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	02/27/2026

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review conducted during a Recertification and Abbreviated Survey (NY00622225) from 2/19/26 to 2/27/26, it was determined that for one (1) of four (4) resident care units (2 East), the facility did not have sufficient nursing staff levels to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically, on 02/08/2026 during 3:00 p.m. -11:00 p.m., there was no documented evidence that medications were administered to 35 residents when Registered Nurse Supervisor #17 was also assigned to work on unit 2 East and 2 West. The findings include The Facility assessment dated [DATE] -10/31/2025 documented the following staff levels 2 East: 3:00 p.m.,-11:00 p.m., 2 Licensed Practical Nurses, with a minimum of 1 Licensed Practical Nurses, 1 Registered Nurse Supervisor as the minimum and the 3 [NAME] 3:00 p.m.,-11:00 p.m., 2 Licensed Practical Nurses with a minimum of 1 Licensed Practical Nurse, and 1 Registered Nurse Supervisor as the minimum. Review of the facility staffing sheets, from 02/01/2026 through 02/27/2026, did not reflect the staffing levels documented on the facility assessment on 2/8/26 there was no Licensed Practical Nurse for 3:00 PM-11:00 PM shift and Registered Nurse Supervisor #17 was assigned to supervise the facility and additionally assigned to 2East and 3West. ^Review of the 02/08/2026 3:00 p.m-11:00 p.m., 2 East Medication Administration Record revealed no documented evidence of medication administration for 35 residents. When interviewed on 02/24/2026 at 12:36 p.m., Resident #90s Designated Representative stated on 02/08/2026 the 2 East unit did not have a nurse. When interviewed on 02/25/2026 at 10:03 p.m., Certified Nurse Aide #33 stated on 02/8/2026 there was no nurse on the 2East unit. When interviewed on 02/27/2026 at 1:45 p.m., the Staffing Coordinator stated they were informed that there was no Licensed Practical Nurse on 2 East unit. The Staffing Coordinator stated they called the Director of Nursing and Administration Registered Nurse about the staffing issue and did not get an answer. The Staffing Coordinator stated it was hard to get staff on the weekends when there were call outs because most staff had other jobs. They stated they do the best they can. When interviewed on 02/27/2026 at 4:03 p.m., Registered Nurse Supervisor #17 stated on 02/08/2026, they were scheduled to work 3:00 p.m. -11:00 p.m., on 3 West. They stated on that day at around 4:00 p.m., they found out they would be supervising the facility and working as the nurse on both 2 East and 3 West. Registered Nurse Supervisor #17 stated they were running to 2 units, and it was crazy. Registered Nurse Supervisor #17 stated the Director of Nursing told them to call other nurses, to see if they could find somebody for the shift. They stated they went back and forth to get all the medications administered on both units. Registered Nurse Supervisor #17 stated before getting called away they were able to get some documentation done on 3 [NAME] but were unable to document on 2 East.^ Registered Nurse Supervisor #17 stated that when they administered medication, they were supposed to sign for medications as they were administered. Registered Nurse Supervisor #17 stated they felt very overwhelmed trying to supervise the facility and pass medications out on 2 units. They stated they had to do what they could to provide medication to the residents on both 2 East and 3 West. When interviewed on 02/27/2026 at 4:46 p.m., The Director of Nursing stated on 02/08/2026 (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335399	A. Building B. Wing	02/27/2026

