administrator stated that the agency nurse Licensed Practical Nurse #3 on that floor had been assigned there for a long time and there were no issues with them passing meds for the whole floor (40 Residents) except that day.</p> <p>During interview on 08/13/2024 at 12:15 PM, the Director of Nursing stated that Licensed Practical Nurse #3 had been assigned to the Second Floor for a long time and they are used to passing meds to 40 residents by themselves that was why they were surprised when they were saying they needed help when they came down with the surveyor that morning. The Director of Nursing stated that they are aware that Licensed Practical Nurse #3 and Licensed Practical Nurse #4 completed the 9 AM med pass after 10 AM for at least 20 residents without calling the physician.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview conducted on 08/13/2024 at 3:30 PM, the Staffing Coordinator #1 stated they try to complete the staffing schedule at least 2-3 weeks ahead so that open shifts can be covered. The Staffing Coordinator stated the number of nurses to be scheduled is based on directions received from the Director of Nursing. There is usually 2 Licensed Practical Nurses scheduled for the day shift on the second floor Dementia Unit. When there is a call out, they try to call everyone on their list or ask the nurses on duty to do a double. The Staffing Coordinator #1 stated they make all attempts to get coverage before they leave the facility at around 4 PM, they do have a lot of agency people to call to. The Nursing Supervisors are trained to call nurses to come and work if there are call outs.</p> <p>During a follow up interview on 08/14/2024 at 3:30 PM, the Director of Nursing stated that they review the dashboard for medication in the Sigma (Electronic Health Record). They do not run a report to see the time the medications are administered. If medication is not documented, they will follow up with the nurses. It is not unreasonable for one medication nurse to pass meds to forty residents. All nurses are aware of the medication administration policy and know they need to notify the medical provider if the medications are going to be administered late. Agency nurses receive the same training as the facility employed nurses.</p> <p>During an interview on 08/21/2024 at 12:05 PM, the Administrator stated they do not have a policy for mandating personnel, and they cannot mandate agency staff, but they can mandate their facility staff. The Administrator stated they go through the building and ask if someone can stay and if not, then the supervisor will go through, and mandate as needed. The Administrator stated the supervisor is responsible for reviewing the mandating list and informing the nurses of the need to mandate. The Administrator stated the staff has 2-3 hours to call in prior to a shift, so staff does not get much notice of mandating and some staff is already doing a double shift, so they cannot be mandated anymore. The Administrator stated some staff also have medical considerations that they cannot be mandated.</p> <p>During a follow up interview on 08/21/2024 at 1:40 PM, the Administrator stated the facility assessment reflects staffing at full capacity on the units, as follows: 40 on unit 1- 2 nurses; 40 on unit 2- 2 nurses; and 38 on unit 3 - 3 nurses.</p> <p>The Facility Administration did not identify the need to ensure there were enough staff to do medication administration that would meet the prescribers orders on the Second Floor Dementia Unit.</p> <p>10 NYRCC 415.13(a)(1)(i-iii)</p>		

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NAME OF PROVIDER OR SUPPLIER  Hudson Valley Rehabilitation & Extended Care Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 260 Vineyard Ave, Rt 44/55 Highland, NY 12528	
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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39070</p> <p>Based on observations, interviews, and record reviews during an abbreviated survey (NY00349142), it was determined that the facility did not ensure residents were free from significant medication errors for 23 (Residents #18, #4, #14, #19, #24) of 40 residents reviewed for late medication administration. Specifically, the Residents on the Second Floor Dementia Unit did not receive medications including but not limited to Antianxiety, Antidiabetic (Insulin), Anticoagulant, Antihypertensive, Antipsychotic, Anti-Parkinson's, and Antiseizure timely from 07/01/2024 to 08/13/2024 in accordance with prescriber's order and accepted health standards established by national boards and councils.