STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335399	A. Building B. Wing	07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hudson Valley Rehabilitation & Extended Care Ctr	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)
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. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews during an abbreviated survey (NY00369602), the facility did not ensure the residents right to a dignified existence or to be treated with respect and care in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for 1 out of 7 residents (Resident #5) reviewed for dignity. Specifically, (1) Resident #5 was video recorded by Certified Nurse Aide #3 and Certified Nurse Aide #4 while cleaning their briefs in the sink. Certified Nurse Aide #3 then posted the video on social media (Tik Tok). Certified Nurse Aide #3 was terminated by the facility for violating abuse policy.The findings are:The facilities undated Resident Dignity policy documented the purpose is to ensure that all residents in the facility are treated with dignity and respect in every aspect of their care. All staff must recognize and uphold each resident's right to dignity, regardless of physical or cognitive ability. This includes respecting privacy during personal care and protecting from abuse, neglect, or demeaning behavior from others.Resident #5 was admitted with diagnoses including Dementia, Cerebral Infarction and Peripheral Vascular disease. An Annual Minimum Data Set, dated [DATE] documented Resident #5 had moderate cognitive impairment, and no behaviors noted. The resident required a wheelchair for locomotion. Resident #5 required set up assistance for eating or cleanup for eating, bed mobility and transfer, supervision for toileting, hygiene and bathing. Review of a behavior/victimization care plan initiated 5/6/2025 documented Resident #5 was at risk for victimization due to Dementia diagnosis and poor safety awareness. Interventions listed included assess for underlying factors impacting mood, monitor for anxiety, hostility and aggression, social services referral as need and protect from injury, abuse, neglect and maltreatment.The 1/26/2025 Nursing Home Investigative Report documented Resident #5 was videotaped by staff at the facility. Employee Statements dated 1/20/2025 to 1/23/2025 documented Certified Nurse Aides were involved in recording Resident #5 while they were washing their briefs at the sink and posted it on Tik Tok. Statements further documented that Certified Nurse Aide # 3 used their Tik Tok account to post the video of Resident #5. During an interview on 6/18/2025 at 3:10 PM, the Administrator stated they had the video of the incident that occurred on 1/18/2025 with Resident #5 saved in their cellphone, but they can no longer locate the video. The Administrator stated they only have a portion of the recording and can see that Resident #5 was at the sink. On the video, the resident could be seen from below the neck washing out their underwear.During an interview on 6/26/2025 at 2:25 PM, Certified Nurse Aide #8 stated they received a call at home from Certified Nurse Aide #9 telling them to go on Certified Nurse Aide #3's page on Instagram to watch a video of them mocking Resident #5 while they washed their pull up. Certified Nurse #8 stated in the video on Instagram you can hear Certified Nurse Aide #3 saying to Resident #5 why are you washing your pull up in the sink and there were also two other voices on the recording. Certified Nurse Aide #8 stated they did watch the video on Instagram, and they were appalled and the next day when they came into work, they reported it and showed the Administrator and the Director of Nursing #2 the video. Certified Nurse Aide #8 stated they were requested to write a statement regarding the incident.During an interview on 6/26/2025 at 2:55 PM, Certified Nurse Aide #9 stated they were not in the facility when the incident occurred on 1/18/2025. Certified Nurse Aide #9 stated their daughter was on Tik Tok at home and told them a resident from their job was on Tik Tok and showed them the video. Certified Nurse Aide #9 stated they were unable to access the video on Tik Tok, so they watched the video on their daughter's device and saw that it was Resident #5. Certified Nurse Aide #9 stated they called Certified Nurse Aide #8 and informed them of what their daughter had showed them and asked if they could check if they could access the video, and Certified Nurse Aide #8 was able to see it. Certified Nurse Aide #9 stated the next day when they arrived to work, they went to the Administrator and showed them the video, and after they showed the Administrator the video they were instructed to delete the videos from their device. 10 NYCRR 415.5(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews during an abbreviated survey (NY00369540, NY00369602), the facility did not ensure residents right to be free from abuse for 2 of 7 residents (Resident #2, Resident #5) reviewed for abuse. Specifically, (1) on 1/19/2025 Resident #2 was involuntarily secluded in their room by Certified Nurse Aide #7 for approximately three hours. Certified Nurse Aide #7 placed wash cloth wipes wedged in the corner of the resident's door preventing them from exiting the room. During a rounding of resident rooms Resident #2 was found by Housekeeper #2 and House Keeping Lead in their room with a puddle of urine on the floor and feces all over the room. Resident #2 was unclothed and had a pair of pants in their which they pulled up over their chest. Resident #2 was cleaned up by Certified Nurse Aide #6 and brought to the day room after the incident. (2) On 1/18/2025 Resident #5 was video recorded by Certified Nurse Aide #3 and Certified Nurse Aide #4 while washing their incontinence brief in the sink in their room The video was posted on Certified Nurse Aide #3's .social media platform. The incidents were not reported by facility staff immediately to the administration, there was no documented evidence that Resident #2 and Resident #5 were assessed by the Registered Nurse, Physician or the Nurse Practitioner after the incidents