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Licensed Practical Nurse #31 was a no call no show for the 3:00 p.m., -11:00 p.m. They stated when they could not get in touch with Licensed Practical Nurse #31 Registered Nurse Supervisor #17 came in at 3:00 p.m. The Director of Nursing stated on 02/08/2026 Registered Nurse Supervisor #17 had the keys for 2 East and 3 [NAME] and was to supervise the facility. They stated they received a printout from pharmacy dated 02/08/2026 which alerted them that medication administration was not documented for the entire 2 East unit. The Director of Nursing further stated if Registered Nurse Supervisor #17 did not sign that they administered medications, it was considered an omission. The Director of Nursing stated the Registered Nurse Supervisor #17 only called to explain they were short staffed on the 3:00 p.m.-11 p.m. shift and were never asked to come in to help.ˆ The Director of Nursing stated they did not feel it was ideal to have the Registered Nurse Supervisor#17 manage 2 units and supervise the facility but did feel the residents were safe.ˆ When interviewed on 02/27/2026 at 4:51 p.m., the Administration Registered Nurse stated the Registered Nurse Supervisor #17 could cover (2) two units because 3 [NAME] only had 20 residents. They further stated each unit had a different medication pass and medication pass was staggered.ˆ The Administration Registered Nurse stated when nurses administered medications they checked orders in the computer, administered medication/s and signed that the medication was administered. When interviewed on 02/27/2026 at 5:07 p.m., the Administrator stated they were not made aware of the 02/08/2026 staffing issue until 02/09/2026.ˆ The Administrator stated it was a tough weekend to get staffed.ˆ The Administrator stated they were informed that the Registered Nurse Supervisor #17 on duty took care of all that needed to be done.ˆThe Administrator stated they did not feel that this was an ideal situation. They further stated they were made aware today 02/27/2026 that medication administration on 02/08/2026 during the 3:00 p.m.-11:00 p.m., shift for 2 East was not signed when administered. The Administrator stated staffing was one of the hardest jobs these days. They stated staffing could vary at times but overall, they were doing well. The Administrator stated they were very persistent at searching for and hiring staff but there were challenges. The Administrator stated they feel the facility assessment was done correctly and felt the minimum staffing was appropriate and that they knew what their staff could handle.ˆ ˆ [10 NYCRR 415.13(a)(1)(i-iii)]

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	02/27/2026

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 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observation, record review, and interviews conducted during the Recertification Survey and Abbreviated Survey (2677034) from 02/19/2026 to 02/27/2026 the facility did not provide sufficient support personnel to safely and effectively carry out the functions of food and nutrition services. Specifically, 1) observations of incomplete refrigerator temperature log documentation in the kitchen and on the units; expired food in unit 3W and 3E pantry refrigerators, and during the Resident Council Meeting held on 02/20/2026 residents stated they had missing food items on their meal trays, and 2) Resident #15's representative stated Resident #15 frequently did not receive 9:00 AM and / or 2:00 PM nutritional supplement snacks. The findings include The policy and procedure titled Refrigerator Temperatures and Checks issued 06/19/2025 documented dietary staff are to perform and document temperature checks at least twice daily using the Refrigerator Temperature Logs; ensure food is labeled, dated, covered and stored properly; and discard expired or unlabeled items. Nursing staff are to check nourishment room refrigerators once per shift; ensure food is labeled, dated, covered, and stored properly; and discard expired or unlabeled items. 1) During the initial tour of the kitchen on 02/19/2026 at 9:17 AM observations of incomplete February 2026 temperature log documentation for the nourishment refrigerator, dairy walk in, produce walk in, and the ice cream freezer. Each of the three (3) refrigerator units had documentation for three (3) of 19 days and the freezer documentation was for two (2) of 19 days. An observation of the January 2026 kitchen temperature logs was also found to be incomplete. During an observation of the 3W unit pantry on 02/27/2026 at 12:47 PM the temperature log was incomplete with documentation 17 out of 27 days and on the same day at 2:30 PM the 3E unit pantry temperature log was incomplete with documentation 17 out of 27 days. During the observation of 3W unit pantry on 02/27/2026 at 12:47 PM paper plates were fitted together as a top and bottom dated 02/22/2026, resident food in a paper bag dated 02/17/2026, resident food in a plastic take out bag undated, grocery store type fruit platter undated, grocery store salad undated and unlabeled, resident large coffee creamer undated, and a Tupperware undated, unlabeled. On the counter next to the refrigerator was a nourishment labeled for Resident #41, a Fortified Shake dated 02/25/2026 9AM. During the observation of 3E unit pantry on 02/27/2026 the following items were observed: brick of cream cheese undated and unlabeled, half sandwich half 02/22/2026, and a cup of celery sticks from the kitchen dated 02/20/2026. During an interview on 02/19/2026 at 9:17 AM the Food Service Director stated they have had staffing issues and there were four (4) new dietary staff that were in training and learning about documenting the temperatures. During an interview on 02/25/2026 at 11:15 AM the Food Service Director stated they had to terminate two (2) dietary employees on that day, and the kitchen was working short staffed again. There has not been a full staff in the kitchen for a while, and the Administrator was aware of the staffing issues in the kitchen. During an interview on 02/25/2026 at 12:59 PM Certified Nurse Aide #1 stated they did not know why (continued on next page)