</p> <p>The findings include but are not limited to:</p> <p>The facility policy titled Medication Administration dated 08/06/2024 documented that the purpose of the policy was to establish guidelines to promote the health and safety of residents by ensuring the safe assistance and administration of medication and treatments. Medications will be administered to residents as prescribed and by persons lawfully authorized to do so. The six rights of medication administration will be observed including(#5) Right Time with guidance to check the frequency of the ordered medication; double check the ordered dose is being given at the correct time; confirm when the last dose was given(pay attention to PRNs - as need medications; medications that are specifically ordered must be administered as per physician's order (with meals, before meals, at HS -hour of sleep, etc.). Medications are administered one hour before or one hour after scheduled times. Unless otherwise specified by prescriber, routine medications are administered according to the established medication administration schedule.</p> <p>According to the Physician Desk Reference (PDR) the 6 rights of safe medication administration includes the right patient, right drug, right dosage, right route, right time, and the right documentation.</p> <p>On 08/13/2024 at 9:35 AM, surveyor observed Licensed Practical Nurse #3 passing medications on the Second Floor Dementia Unit with a census of 38.</p> <p>During interview on 08/13/2024 at 9:35 AM, Licensed Practical Nurse #3 stated that it looked like no one was coming and that they will be the only nurse on the unit to administer medications. They stated they needed to administer the 9 AM medications to around 20 more residents. Licensed Practical Nurse #3 stated when there is no nurse on the opposite side of the unit, the expectation is to pass all meds by themselves without assistance to about 38 to 40 residents on the second floor. Licensed Practical Nurse #3 stated this is usually the case when they are the only nurse to give meds, and since meds must be passed 1 hour before or 1 hour after the scheduled time, it is impossible for them to finish by 10 AM, and they usually have to administer the meds late. They stated they do not usually call for assistance, and they do not have time to call the doctor. Licensed Practical Nurse #3 also stated that Licensed Practical Nurse #4 is the Unit Manager who does treatments and care plans for the unit.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During interview on 08/13/2024 at 9:56 AM, Licensed Practical Nurse #4 stated that they were asked to pass meds to 19 residents on the 2nd Floor (North side) and they know the meds are late because the dashboard turned yellow in the Electronic Medical Record. They were just following what they were asked to do. Licensed Practical Nurse #4 stated that they are the 2nd Floor Unit Manager, and their role is to do treatment, revise the care plans and set up appointments which no one is doing right now because they had to pass meds.</p> <p>Observed Licensed Practical Nurse #4 administer 10 - 9 AM scheduled medication to Resident #18 between 10:05 AM to 10:12 AM without calling the residents primary care physician.</p> <p>During a follow up interview on 08/13/2024 at 10:12 AM, Licensed Practical Nurse #4 showed the Electronic Medical Record dashboard to the surveyor. The dashboard had turned yellow for all medications that were already late.</p> <p>Record review revealed that 23 residents on the 2nd floor dementia unit received their 9 AM physician ordered medications between 10:04 AM-11:58 AM on 08/13/2024.</p> <p>Resident #18 had diagnoses which include Dementia, Schizophrenia, and generalized anxiety disorder.</p> <p>The Physician Order with original order date of 02/14/2022 and renewed on 08/07/2024 documented the following medications be administered at 9 AM: Aspirin 81 milligram every day at 9 AM for Atherosclerotic Heart disease by oral route; Cozaar 100 milligram every day at 9 AM for Atherosclerotic Heart Disease by oral route; Demadex 20 milligram every day at 9 AM for Hypertension by oral route; Potassium Chloride ER 20 milliequivalent every day at 9 AM for Hypertension by oral route; Cholecalciferol 50 microgram every day at 9 AM for Prophylaxis by oral route; Ativan 1 milligram twice a day at 9 AM, 9 PM for anxiety disorder by oral route; Depakote 500 milligram twice a day at 9 AM, 9 PM for Major Depressive Disorder by oral route; Perphenazine 8 milligram twice a day at 9 AM, 9 PM for Schizophrenia by oral route; Seroquel 25 milligram twice a day at 9 AM, 9 PM for Schizophrenia by oral route; and Docusate Sodium 100 milligram twice a day at 9 AM, 9 PM for Constipation by oral route.</p> <p>Review of Resident #18 Medication Administration History detailed report from 07/01/2024 to 08/13/2024 revealed the 9 AM scheduled medications were not administered as per prescriber's order for 11 out of 44 days reviewed.</p> <p>Resident #4 had diagnoses which include Dementia, Psychosis and Anxiety.</p> <p>The Physician Order with original order date of 04/04/2023 and renewed on 07/18/2024 documented the following medications be administered as follows: Buspirone (anti-psychotic) 15 milligram 1 tablet by oral route three times a day at 9 AM, 1 PM, 5 PM and Lorazepam (anti-anxiety) 0.5 milligram 1 tablet by mouth 3 times a day at 9 AM, 1 PM, 5 PM.