occurred. The incidents were not reported to local law enforcement.The findings are:The facility Abuse policy last revised 1/20/2025 documented it is the policy that all residents will be protected and free from any types of abuse, neglect and mistreatment. The policy defines abuse as unreasonable confinement with resulting mental anguish and treating a resident in any manner that does not uphold a resident's sense of self-worth and individuality dehumanizes the resident and creates an environment that perpetuates a disrespectful or potentially abusive attitude towards the resident (s).The facility Abuse Prohibition Specific to Mental Abuse related to photographs, audio video recordings and unauthorized use of social media policy last revised 1/21/2024 documented residents in the facility have the right to be free from all types of abuse, including mental abuse. Mental abuse includes but is not limited to abuse that is facilitated or caused by our facility staff taking or using photographs or recordings in any manner that demean or humiliate a resident. 1) Resident #2 was admitted with diagnoses including but not limited to Alzheimer's disease, Parkinsonism and Bipolar disorder.A Quarterly Minimum Data Set, dated [DATE] documented Resident #2 had severe cognitive impairment. The resident required moderate assistance with eating, maximal assistance with toileting, set up assistance with bed mobility and supervision with transfers.Review of a behavior/victimization care plan initiated 8/14/2024 documented Resident #2 was at risk for victimization due to wandering, being socially inappropriate and verbally disruptive. Interventions listed included monitor for anxiety, hostility and aggression, protect from injury, abuse and maltreatment. Review of the facility investigative summary dated 1/19/2025 documented it was brought to the Administrators attention on 1/20/2025 that Resident #2 was allegedly barricaded in their room. The summary documented that during the afternoon cleaning resident rooms, Housekeeper #2 noticed they could not open the door to Resident #2's room and called the Housekeeping: Lead to assist. Upon arrival the Housekeeping Lead saw washcloth wipes stuffed in the corner Resident #2's room outside the door. The washcloth wipes were removed, and Resident #2 was found inside the room sitting in a chair watching television calmly. The Housekeeping Lead stated they saw Resident #2 was incontinent and they went and got the assigned Certified Nurse Aide who provided cares to the resident and brought the resident to the dayroom around change of shift. After the video footage was reviewed by the Administrator the perpetrator was identified as Certified Nurse Aide #7. Certified Nurse Aide #7 was seen with Resident #2 walking towards the double doors by the elevator after lunch. Certified Nurse Aide #7 brought the resident back to their room. While walking pass the nurse's station Certified Nurse Aide #7 grabbed a few washcloths wipes, took Resident #2 to their room and a few moments later was seen shutting the door and placing the cloths in the corner of the door and frame. Certified Nurse Aide #7 continued their work and did not alert anyone. Facility Incident report included a written statement by the Housekeeping Lead which documented that Resident #2 was found in the room with a puddle of urine on the floor and feces all over the room. Resident #2 was unclothed and had a pair of pants in their hands which they pulled up over her chest. Certified Nurse Aide #7 was interviewed by the Director of Nursing #2 and the Administrator on 1/21/2025 when they returned to work. Certified Nurse Aide #7 did not deny placing the cloth in the door of Resident #2's room but stated angrily that they were trained that way. Certified Nurse Aide #7 was terminated for abuse and neglect There was no documented evidence of Resident #2 being

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0603 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0603 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews during an abbreviated survey (NY00383624, NY00369540) the facility failed to ensure a resident's right to be free from involuntary seclusion for one (1) (Resident #2) out of six (6) residents reviewed for seclusion. Specifically, on 01/19/2025, Certified Nurse Aide #7 was observed on surveillance video following Resident #2 down the hallway to their room, closing the door and placing disposable washcloths in the corner of the door to prevent the resident from easily opening the door and exiting the room. This occurred at approximately 12:25 PM and was not discovered until 2:55 PM by the Housekeeper Lead and Housekeeper #2. Resident #2 who was assessed as requiring maximal assistance (helper does more than half the effort, helper lifts or holds trunk or limbs and provides more than half the effort) with toileting, was found naked, with urine and feces observed on floor. According to the Housekeeping Lead, resident #2 was observed to be anxious to exit the room as evidenced by the resident quickly getting up from the chair they were in and running out of the room once the door was opened. Applying the reasonable person concept, this resulted in psychosocial harm for Resident #2 that was not immediate jeopardy. The findings are:The facility Abuse policy last revised 11/21/2024 documented it is the policy that all residents will be protected and free from any types of abuse, neglect and mistreatment. The policy defines abuse as the unreasonable confinement with resulting mental anguish. Resident #2 was admitted to the facility on [DATE] with diagnoses including but not limited to Alzheimer's disease, Parkinsonism (brain conditions that cause slowed movements, stiffness, and tremors), and bipolar disorder (episodes of mood swings ranging from depressive lows to manic highs).A Quarterly Minimum Data Set (a resident assessment tool) dated 01/08/2025 documented Resident #2 had moderately impaired cognitive status. The resident required set-up assistance with eating, maximal assistance (helper does more than half the effort, helper lifts or holds trunk or limbs and provides more