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	02/27/2026

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 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the nourishment was not given to Resident #41 at 9 AM, maybe it didn't arrive to the unit on time. They stated if nourishments were not delivered to the unit on time, the nursing staff called the kitchen to request the nourishment be sent. They stated there were new staff in the kitchen and maybe they were still learning. 2) Resident #15's diagnoses included unspecified heart disease, unspecified dementia, unspecified severity, with anxiety, with psychotic disturbance, and chronic obstructive pulmonary disease. A significant change Minimum Data Set (a resident assessment tool dated 12/08/2025 documented Resident #15 had severe cognitive impairment, was independent with eating and received hospice services. A physician order dated 02/12/2026 documented fortified shake three times a day. A physician order dated 02/12/2026 documented allowance for soft sandwiches no crust. A care plan titled Nutritional Status updated 11/02/2025 documented Resident #115 was at risk for altered nutritional status. Provide/offer additional fluids between meals and provide tuna in bowl/egg salad in bowl at 2:00 PM. A grievance report dated 10/07/2025 documented an e-mail dated 10/07/2025 from Resident #15's Representative sent to Director of Nursing and Social Worker with concerns including Resident #15 being hungry and not receiving 2:00 PM snacks. Resident representative had discussed with unit staff, including manager, and was told the problem was from the kitchen not sending snacks to units. The investigative findings documented most of the Resident Representative complaints were addressed by the Administrator, Unit Coordinator and Dietician. Final disposition documented resolved with Resident Representative overall. During an interview on 02/19/2026 at 7:45 PM, Resident #15's Representative stated Resident #15 did not always receive daily 9:00 AM and 2:00 PM nutritional supplements/snacks. Resident #15's Representative stated many days while they were visiting in the afternoon, they have had to seek unit staff to check the status of snacks/supplements. They stated they discussed this concern with Administration and the Director of Nursing, and that snack/supplement delivery had improved somewhat. During interviews on 02/24/2026 at 1:06 PM and 02/27/2026 at 2:13 PM, Certified Nurse Aide #22 stated there have been days when 9:00 AM and/or 2:00 PM nourishments have not been delivered by the kitchen. They stated when this occurred the kitchen was notified and most of the time the kitchen would send nourishments to the unit but there have been times when this has not happened. They stated kitchen staff have stated they do not have enough staff to prepare or deliver the nourishment snacks. They stated there have been days when Resident #15 did not receive a nourishment snack from the kitchen and when this occurred, the kitchen was notified and snack/supplement sent to the unit. They stated Resident #15 would present to the nurse station or inform staff when they were hungry and they were provided a snack from the pantry, such as a yogurt. During an interview on 02/25/2026 at 10:58 AM Geriatric Aide #23 stated they assist unit staff handing out nutritional supplement snacks daily at 10:00 AM and 2:00 PM. They stated there were days, about five (5) times a month, when nourishment snacks were not delivered to units. They stated the kitchen would send the nourishments to the unit most of the time, but about one (1) or (2) times a (continued on next page)

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	02/27/2026

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 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	month the kitchen would not. They stated due to short kitchen staffing; they have been assigned to work in the kitchen frequently. During an interview on 02/25/2026 at 2:43 PM and 2/27/2026 at 10:35 AM, the Food Service Director stated nourishment snacks were provided to units at 9:00 AM, 2:00 PM and 8:00 PM. They stated when the was kitchen was adequately staffed nourishments were sent daily and on time. They stated when understaffed, the nourishment snacks for 9:00 AM and 2:00 PM were sometimes not prepared and sent to the units. They stated not delivering unit nourishments occurred about once a week with weekends being worse due to short staffing. They stated unit pantries were restocked nightly with cookies, drinks, puddings and juices/water. The Director of Food Services stated they have discussed the inability to provide nourishment snacks to the units every day with the Dietician, Administration Registered Nurse and with Administrator. During an interview on 02/26/2026 at 5:02 PM, the Registered Dietician stated Resident #15 had weight loss in December 2025 after hospitalization and has recently stabilized. Interventions included a fortified shake three times a day, allowance for sandwiches with no crust 7:00 AM, 9:00 AM, 12:00 PM and 2:00 PM with alternates egg salad/tuna in a bowl. They stated that were aware that Resident 15's Representative complained about not receiving the supplementals/extra food at 9:00 AM and 2:00 PM. 10 NYCRR 415.14(b)(1)(2)