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #4's Medication Administration History Detailed Report revealed from 07/01/2024 to 08/13/2024 Buspirone(antipsychotic) and Lorazepam(antianxiety) were not administered at 9 AM as ordered on 34 out of 132 occasions (44 days). This included 3 omissions on 07/19/2024 for the 9 AM, 1 PM, and 5 PM doses and 5 occasions when 2 doses were documented as given at the same time, as follows: on 07/14/2024 the 9 AM and 1 PM doses documented as administered at 12:23 PM; on 07/21/2024 the 9 AM and 1 PM doses documented as administered at 12:24 PM; on 07/23/2024 the 9 AM and 1 PM doses documented as administered at 12:34 PM; on 08/01/2024 the 9 AM and 1 PM doses documented as administered at 12:17 PM; and on 08/07/2024 the 9 AM and 1 PM doses administered at 12:00 PM.</p> <p>Resident #14 had diagnoses which include Dementia, Schizophrenia, generalized anxiety disorder, and history of venous thrombosis and embolism.</p> <p>The Physician Order with original order date of 02/21/2022 and renewed on 08/01/2024 documented an order for Xarelto (Anticoagulant) 10 milligram by mouth to be administered every day at 9 AM for Venous Thrombosis and prevention of blood clot. Review of Resident #14's Medication Administration History Detail report from 07/01/2024 to 08/13/2024 revealed Xarelto (anticoagulant) was not administered per prescriber's order for 24 out of 44 days. On 07/07/2024 the 9 AM (Xarelto for anticoagulation) dose was documented as administered at 1:35 PM; on 07/08/2024 the 9 AM dose was administered at 10:14 AM; on 07/09/2024 the 9 AM dose was administered at 12:24 PM; on 07/16/2024 the 9 AM dose was administered at 11:21 AM; on 07/20/2024 the 9 AM dose was administered at 1:58 PM; on 07/21/2024 the 9 AM dose was administered at 3:32 PM; on 07/22/2024 the 9 AM dose was documented as administered at 10:37 AM; on 07/23/2024 the 9 AM dose was administered at 12:11 PM; 07/24/2024 the 9 AM dose was administered at 12:11AM; on 07/25/2024 the 9 AM dose was documented as administered at 12:04 PM; 07/26/2024 the 9 AM dose was documented as administered at 12:50 PM; on 07/28/2024 the 9 AM dose was administered at 11:11AM; on 07/29/2024 the 9 AM dose was documented as administered at 10:13 AM; on 07/30/2024 the 9 AM dose was documented as administered at 11:00 AM; on 08/01/2024 the 9 AM dose was documented as administered at 1:25 PM; on 08/02/2024 the 9 AM dose was documented as administered at 12:28 PM; on 08/03/2024 the 9 AM dose was documented as administered at 2:34 PM; on 08/04/2024 the 9 AM dose was documented as administered at 2:47 PM; on 08/06/2024 the 9 AM dose was documented as administered at 10:17AM; on 08/07/2024 the 9 AM dose was documented as administered at 10:42 AM; on 08/08/2024 the 9 AM dose was documented as administered at 10:57AM; on 08/12/2024 the 9 AM dose was documented as administered at 11:49 AM; on 08/13/2024 the 9 AM dose was documented as administered at 10:50AM; and on 07/19/2024 there was no documentation that the 9 AM was administered.</p> <p>Resident #19 had diagnoses which include Parkinson, Type II Diabetes, Epilepsy, Dysphagia.</p> <p>The Physician Order with original order date of 07/11/2024 and renewed on 08/01/2024 documented an order for Levetiracetam (Anti-seizure) 100 milligram to administer 10 milliliters orally twice daily at 9 AM and 8 PM. Review of Resident #19's Medication Administration history Detailed Report from 07/01/2024 to 08/13/2024 revealed the medication was not administered per prescriber's order for 22 out of 88 occasions (44 days) including 2 missed doses on 07/19/2024 at 9 AM and 8 PM.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The Physician Order with original order date of 04/13/2024 and renewed on 08/01/2024 documented an order for Novolog Flex Pen U-100 Insulin (Diabetes) Aspart 100unit/ml (3milliliters) inject by subcutaneous route four times daily before meals and at bedtime per sliding scale at 6:00 AM, 11:30 AM, 4:30 PM, 9:00 PM after blood sugar check. Review of Resident #19's Insulin Medication Administration History detailed Report from 07/01/2024 to 08/13/2024 revealed that for 16 days Insulin was administered late beyond the 1 hour timeframe specifically, on 08/03/2024 the resident received 6 AM dose of Insulin at 5:21 AM in response to a blood sugar level of 203 mg/dl, the 11:30 AM insulin dose was not administered until 2:13 PM in response to a blood sugar level of 220 mg/dl, the 4:30 PM dose was administered at 5:14 PM in response to a blood sugar level of 300 mg/dl, the 8 PM dose was administered at 9 PM in response to a blood sugar of 320 mg/dl, on 08/04/2024 the 11:30 AM dose was not documented as administered with notation that blood sugar was not collected, the 4:30 PM dose was administered at 7:22 PM in response to a blood sugar level of blood sugar level of 400 mg/dl. In addition, there was no documented evidence that any scheduled medication and blood sugar check was administered on 07/19/2024.