than half the effort) with toileting.)Review of a behavior/victimization care plan initiated 08/14/2024 documented Resident #2 was at risk for victimization due to wandering, being socially inappropriate and verbally disruptive. Interventions listed included: monitor for anxiety, hostility and aggression, protect from injury, abuse and maltreatment. Review of the undated facility investigative summary included written statements from the Housekeeping Lead, Housekeeper #2, Director of Housekeeping, Licensed Practical Nurse's #2, and #5, and Certified Nurse Assistant #6. The report also documented interviews of Certified Nurse Aide #7 by the Director of Nursing #2 and the Administrator. The summary documented that Resident #2 was alleged to have been barricaded in their room on 01/19/2025. Housekeeper #2 reported that during cleaning rounds they attempted to enter Resident #2's room, but the door wouldn't open. Housekeeper #2 called their supervisor to assist. The Housekeeping Lead stated that upon arrival to the room they saw a disposable washcloth stuffed in the corner of the door. They removed it and saw Resident #2 sitting in a chair watching television calmly. The Housekeeping Lead saw that Resident #2 had been incontinent, so they got Certified Nurse Aide #6 who went to the room and provided care. The surveillance video footage was reviewed by the Administrator and the perpetrator was identified as Certified Nurse Aide #7. According to the Administrator's report, the video surveillance revealed that Certified Nurse Aide #7 saw Resident #2 walking towards the double doors by the elevator after lunch. While passing the nurse's station, Certified Nurse Aide #7 grabbed a few washcloths, took Resident #2 to their room and a few moments later was seen shutting the door and placing the washcloths in the corner of the door and frame. Certified Nurse Aide #7 then continued their work and did not alert anyone. The report documented that Director of Nursing #2, and the Administrator interviewed Certified Nurse Aide #7 upon their return to work on 01/21/2025. Certified Nurse Aide #7 did not deny placing the washcloths in the doorframe of Resident #2's room and stated they were trained that way. Certified Nurse Aide #7 was terminated for abuse and neglect.Review of Housekeeper Lead written statement attached to the facility investigative report documented the resident was found in the room with a puddle of urine on the floor and feces all over the room. The resident was unclothed except for a pair of pants which they pulled up over their chest.There was no documented evidence of a Physician's order for seclusion during the onsite survey on 06/17/2025.During an Interview on 06/20/2025 with the Administrator, they stated they spoke to the Director of Housekeeper concerning timely reporting of incidents. Housekeeping staff were retrained on timely reporting and Abuse. During an interview on 06/26/2025 at 1:15 PM, the Housekeeper Lead stated they remembered the incident that occurred with Resident #2, and it occurred on a weekend, at approximately 3:00 PM or 3:15 PM, right

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Hudson Valley Rehabilitation & Extended Care Ctr	260 Vineyard Ave, Rt 44/55 Highland, NY 12528

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews during an abbreviated survey (NY00369540, NY00369602), the facility did not ensure a reasonable suspicion of a crime against a resident was reported to law enforcement or an allegation involving abuse was reported immediately, but no later than two hours after the allegation is made if the events that cause the allegation involve abuse for 2 out of 6 residents (Resident #2, Resident #5) reviewed for abuse. Specifically, (1) on 1/19/2025 Resident #2 was barricaded in their room by Certified Nurse Aide #7 by placing wash cloth wipes in their door frame preventing the resident from exiting. Resident #2 was found by the Housekeeping Lead and Housekeeper #2 after getting the door opened. The facility Administrator was not informed of the incident until 1/20/2025, the incident was reported to the New York State Department of Health on 1/27/2025, and the incident was never reported to local law enforcement; (2) Resident #5 was video recorded by Certified Nurse Aide #3 and Certified Nurse Aide #4 washing their brief in the sink on 1/18/2025. Certified Nurse Aide #3 posted the video on their social media platform Tik Tok. The facility Administrator was not made aware of the incident until 1/21/2025, the incident was reported to the New York State Department of Health on 01/26/2025, and the incident was never reported to local law enforcement. The findings are:The facility Abuse policy last revised 1/20/2025 documented it is the policy that all residents will be protected and free from any types of abuse, neglect and mistreatment. Staff are expected to report any action of abuse to the charge nurse or supervisor. Each employee is responsible and obligated to report to Administration or the Director of Nursing immediately, within one hour, of any incidents of abuse. 1) Resident #2 was admitted with diagnoses including but not limited to Alzheimer's disease, Parkinsonism and Bipolar disorder.A Quarterly Minimum Data Set, dated [DATE] documented Resident #2 had severe cognitive impairment. The resident required moderate assistance with eating, maximal assistance with toileting, set up assistance with bed mobility and supervision with transfers.Review of the facility investigative summary dated 1/19/2025 documented it was brought to the Administrators attention on 1/20/2025 that Resident #2 was allegedly barricaded in their room. The summary revealed that during the afternoon cleaning of resident rooms, the housekeeper noticed they could not open the door to Resident #2's room and called their supervisor to assist. Upon arrival the Housekeeping Lead saw washcloth wipes stuffed in the corner of the door. The Housekeeping Lead removed the washcloth wipes and Resident #2 was found inside the room sitting on a chair. The Housekeeping Lead stated Resident #2 was incontinent and they went and got the assigned Certified Nurse