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	02/27/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews conducted during the recertification survey from 02/19/2026 to 02/27/2026, the facility did not store, prepare and serve food in accordance with professional standards for food service safety. Specifically, 1) unlabeled and undated food were stored in the kitchen and unit pantry refrigerators, and 2) expired foods were stored in the kitchen, unit pantry refrigerators, and dry pantry.The findings includeThe policy dated 06/19/2025 titled Refrigerator Temperatures and Checks documented temperatures must be monitored, documented, and staff are responsible for ensuring safe storage, and proper labeling.During the initial tour of the kitchen on 02/19/2026 at 9:17 AM Kitchen refrigerators contained 1/2 roll of uncut bologna, storage container of peaches, (13) individual portions of pineapple, (15) jello, (5) butterscotch pudding, (11) applesauce, (2) egg salad, (1) cottage cheese, and (16) prune juice that were unlabeled and undated. Kitchen refrigerators and the dry pantry storage contained a storage container of fruit cocktail dated 02/12/2026 and a case of individual cups of honey thickened waters that were expired. At the time of observation, the Food Service Director was interviewed and stated they usually dated food items, especially when stocking but they had just hired 4 new aides and a cook and they were in training. The Food Service Director stated it was the responsibility of all staff to discard any expired items. They stated the thickened waters had just been delivered and must have been delivered already expired.During an observation on 02/25/2026 at 12:52 PM Unit 3W refrigerator pantry contained resident food in a paper bag dated 02/17/2026, resident food in a plastic take out bag undated, grocery store type fruit platter undated, grocery store salad undated and unlabeled, large coffee creamer undated. Unit 3E refrigerator pantry contained an expired cup of celery sticks dated 02/202/2026 and an unlabeled, undated opened brick of cream cheese. At the time of observation, the Food Service Director was interviewed and stated new staff were still receiving training on the tasks related to unit pantries.During an interview on 02/27/2026 at 3:30 PM the Food Service Director stated dietary staff had a lot of responsibility and they were continually training new employees due to high staff turnover. 10 NY CRR 415.14(h)

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	02/27/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and record review conducted during the recertification survey, the facility did not ensure the resident's right to a safe, clean, comfortable, and homelike environment for three (3) of eight (8) residents (Resident #23, Resident #28, Resident #72) reviewed for the environment. Specifically, 1) Resident #23 was observed in their room with garbage and linens scattered on the floor and a disconnected catheter bag containing urine was hanging on the bed rail. 2)Resident #28 was observed sitting in a wheelchair with dust and dirt on the frame, the wheelchair cushion had brown stains on it, and the room bathroom had sticky floors and a smell of urine; 3) Resident #72's bathroom had an approximately 20-inch by 10-inch opening in the wall which allowed plumbing underneath the bathroom sink to be exposed. The findings include: 1)When observed on 02/19/2026 at 12:13 p.m., Resident #23's room had a dirty sheet on the floor, a disconnected catheter bag was on the bed rail and there were empty water bottles on the bedside table and bureau. When observed on 02/26/2026 at 9:14 a.m., Resident #23's room pillows and sheets were on the floor, paper, garbage, and empty water bottles were scattered around the room. When observed on 02/27/2026 at 10:24 a.m., Resident #23's room had plastic wrappers on the floor, the garbage can was full, and dirt stains were on the floor. 2)When observed on 02/19/2026 at 10:26 a.m., Resident #28's bathroom had a urine smell, and the floors were sticky. When observed on 02/20/2026 at 9:54 a.m. the floor in Resident #28's bathroom was sticky and there was a faint urine smell. When observed on 02/24/2026 at 10:59 a.m., Resident #28's room had a faint smell of urine, the bed linens had stains, old cups and plastic wrappers were on the bedside table, and the floor was soiled with scattered dirt. When observed on 02/25/2026 at 11:00 a.m., Resident #28's blue wheelchair cushion had brown stains and dirt/rust on the metal of the wheelchair. When observed on 02/26/2026 at 8:53 a.m., Resident #28's room had brown dry spots on the floor between the entry and their bed. When interviewed on 02/27/2026 at 10:26 a.m., Registered Nurse Unit Manager #24 stated there was one housekeeper daily on the unit and they cleaned all the rooms daily. They stated housekeeping was also available for other housekeeping concerns as needed. They stated wheelchairs were cleaned on the evening or night shift, but they were not sure of the schedule. When interviewed on 02/27/2026 at 10:31 a.m., the Director of Housekeeping stated they had a housekeeper on each unit daily, during the day shift. They stated their tasks included cleaning all resident rooms and included mopping floors, light dusting, bathroom cleaning, and stocking supplies in the bathroom. They stated any staff could pick up debris or garbage if noted in a room or hallway, but housekeeping would address when cleaning rooms. They stated wheelchairs were cleaned on the (continued on next page)