</p> <p>The Physician Order with original order date of 06/14/2024 and renewed on 08/01/2024 documented the following: Carbidopa (Sinemet for Parkinson's) 25 milligram / Levodopa 100 milligram tablet give 1.5 tablet orally four times daily at 6 AM, 10 AM, 2 PM and 6 PM. Review of Resident #19's Medication Administration History Detail Report from 07/01/2024 to 08/13/2024 revealed Carbidopa / Levodopa for Parkinson was not given per prescriber's order for 37 out of 176 occasions (44 days), including missed doses on 07/01/2024 at 2 PM and on 07/19/2024 at 6 AM,10 AM, 2 PM and 6 PM doses, 3 occasions where 2 doses were documented as given at the same time - on 07/07/2024 10 AM and 2 PM doses were documented as administered at 1:10 PM; on 07/21/2024 10 AM and 2 PM doses were documented as administered at 2:26 PM and on 08/01/2024 2 PM and 6 PM doses were documented as administered at 6:34 PM.</p> <p>Resident #24 had diagnoses which include Cerebral Infarction. Heart Disease, Chronic Obstructive Pulmonary Disease, Major Depressive Disorder.</p> <p>The Physician Order with original order date of 02/15/2022 and renewed on 08/07/2024 documented an order for Eliquis (anticoagulant) 2.5 milligram every 12 hours at 9 AM and 9 PM by oral route. Review of Resident #24's Medication Administration History Detail Report from 07/01/2024 to 08/13/2024 revealed the 9 AM and 9 PM doses of Eliquis were not administered per prescriber's order for 18 out of 88 occasions (44 days) including the 9 AM and 9 PM doses missed on 07/19/2024.</p> <p>During an interview on 08/13/2024 at 12:15 PM, the Director of Nursing stated that Licensed Practical Nurse #3 has always been assigned to the Dementia Unit and they were used to passing meds to 40 residents by themselves. They stated, I was surprised the nurse was asking for help this morning. The Director of Nursing stated they were aware that Licensed Practical Nurse #3 and Licensed Practical Nurse #4 completed the 9 AM med pass after 10 AM for at least 20 residents without calling the physician. The Director of Nursing stated that they will have all the residents who received their medications late assessed and have their primary physicians notified. They will also have the social worker interview the residents who are interview able if they have any complaints. The Director of Nursing stated that all residents on the Dementia unit were stable, and no one had any acute issues/concerns.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a follow up interview on 08/14/2024 at 3:30 PM, the Director of Nursing stated that they are responsible for reviewing the dashboard for medication in Sigma (Electronic Medical Record). They do not run a history detailed report to see the time medication are administered. They follow up with the nurses if there is no documentation as administered. The Director of Nursing denied knowledge that facility staff were administering medications significant to residents' health late and was not aware of missed dosages. They stated it is not unreasonable for one medication nurse to pass meds to 40 residents. All nurses are aware of the medication administration policy and know they need to notify the medical provider if the medications are going to be administered late. Agency nurses receive the same training as the facility employed nurses .</p> <p>During interview on 08/14/2024 at around 4:30 PM, the Medical Director stated they only became aware that medications were being administered late on 08/13/2024 and so far, they had monitored the residents on the second and third floor and there were no residents with any acute concerns, no residents were transferred out to the hospital and there has been no discharge to the hospital, or any deaths reported. The Medical Director stated that they will not know for sure if there would be any ill effects to the residents so they will continue to monitor and evaluate all the residents who had their medications administered late on the second floor. At that moment there were no acute conditions reported. The Medical Director stated that in their opinion the following drug classes such as Hypertensives like the Beta Blockers, Antibiotics, Insulin, Psych Meds, and Short Acting medications like Ativan, including Anticoagulants, Anticonvulsants, and some Controlled Pain Medications are time sensitive.</p> <p>During a telephone interview on 08/20/2024 at 4:30 PM, the Pharmacy Consultant stated they have serviced the facility for [AGE] years or more. Medication regimen reviews are completed monthly for existing residents and new admission including medication reconciliation, poly pharmaceutical review and drug interactions. They stated they are not aware of any issues, and if there were issues to be addressed, a report is generated for the facility. The Pharmacy Consultant stated the Medication Administration Record they review is not time stamped with the administration time.</p> <p>10 NYRCC 415.12(m)(2)</p>		