Aide who provided cares to the resident and brought the resident to the dayroom around change of shift. After the video footage was reviewed by the Administrator, the perpetrator was identified as Certified Nurse Aide #7. Certified Nurse Aide #7 saw Resident #2 walking towards the double doors by the elevator after lunch, and is seen bringing the resident back to their room. While walking pass the nurse's station Certified Nurse Aide #7 grabbed a few washcloth wipes. Certified Nurse Aide #7 took Resident #2 to their room and a few moments later was seen shutting the door and placing the cloths in the corner of the door and frame. Certified Nurse Aide #7 then continued their work and did not alert anyone. The Administrator was not made aware of the incident until 1/20/2025.There was no documented evidence of the incident being reported to local law enforcement. The incident was not reported to New York State Department of Health until 1/27/2025.2) Resident #5 was admitted with diagnoses including Dementia, Cerebral Infarction and Peripheral Vascular disease. An Annual Minimum Data Set, dated [DATE] documented Resident #5 had moderate cognitive impairment, and no behaviors noted. The resident required a wheelchair for locomotion Resident #5 required set up assistance for eating or cleanup for eating, bed mobility and transfer, supervision for toileting, hygiene and bathing. The 1/26/2025 Nursing Home Investigative Report documented Resident #5 was videotaped by Facility staff on 1/18/2025. Employee Statements dated 1/20/2025 to 1/23/2025 documented 3 Certified Nurse Aides were involved in the recording of Resident #5 while they were washing their briefs at the sink. The video recording was posted it on Tik Tok (social media). Statements further documented that Certified Nurse Aide # 3 used their Tik Tok account to post the video of Resident #5. Certified Nurse Aide #3, #4, and #5 were present while resident was washing their briefs. Certified Nurse Aide #4 stated they were present during cares but was unaware Resident #5 was being videotaped while washing their briefs. The Director of Nursing met with Certified Nurse Aide #3 after the incident was reported to them on 1/20/2025 that staff recorded Resident #5 and posted a video on Tik Tok. The Director of Nursing and Administrator reviewed the video and immediately

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview during an abbreviated survey (NY00369540) the facility did not ensure in response to allegations of abuse that all alleged violations are thoroughly investigated for 1 out of 7 residents (Resident #2) reviewed for abuse. Specifically, on 1/19/2025 Resident #2 was barricaded in their room by Certified Nurse Aide #7 by stuffing wash cloth wipes in the door of their room preventing the door from opening. There was no documented evidence of Resident #2 being assessed for injury after the incident and statements were not obtained from all staff on duty at the time of the incident. There was also no available video footage to review for the incident that occurred on 1/19/2025. The findings are:The facility Abuse policy last revised 1/20/2025 1) Resident #2 admitted to the facility on [DATE] with diagnoses including but not limited to Alzheimer's disease, Parkinsonism and Bipolar disorder.A Quarterly Minimum Data Set, dated [DATE] documented Resident #2 had severe cognitive impairment. The resident required moderate assistance with eating, maximal assistance with toileting, set up assistance with bed mobility and supervision with transfers.Review of a behavior/victimization care plan initiated 8/14/2024 documented Resident #2 was at risk for victimization due to wandering, being socially inappropriate and verbally disruptive. Interventions listed included monitor for anxiety, hostility and aggression, protect from injury, abuse and maltreatment. Review of the facility investigative summary dated 1/19/2025 documented it was brought to the Administrators attention on 1/20/2025 that Resident #2 was allegedly barricaded in their room. The summary documented that during the afternoon cleaning resident rooms, Housekeeper #2 noticed they could not open the door to Resident #2's room and called the Housekeeping: Lead to assist. Upon arrival the Housekeeping Lead saw washcloth wipes stuffed in the corner Resident #2's room outside the door. The washcloth wipes were removed, and Resident #2 was found inside the room sitting in a chair watching television calmly. The Housekeeping Lead stated they saw Resident #2 was incontinent and they went and got the assigned Certified Nurse Aide who provided cares to the resident and brought the resident to the dayroom around change of shift. After the video footage was reviewed by the Administrator the perpetrator was identified as Certified Nurse Aide #7. Certified Nurse Aide #7 was seen with Resident #2 walking towards the double doors by the elevator after lunch. Certified Nurse Aide #7 brought the resident back to their room. While walking pass the nurse's station Certified Nurse Aide #7 grabbed a few washcloths wipes, took Resident #2 to their room and a few moments later was seen shutting the door and placing the cloths in the corner of the door and frame. Certified Nurse Aide #7 continued their work and did not alert anyone.There was no documented evidence of Resident #2 being assessed by the Registered Nurse, Physician, or the Nurse Practitioner after the incident that occurred on 1/19/2025.The facility did not provide documented evidence from all staff on the unit on 1/19/2025. During an interview on 6/20/2025 at 3:16 PM the Administrator stated Resident #2 was on the 2 East unit and they did not interview all the staff on the unit, because when they reviewed the video footage there was no nurse in the hallway. The Administrator stated they were able to eyeball each hall and the nurse's desks on the video footage as this helps to determine who needs to be interviewed. The Administrator stated it is not their policy to interview all the staff that were on the unit at the time of an incident. Prior to installing cameras in the facility, they used to interview all staff. The Administrator stated the surveillance video for the incidents that occurred in the facility were not available for review by the surveyors as they do not always save the tape. The Administrator stated they do not think they are required to hold on to the video footage. The video footage is used by the facility to identify the staff involved in the incidents. The Administrator stated they know how to work the videos, but they did not know how to copy the footage and so it was not saved. The Administrator stated they can attest that they reviewed the video footage. 