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	02/27/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	evening shift however they don't have a set schedule. They stated they tried to clean 6 (six) weekly. They stated nursing should inform them if there is a dirty wheelchair, so they can add that one to the list for cleaning. They stated they did not receive any requests from nursing for Resident #28's wheelchair and there was no documented evidence it had been cleaned since they were admitted . 3) When observed on 02/20/2026 at 1:04 p.m., the wall in Resident #72's room had an approximately 20-inch by 10-inch exposed opening underneath the bathroom sink. The opening had the wall tiles and sheetrock removed exposing the sink plumbing. When interviewed on 02/26/2026 at 9:11 a.m., the Director of Maintenance stated they were not aware of the opening of the wall. They stated the opening may have been from a plumbing repair and they did not know when the repair was made or why the wall opening was left exposed. They stated the wall was not repaired to the level that they expected. When interviewed on 2/27/2026 at 10:21 a.m., the Administrator stated they were not aware of the opening in the wall and expected the work to be completed. They stated the wall opening should have been fixed. 10NYCRR 415.5(h)(2)

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	02/27/2026

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation and interview conducted during the Recertification survey from 02/19/2026 to 02/27/2026, the facility did not ensure residents were provided food that was safe and/or at an appetizing temperature. Specifically, a test tray revealed lasagna that was being served to residents on the 3 W unit had a temperature of 120.5 degrees. The findings include:According to USDA Food Code and CDC guidelines for food safety, food safety requires consistent temperature control from the time food leaves the kitchen, to transport and distribution to prevent contamination (e.g., covering food items). Timely distribution is essential to ensure food and beverages are served at the proper temperature.During an interview on 02/19/2026 at 4:00 PM with Resident #104, they stated the food was delivered to the unit cold and the only way to get a hot meal was to eat in the dining room. During an observation and interview on 02/25/2026 at 11:15 AM the Food Service Director stated lunch tray line would start at 11:30 AM. Temperature of the lasagna was tested within normal limits at 150 degrees Fahrenheit. That same day at 12:24 PM the lunch meal trays arrived to unit 3W. Certified Nurse Aides delivered the meals to residents in dining in their rooms at 12:26 PM and then to the residents dining in the unit 3W dining room at 12:37 PM. At that time the Food Service Director was requested to come to the unit with the thermometer. The test tray was sampled at 12:41 PM, the lasagna was lukewarm. The temperature of the lasagna at that time was 120.5 degrees Fahrenheit.During an interview at that time the Food Service Director stated a new tray delivery system would be helpful in holding the temperatures of hot food from the tray line to the time the residents receive it and that they had been looking into a few new products.10NYCRR 415.14 (d)(1)(2)