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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have a plan that describes the process for conducting QAPI and QAA activities.</p> <p>39070</p> <p>Based on record review and interviews conducted during an abbreviated survey (NY00349142), the facility did not ensure that the Quality Assessment and Assurance (QAA) Committee developed and implemented appropriate plans of action to correct identified quality deficiencies and regularly review, analyzed, and act on available data to make improvements and to ensure improvements are sustained. Specifically, 1) On 06/28/2024 the facility received feedback from Bureau of Narcotics representative regarding facility staff not administering medications according to prescriber's order; 2) a complaint from the facility's Resident Council indicated residents received their medications late on 07/20/2024 and 07/21/2024, the facility did not conduct a thorough investigation, and/or audit the medication administration practice in the facility; 3) during an observation on 08/13/2024 on the Second Floor Dementia Unit and further record review from 07/01/2024 to 08/13/2024 revealed that 23 Residents did not receive significant medications including but not limited to Antianxiety, Antidiabetic (Insulin), Anticoagulant, Antihypertensive, Antipsychotic, Anti-Parkinson's and Antiseizure according to prescriber's order.</p> <p>The findings are:</p> <p>The undated facility policy titled Quality Assurance and Performance and Performance Improvement (QAPI) Program documented that the facility believes in the importance of quality assurance and performance improvement to deliver the best care and service to their residents. The facility Performance Improvement Plans (PIPs) will identify opportunities for improvements and the following areas will be routinely evaluated by the committee: Resident Council, Infections, Falls, Safety, Medication Errors, Rehospitalization Rates, Pressure Ulcers, Weight Loss, Abuse, Neglect, Mistreatment, Exploitation Reports, Complaints, Quality Indicators/measures, and other issues of concern.</p> <p>Review of the Quality Assurance and Performance and Performance Improvement (QAPI) Meeting Agenda for the month of June 2024 held on 06/27/2024 revealed no discussion specific to late medication administration.</p> <p>Review of the Quality Assurance and Performance and Performance Improvement (QAPI) Meeting Agenda for the month of July 2024 held on 08/06/2024 revealed no discussion specific to late medication administration.</p> <p>Review of the Resident Council Meeting Minutes dated 07/22/2024 revealed that the residents complained that they are not receiving their medication on time and this was causing them not be able to attend activity programs.</p> <p>A Facility Grievance Reporting and Response Form dated 07/24/2024 documented that the Director of Nursing was made aware the Resident Council complained about late set ups and medications due to staffing issues. The Investigative findings documented that there were enough staff scheduled on 07/20/2024 and 07/21/2024; however, multiple call outs occurred. The Director of Nursing met up with Resident #40, the Resident Council [NAME] President who was upset about the staffing, late set up and late medications.</p> <p>(continued on next page)</p>		

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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During the Entrance Conference on 08/12/2024 at 10:30 AM, the Administrator and Director of Nursing were informed by the surveyor that they are working on confidential cases that are both related to medication administration. The surveyor asked if there have been any Resident/Resident Representative complaints / grievances / incidents related to medication from 06/01/2024 to present; 2) Whether there was Staff write ups / counselling for medication error; 3) Any Resident Council meeting discussion / complaints for June, July, and August 2024 regarding medication issues / concerns? Both the Administrator and Director of Nursing stated there was none to all the questions.</p> <p>During a telephone interview on 08/30/2024 at 2:52 PM, the Administrator stated that they review and update their Quality Assurance and Improvement Program (QAPI) Plan annually and as needed. The Administrator stated that they were not able to relate the medication administration issues with the narcotic issues when asked during the entrance conference on 08/12/2024. The Administrator stated that whatever feedback or discussion they had with the representative from Bureau of Narcotic was only related to narcotics diversion where a nurse was signing out narcotics and had nothing to do with medications being administered late. The Administrator stated that they are now aware that staff have not been notifying the attending physicians when medications were administered late until the onsite visit on 08/12/2024. The Administrator stated that staffing has been an issue. Staffing was a challenge even before COVID and the facility had actively use agency staff and they continue to actively recruit new staff. The Administrator stated they will be working with the physicians to come up with a solution. The Administrator stated that they are very aware of the seriousness of the late medication administration, and they had been addressing the situation now such as the collaboration with the physicians on changing medication times and re-educating all their staff regarding the importance of timely medication administration.</p> <p>10NYRCC 415.27</p>		