10 NYCRR 483.12(c)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews during an abbreviated survey (NY00383624) the facility did not ensure assessments accurately reflected the resident's status for 2 out of 3 residents (Resident #2, Resident #4) reviewed for assessments. Specifically, Resident #2 was a known wanderer and always has a wander guard in place. The quarterly Minimum Data Set assessment dated [DATE] (under section E) did not document the resident had wandering behavior. (2) Resident #4's was care planned as having a known behavior of rejecting medications and cares. Known to the facility staff as rejecting medication and cares. The Comprehensive Minimum Data Set, dated [DATE] did not accurately reflect the resident's behavior.The Findings are:The facility Completion of the RAI/MDS Process policy last revised 5/25 documented it is the policy of the facility to assure that all residents achieve their highest level of functioning possible and maintain their sense of individuality. Assessments will be completed within the guidelines outlines in the Resident Assessment Instrument Manual and include the CAA and care planning processes to lead to the development of a plan of care to address and monitor each resident's needs and function, and to track changes in the resident's status. 1)Resident #2 admitted to the facility on [DATE] with diagnoses including but not limited to Alzheimer's disease, Parkinsonism and Bipolar disorder. A Quarterly Minimum Data Set, dated [DATE] documented Resident #2 had severe cognitive impairment. Resident #2 did not have wandering behavior. The resident required moderate assistance with eating, maximal assistance with toileting, set up assistance with bed mobility and supervision with transfers. Review of a behavior care plan initiated 7/17/2024 documented Resident #2 exhibited wandering behavior as evidenced by having no purposeful destination. Interventions listed included identify pattern of behavior, document in progress notes the intensity, frequency and duration of behavior and redirect negative behaviors.2) Resident #4 admitted to the facility on [DATE] with diagnoses including but not limited to Peripheral Vascular Disease, Diabetes Mellitus and Delusional disorder. A Comprehensive Minimum Data Set, dated [DATE] documented Resident #4 was cognitively intact with no behaviors noted. The resident had impairment to the lower extremities on both sides and was bedridden. Resident #4 required set up assistance with eating, moderate assistance with bed mobility and dependent for toileting. Facility Behavior care plan last revised 3/22/2024 documented that Resident #4 resists care as evidence by his long-standing history of been non-compliant. Refuses to follow MD orders, refusal of all medications and refuses to have staff perform wound care at times and interventions listed included document frequency of behavior and redirect negative behaviors and notify physician. Of behaviors. The Minimum Data Set assessment completed on 3/20/2025 did not reflect Resident #4's rejection of care behavior.Review of Resident #4's progress noted dated 3/13/2025 and 3/20/2025 revealed the resident had refused their medications. During an interview on 6/25/2025 at 2:30 PM the Minimum Data Set Coordinator stated Resident #2 not being coded as a wander was probably and error on their part as they were still learning. The Minimum Data Set Coordinator stated Resident #2 does wear a wander guard, does wander on the unit and has the potential to wander. The Minimum Data Set Coordinator stated they were just learning the books and thought this did not include when Resident #2 was wandering on the unit and that it only applied to a resident leaving their unit. The Minimum Data Set Coordinator stated they were informed if a resident is care planned for a behavior, then this does not need to be captured in their Minimum Data Set, but if they are wrong or misinterpreted this information, then they will correct this. The Minimum Data Set Coordinator stated when Resident #4's Minimum Data Set was completed 3/20/2025, with the seven day look back period, the resident had not had any outbursts, so this is why this was not coded in the Minimum Data Set. 10 NYCRR 415.11(b)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview during an abbreviated survey (NY00318055, NY00383624) the facility did not ensure that residents receive treatment and care in accordance with professional standards of practice for 2 out of 3 residents (Resident #3, Resident #6) reviewed for quality of care. Specifically, (1) Resident #3 had a wound care treatment ordered for their left below the knee area to be completed daily. Review of Resident #3's treatment administration record for March 2025 revealed their treatment was not signed as completed by the Licensed Practical Nurse on 3/9/2025, 3/11/2025, 3/16/2025. (2) Resident #6 had a known history of constipation and a history of small bowel obstruction in 2020. Review of Resident #6's certified nurse aide accountability revealed direct care staff did not consistently document the resident's bowel movement activity, the February 2025 documentation had certified nurse aide signature omissions on 25 occasions and March 2025 on 19 occasions. The findings are:The facility Certified Nurse Aide Electronic Medical Record Documentation policy initiated 10/5/2022 documented the purpose is to ensure accurate, timely and compliant documentation by the certified nurse aides in electronic medical records, supporting high-quality resident care. Certified Nurse Aides will adhere