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	02/27/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews conducted during the recertification survey from 02/19/2026 to 02/27/2026, the facility did not ensure infection control prevention practices were maintained to prevent the development and transmission of communicable diseases and infection for 4 (four) residents observed during dining (Residents #63, #58, #39 and #30), one (1) of seven (7) residents reviewed for activities of daily living (Resident #84), and one (1) of one (1) resident (Resident #23) reviewed for bladder and bowel incontinence. Specifically, 1) During lunch tray delivery and tray set-up on 02/24/2026, Certified Nurse Aide #7 was observed touching the tops of straws and buttering a resident's roll with their bare hands 2) Resident #84 was lying in bed with their catheter collection bag hanging on the bed rail and touching the floor; 3) Resident #23's was lying in bed with their catheter collection bag lying on the floor between the bedside table and bed frame.The findings included: The policy titled Infection Control and Prevention reviewed 08/27/2025 documented the primary purpose of facility Infection Prevention and Control Program is to establish guidelines to provide a safe, sanitary, and comfortable environment while preventing the development and transmission of communicable diseases and infections. The undated Foley Catheter Care procedure documented the purpose is to maintain a clean area at the meatus and prevent infection. Catheter care is included in daily care provided by the certified nurse aides. ^ 1) During a lunch observation on 02/24/2026 at 12:00 PM, Certified Nurse Aide #7 obtained a lunch tray from the food cart for Resident #63, when they opened the straw, they touched the top of the straw with their bare hands. Certified Nurse Aide #7 proceeded to handle Resident #63's fork by touching the fork prongs with their bare hands. Certified Nurse Aide #7 proceeded to obtain a lunch tray for Resident #58, touched the top of the straw with their bare hands and placed it into the milk container. Certified Nurse Aide #7 proceeded to obtain a tray from the food cart for Resident #39 without performing hand hygiene and touched the top of the straw with their bare hands as they opened the straw. Certified Nurse Aide #7 obtained a tray from the food cart for Resident #30 without performing hand hygiene and touched the top of the straw with their bare hands as they opened the straw and placed it into the milk container. Certified Nurse Aide #7 then opened the plastic covering on Resident #30's roll and touched the roll with bare hands when they buttered the roll. During an interview on 02/24/2026 at 12:00 PM Certified Nurse Aide #7 stated they were aware that they should have performed hand hygiene in between distributing lunch trays and assisting residents with tray set up. They stated they should not have touched the top of straws or touched food items such as the roll without wearing gloves or performing hand hygiene. They stated they were in a hurry to get trays out and did not perform hand hygiene. During an interview on 02/25/2026 at 1:46 PM, Licensed Practical Nurse #6 stated staff should utilize hand sanitizer or hand wipes in between residents when assisting with meal distribution and tray set up. During an interview of 02/27/2026 at 2:30 PM, Licensed Practical Nurse Unit Manager #4 stated that aides should be sanitizing hands in between assisting residents with set up using towelette or wall dispenser sanitizers. They should not touch tops of straws or resident food items without gloves and (continued on next page)

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	02/27/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	proper hand hygiene. 2) Resident #84 had diagnoses including Obstructive Uropathy, benign prostatic hyperplasia, and dementia. The admission Minimum Data Set, dated [DATE] documented Resident #84 had severely impaired cognition, was dependent on staff for toileting hygiene, and had an indwelling catheter. A Care Plan for urinary indwelling catheter dated 2/5/2026, documented catheter care per policy, maintain infection control, observe for signs and symptoms of infection, and urology consult as needed. During an observation on 02/19/2026 at 10:09 AM, Resident #84 was observed lying in bed with their catheter collection bag hanging on the bed rail draining yellow urine with some sediment and/or mucus noted. During an observation on 02/26/2026 at 8:54 AM, Resident #84 was observed lying in bed with their eyes closed. Their catheter collection bag was hanging on the bed rail with the bottom portion of the bag resting on the floor. 3) Resident #23 had diagnoses that included obstructive and reflux uropathy, urinary tract infection, and acute kidney failure. The admission Minimum Data Set, dated [DATE] documented Resident #23 had moderately impaired cognition, received maximal assistance for toileting hygiene, and had an indwelling catheter. The Care Plan for urinary indwelling catheter dated 01/06/2026 documented foley catheter care each shift, observe for signs of infection, maintain infection control practices such as hand hygiene, care of catheter, tubing, and collection bag. Ensure the collection bag and tubing are not touching the floor or floor mat. During an observation on 02/26/2026 at 9:14 AM, Resident #23 was lying in bed with their catheter collection bag lying on the floor stuck between the bedside table and bed rail. During an interview on 02/26/2026 at 9:31 AM, Certified Nurse Aide #28 stated they did see Resident #23's foley bag on the floor and it should not be touching the floor. During an interview on 02/27/2026 at 3:43 PM Registered Nurse Unit Manager #24 stated that catheter collection bags should not be touching the floor. 10 NYCRR415.19