to timeliness, accuracy and completeness. Once documentation is completed.1)Resident #3 was admitted with diagnoses including but not limited to Dementia, Multiple Sclerosis and Peripheral Artery disease.A significant Change Minimum Data Set, dated [DATE] documented Resident #3 had severe cognitive impairment. The resident had impairment on both sides to the upper and lower extremities and was bedridden. The resident required maximal assistance with eating and was dependent for toileting and bed mobility.Review of a skin integrity care plan last revised 3/20/2025 documented Resident #3's plan of care was revised due to newly noted wounds to the left dorsal foot and lateral below the knee area, arterial/venous ulcers as well as overall decline in condition. Plan of care revised ongoing and appropriate.Review of a Physician's order dated 3/6/2025 documented Santyl 250 unit/gram topical ointment apply by topical route once daily for 30 days. Cleanse left lateral below knee area with normal saline apply topical cream to area and cover with silicone dressing daily.Review of Resident #3's treatment administration record for March 2025 revealed the resident's treatment was not signed as being completed on the following days: 3/9/2025, 3/11/2025, 3/16/2025.There was no documented progress note regarding the treatment not being completed and the Physician being notified.During a telephone interview on 7/23/2025 at 10:15 AM Licensed Practical Nurse #7 stated they do not recall, not signing for completion of Resident #3's treatment to their left lateral below the knee area on 3/9/2025. Licensed Practical Nurse #7 stated they complete all their treatments, but they probably forgot to click off in the electronic medical record. Licensed Practical Nurse #7 stated an empty box without a signature on the treatment administration record could mean that they did not do the treatment, or they forgot to click off the task in the electronic medical record. Call placed to Licensed Practical Nurse #10 on 7/23/2025 at 10:20 AM-no answer, voicemail left.Call placed to Licensed Practical Nurse #11 on 7/23/2025 at 10:22 AM-no answer, voicemail full/unavailable. 2)Resident #6 admitted with diagnoses including but not limited to Schizophrenia, Dysphagia and Constipation. An admission Minimum Data Set, dated [DATE] documented Resident #6 had severe cognitive impairment. The resident required a walker for locomotion and supervision for eating, maximal assistance with toileting and moderate assistance with bed mobility and transfers. The resident was always incontinent of bladder and bowel. Review of a bowel evacuation and maintenance care plan last reviewed 1/22/2025 documented Resident #6 was at high risk for constipation and had a history of constipation. Interventions listed included monitor for signs and symptoms of constipation, bowel movement and monitoring to be updated and reviewed every shift and bowel elimination record to be completed by the certified nurse aide every shift. Review of Resident #6's certified nurse aide accountability for February 2025 revealed direct care staff did not consistently document if the resident had a bowel movement. There was no documentation noted on the Certified Nurse Accountability in February as follows: 7 AM to 3 PM shift twelve occasions, 3 PM to 11 PM shift six occasions, 11 AM to 7 AM shift five occasions.Review of Resident #6's certified nurse aide accountability for March 2025 revealed direct care staff did not consistently document if the resident had a bowel movement. There was omissions noted on the Certified Nurse Accountability sheet as follows: 7 AM to 3 PM shift nine occasions, 3 PM to 11 PM shift five occasions, 11 AM to 7 AM shift four occasions.During an interview on 7/3/2025 at 12:12 PM Certified Nurse Aide #10 stated when residents have a bowel movement it is logged in Sigma (the electronic medical record), in the toileting section and this is the only

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews during an abbreviated survey (NY00383624), the facility did not ensure residents were free from medication errors and accepted professional standards and principles which apply to professionals providing services for 1 out of 3 residents (Resident #3) reviewed for medications. Specifically, Resident #3 was prescribed some narcotic pain medication (Morphine-medication used to help relieve severe pain) to be administered (while on comfort care) at the following scheduled times: 12 AM, 9 AM and 7 PM. Review of Resident #3's administration record for April 2025 and May 2025 revealed the standing doses were not administered within regulated times of one hour before or one hour after scheduled time. There was also no documented evidence of Resident #3 receiving three standing doses of their narcotic pain medication on 5/4/2025 and 5/9/2025 when they were on comfort care. There was pain assessment documented and there was no documentation that the physician was notified of the omission or why the medication was administered late. The findings are:The facility Medication Administration policy last revised 8/13/2024 documented 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. The facility is responsible for meeting the health service needs including medication-related services of the residents. Medications will be administered to residents as prescribed in a manner consistent with good standards of practice. The six rights of medication will be observed; right time-check the frequency of the ordered medications and confirm when the last dose was given (pay attention to the as needed medications). Medications are administered within one hour before or one hour after scheduled time. Unless otherwise specified by prescriber, routine medications are administered according to the established medication administration schedule for the facility.Resident #3 was admitted with diagnoses including but not limited to Dementia, Multiple Sclerosis and Peripheral Artery disease.A Significant Change Minimum Data Set, dated [DATE] documented Resident #3 had severe cognitive impairment. The resident had impairment on both sides to the upper and lower extremities and was bedridden. The resident required maximal assistance with eating and was dependent for toileting and bed mobility.A Physician's progress note dated 4/21/2025 documented Resident #3 had a history of Multiple Sclerosis with bilateral lower extremity contractures and was on comfort care with standing orders for Morphine and as needed. Review of a Physician's order dated 4/24/2024 documented Morphine (medication used to help relieve severe pain) concentrate 100 mg/5 ml (20 mg/ml) oral solution- give 5 milligrams (0.25 ml) by oral route three times per day and as needed every four hours. Maximum Daily Dose: 30 milligrams. Every day at 12 AM, 7 PM and 9 AM.Review of Resident #3's Medication Administration Records for May 2025 revealed the 5/3/2025 12 AM dose was given at 3:42 AM; the 5/4/2025 9 AM dose was given at 11:53 AM; the 5/4/2025 7 PM dose was given at 12:35 AM; the 5/6/2025 7 PM dose was given at 8:52 PM; the 5/9/2025 7 PM dose was given at 9 PM; the 5/11/2025 12 AM dose was given at 1:57 AM; the 5/13/205 12 AM dose was given at 2:14 AM; the 5/16/2025 9 AM dose was given at 11:32 AM; the 5/17/2024 9 AM dose was given at 6:14 PM; 5/19/2025 7 PM dose was given at 5:20 PM.Review of Resident #3's Medication Administration Records for April 2025 revealed the 4/7/2025 7 PM dose was given at 9:09 PM; 4/11/2025 7 PM dose was given at 11:09 PM. Review of Resident #3's Narcotic Log Sheet revealed the 3/28/2025 9 am dose was not signed out but was administered at 10:30 AM; the 3/29/2025 9 am dose was not signed out but was administered at 11:41 AM; the 3/30/2025 9 am dose was not signed out but was administered at 12:03 PM; the 5/4/2025 12 AM dose was not signed out as given; the 5/9/2025 7 PM dose was signed out at 10 PM. During an interview on 6/23/2025 at 2:20 PM, the Director of Nursing stated the standing orders and the as needed orders for narcotics are logged on the same narcotic sheet because they the Physicians are writing the script out on the same order with the separate medication timings on it. The Director of Nursing stated the narcotics should be administered one hour before or one hour after the scheduled administration times as like any other medication. During an interview on 7/8/2025 at 2:50 PM, Licensed Practical Nurse #4 stated they have the heaviest med pass on the third floor in the facility and when they are alone on the unit they can be done with the medication administration within two hours per side of the unit. Licensed Practical Nurse #4 stated if a medication is administered to a resident late then the Physician is notified, and a progress note is written. During a telephone interview on 7/22/2025 at 11:18 AM, Licensed Practical Nurse #9 stated they gave Resident #3 their standing dose of Morphine on 3/28/2025 and 3/29/2025. Licensed Practical Nurse #9

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on record review and interview during an abbreviated survey (NY00369540, NY00369602), the facility did not ensure the Quality Assurance and Performance Improvement committee developed and implemented appropriate plans of action to correct identified quality of care deficiencies. Specifically, there was no documented evidence of the Quality Assurance and Performance Improvement committee convening to discuss, develop and prioritize actionable plans for the reportable incidents that occurred on 1/18/2025 and 1/19/2025. On 1/18/2025 Resident #5 was videorecorded by staff; the recording was posted on social media by Certified Nurse Aide #3. On 1/19/2025 Resident #2 was barricaded in their room by Certified Nurse Aide #7, the resident was found in their room by Housekeeper #2 and the Housekeeper lead approximately three hours later.The findings are:The facility Quality Assurance and Performance Improvement policy last revised 10/7/2024 documented the purpose is to promote high-quality care and ensure compliance with federal and state regulations through continuous quality improvement. The objectives listed included to enhance resident safety and quality of care, to identify and address performance issues proactively and to engage staff, residents, and families and other stakeholders in the improvement process.Resident #2 was admitted with diagnoses including but not limited to Alzheimer's disease, Parkinsonism and Bipolar Disorder.Review of the facility investigative summary dated on 1/19/2025 documented it was brought to the Administrators attention that Resident #2 was alleged to have been barricaded in their room. The video footage was reviewed by the Administrator and the perpetrator was identified as Certified Nurse Aide #7. Resident #2 is seen walking towards the double doors by the elevator after lunch certified nurse Aide #7 brought the resident back to their room. While walking pass the nurse's station Certified Nurse Aide #7 grabbed a few washcloths wipes, took Resident #2 to their room and is later seen shutting the door and placing the washcloths wipes in the corner of the door and frame. Certified Nurse Aide #7 then continued their work and did not alert anyone.Resident #5 admitted with diagnoses including Dementia, Cerebral Infarction and Peripheral Vascular disease. The 1/26/2025 Nursing Home Investigative Report documented Resident #5 was videotaped by facility staff and posted on social media (Tik Tok). Employee Statements dated 1/20/2025 to 1/23/2025 documented Certified Nurse Aides were involved in recording Resident #5 while they were washing their briefs at the sink. Statements further documented that Certified Nurse Aide # 3 used their Tik Tok account to post the video of Resident #5. Certified Nurse Aide #3, #4, and #5 were present while resident was washing their briefs. The Director of Nursing and Administrator reviewed the video and immediately pulled Certified Nurse Aide #3 off the unit. The Director of Nursing terminated Certified Nurse Aide #3 for violation of the facility abuse policy. Review of the facility Quality Assurance and Performance Improvement agenda dated 2/28/2025, 3/26/2025, 4/29/2025, 5/29/2025 and 6/26/2025 revealed the incident of Resident #5 being videorecorded by staff on 1/18/2025 and Resident #2 being secluded in their room by Certified Nurse Aide #7 on 1/19/2025 were not discussed. There were also no documented action plans to address the incidents that occurred.During an interview on 6/25/2025 at 11:18 AM, the Administrator stated they discussed the incidents for a couple of days during morning report and the quality measure was to reeducate the staff regarding the two areas of concern. At the time they had a lot of new staff in the facility, so they re-in-serviced all the staff. The Administrator stated they did not discuss either incident in the Quality Assurance and Performance Improvement meeting. The Administrator stated they included the discussion on seclusion and videotaping residents in the in-services as they always do and instructed the staff educator to include the two areas in their in-services to the staff as well. 10NYCRR 415.27(a-c)