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	02/27/2026

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. Based on observations, interviews, and record review during the recertification survey from 02/19/2026 to 02/27/2026, the facility did not ensure that each resident was treated in a manner and in an environment that maintains or enhances each resident's dignity and respect for three (3) residents (Resident #47, Resident #55, and Resident #90) observed during dining. Specifically, on 02/24/2026, Certified Nurse Aide #7 placed a clothing protector on Resident #47, Resident #55 and Resident #90 without asking the residents permission to do so.The findings included:A facility policy titled Dignity and Resident Rights revised 08/01/2025 documented all residents of facility are treated with dignity and respect in all aspect of their care. In practice, staff must communicate courteously, maintain confidentiality, and involve residents in decisions affecting their lives. Proper attention to residents' choices reinforces autonomy and enhances well-being.During observation and interview on 02/24/2026 at 12:00 p.m., Certified Nurse Aide #7 was observed placing clothing protectors on Resident #47, Resident #55 and Resident #90, without asking permission before applying. Certified Nurse Aide #7 stated they did not ask the residents if they would like a clothing protector because they always get one. They stated they should have asked the residents if they would like to use a clothing protector prior to applying and they did not do so.When interviewed on 02/25/2026 at 1:46 p.m., Licensed Practical Nurse #6 stated clothing protectors should be offered to residents and not just automatically placed. When interviewed on 02/27/2026 at 2:30 p.m., Licensed Practical Nurse Unit Manager #4 stated all residents should be asked if they would like a clothing protector and not just applied on residents. They stated applying a clothing protector on a resident without asking permission to do so could lead to residents being startled.10 NYCRR 415.5 (d) (1)(i)

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	02/27/2026

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review during the recertification survey, the facility did not ensure that the resident's right to formulate an advanced directive was documented in a manner to prevent those wishes from being followed for one (1) of 38 residents reviewed for advanced directives. Specifically, Resident #136 completed a Medical Orders for Life Sustaining Treatment form specifying their wishes as Do Not Resuscitate and Do Not Intubate, but the orders in the electronic medical record and the resident's wrist band did not all match the form. The findings include:The policy titled Advanced Directives and Advanced Care Plan Policy, last reviewed 08/2025, documented all residents have the right to formulate an advanced directive. Advanced directives are reviewed at admission, quarterly, annually, and with any significant change in condition. Medical Orders for Life Sustaining Treatment or medical orders are updated when preferences change. [NAME] band means resident has a valid Do Not Resuscitate order. Resident #136 had diagnoses that included hypertension, peripheral vascular disease, and coronary artery disease. The admission Minimum Data Set, dated [DATE] documented Resident #136 had intact cognition. The physician order dated [DATE] documented Do Not Resuscitate. An additional order dated [DATE] documented check blue arm band I want CPR. The Medical Orders for Life Sustaining Treatment form, dated and signed by Resident #136 on [DATE], documented Do Not Resuscitate and Do Not Intubate.During an observation on [DATE] at 1:19 p.m., a blue wristband was observed on Resident #136.During an interview on [DATE] at 1:37 p.m., Resident #136 stated they did not want Cardiopulmonary Resuscitation. They stated there was some confusion when they returned from the hospital, but they clarified their wishes with staff. During an observation and interview on [DATE] at 3:24 p.m., a white wrist band was observed on Resident #136 who stated the staff just gave them a new wrist band. During an interview on [DATE] at 03:29 p.m., Registered Nurse Unit Manager #24 stated advanced directives were reviewed with residents, or the resident's representative, during admission or readmission. They stated they were responsible for making sure the advanced directives were reviewed and completed for the residents on their unit. They stated Resident #136 recently returned from the hospital and changed their wishes to Do Not Resuscitate and Do Not Intubate. They stated they should have checked the orders and changed their wrist band when the Medical Orders for Life Sustaining Treatment form was signed by Resident #136 on [DATE]. During an interview on [DATE] at 10:49 a.m., the Director of Nursing stated that a resident's advanced directives should be reviewed and confirmed on admission. They stated the admitting nurse should confirm the orders. They stated they should then place the corresponding wristband on the resident, white for Do Not Resuscitate and blue for Cardiopulmonary Resuscitation. They stated that when a resident's wishes change, the wristband and orders should be corrected immediately. 10NYCRR 415.3(f)(2)(iii)