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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. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews during an abbreviated survey (NY00383624), the facility did not ensure enhanced barrier precautions were followed by staff for 2 out of 3 residents (Resident #4, Resident #15) reviewed for infection control. Specifically, (1) on 6/17/2025 Certified Nurse Aide #1 and Certified Nurse Aide #2 provided care to Resident #4, who was on enhanced barrier precautions and did not don gowns; (2) On 6/18/2025 Resident #15 was observed walking down the hallway from their room to the nurse's station with their Foley catheter drainage bag in their hand and used the telephone at the nurse's desk. Resident #15 was noted to be on enhanced barrier precautions.The findings are:The facility Infection Control: Enhanced Barrier Precautions policy last revised 4/8/2024 documented it is the policy that Enhanced Barrier Precautions, in addition to Standard and Contact Precautions will be implemented during high-contact resident care activities when caring for residents that have an increased risk for acquiring multidrug-resistant organism such as a resident with wounds, indwelling medical devices or residents with infection or colonization with an multi-drug resistant organism. This policy applies to all employees who provide cares to the residents of this facility to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. Resident #4 was admitted with diagnoses including but not limited to Peripheral Vascular Disease, Diabetes Mellitus and Delusional disorder.A Comprehensive Minimum Data Set, dated [DATE] documented Resident #4 was cognitively intact with no behaviors noted. The resident had impairment to the lower extremities on both sides and was bedridden. Resident #4 required set up assistance with eating, moderate assistance with bed mobility and dependent for toileting. Review of an Enhanced Precautions care plan last reviewed 3/31/2025 documented Resident #4 has wounds requiring dressing changes. Staff will prevent the spread of infection with the following interventions apply isolation equipment upon entry to the room; discuss with patient and family the importance of handwashing; maintain enhanced barrier precautions; maintain infection control practices through proper handwashing; maintain isolation cart outside of patient room. On 6/17/25 at 12:56 PM, Resident #4 was observed in bed, Certified Nurse Aide #1 and Certified Nurse Aide #2 had finished providing care to the resident and were in the room standing by the residents' bed without a gown. Resident #4 was asked when the Certified Nurse Aides left the room if they had worn gowns while providing care, and the resident responded the Certified Nurse Aides did not wear gowns today and further stated sometimes they wear the gowns and sometimes they do not. The enhanced barrier sign on the wall by the door outside Resident #4's room was marked B that indicated Resident #4(in bed B) required enhanced barrier precautionsDuring an interview on 6/17/25 at 1:00 PM, Certified Nurse Aide #1 stated they did not wear a gown while providing care for Resident #4 and they were not informed the resident was on enhanced barrier precautions.During an interview on 6/17/25 at 1:02PM, Licensed Practical Nurse #2 and Administrator looked at enhanced barrier sign and indicated the Resident #4's bed was the window bed which required enhanced precaution protocols to be followed.During an interview on 6/17/25 at 1:04 PM, Certified Nurse Aide #2 stated they did not receive report today and did not know Resident #4 was on enhanced barrier precautions, and did not wear a gown while providing care. During an interview on 6/17/25 at 1:20 PM, Registered Nurse #1 stated Resident #4 was on enhanced barrier precautions for the left foot wound infection. Registered Nurse #1 stated they were to add Resident #4's roommate as needing enhanced barrier precautions, but they got distracted. Registered Nurse #1updated the enhanced barrier precaution sign at the door and added Resident #4's roommate (in bed A) on the sign, in the presence of the surveyors. Resident #15 was admitted with diagnoses including but not limited to Malignant Neoplasm of the Bladder, Metabolic Encephalopathy and Dementia.A Comprehensive Minimum Data Set, dated [DATE] documented Resident #15 had severe cognitive impairment with no behaviors noted. The resident was independent for ambulation, bed mobility and transfers and required set up assistance for eating and toileting. The resident had an indwelling catheter and was occasionally incontinent of urine.Review of a Dementia care plan initiated 12/24/2024 documented Resident #15 had impaired decision making. Interventions listed included use simple word instructions, evaluate medication regimen and offer choices between two items.Review of an enhanced barrier precautions care plan initiated 4/1/2025 documented Resident #15 was on enhanced barrier precautions related to foley use to help reduce risk of infection. Interventions listed included discuss with resident and family the importance of handwashing and maintain enhanced barrier precautions During rounds on the second floor on 6/18/2025, Resident #15