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	02/27/2026

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility did not ensure that a copy of the notice of transfer or discharge was sent to the State Long Term Care Ombudsman for four (4) of five (5) residents (Resident #15, Resident #2, Resident #84, and Resident #132) reviewed for Hospitalization. Specifically, there was no documented evidence that a notice of transfer was sent to the New York State Ombudsman and a bed hold policy was provided to the resident representative when 1) Resident #15 was transferred to the hospital on [DATE], 2) Resident #2 was transferred to the hospital on [DATE] and, 3) Resident #84 was transferred to the hospital on [DATE]. Additionally, Resident #132 was hospitalized on [DATE] and a bed hold policy was not provided. The findings include: The policy titled Transfer and Discharge, last reviewed 11/11/2022, documented the facility will provide notice of the transfer or discharge to the resident and resident representative along with a copy to the ombudsman. It must be sent to the ombudsman at the same time it is provided to the resident and resident representative. The policy titled Bed Hold policy, last updated 4/28/2025, documented the facility adheres to all requirements under 10NYCRR 415.3. Residents and their representatives are provided with written and verbal notice of bed hold policies upon admission and again at time of transfer. 1) Resident #15's diagnoses included unspecified dementia, unspecified severity, with anxiety with psychotic disturbance. The nursing progress note dated 11/24/2025 documented Resident #15 was sent to the hospital at 2:00 p.m., for altered mental status. There was no documented evidence that the New York State Ombudsman office was notified of the transfer to the hospital. There was no documented evidence that a bed hold policy was provided to Resident #15 and/or the resident representative. Resident #15 returned to the facility on [DATE]. When interviewed on 02/26/2026 at 4:28 p.m., the Director of Social Work stated they were unable to provide documentation that the Ombudsman was sent a transfer/discharge notification for the 11/24/2025 hospitalization. They stated hospital/transfer forms were in a binder in the social work office and were available for the Ombudsman to review. The Director of Social Work stated they have not reviewed bed hold policy with residents and/or resident representatives for a few years. They stated residents always returned to their room after hospitalization. When interviewed on 02/27/2026 at 9:39 a.m., the Administrator stated bed hold policies were provided upon admission and not discussed at transfer; however, residents do not lose their beds and return to their same rooms. 2) Resident #2 diagnoses included non-Alzheimer dementia, hypertension, and diabetes mellitus. The nursing progress note dated 02/05/2025 documented Resident #2 had an unwitnessed fall and was transferred to the emergency room for evaluation. (continued on next page)

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	02/27/2026

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documented evidence that the New York State Ombudsman office was notified of the transfer to the hospital. There was no documented evidence that a bed hold policy was provided to Resident #2 and/or the resident representative. The nursing progress note dated 12/08/2025 documented Resident #2 was readmitted to the facility. 3) Resident #84 diagnoses included dementia, benign prostatic hyperplasia, and hypertension. The nursing progress note dated 01/22/2026 documented Resident #84 was in dining room having trouble breathing. Order was received to send the resident to the hospital. There was no documented evidence that the New York State Ombudsman office was notified of Resident #2's transfer to the hospital. There was no documented evidence that the bed hold policy was provided to the resident/resident representative. The nursing progress note dated 01/29/2026 documented Resident #84 was readmitted to the facility. When interviewed on 02/25/2026 at 4:04 p.m., the Director of Social Work stated they do send notifications to the ombudsman via email but was unable to provide documented evidence that an email had been sent for Resident #2, Resident #84, and Resident #15. 10 NYCRR 483.15 © (3)

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	02/27/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, interview, and record review conducted during the recertification and abbreviated survey (#2677034) from 02/19/2026 to 02/27/2026, the facility did not ensure Comprehensive Care Plans were reviewed and/or revised as needed to reflect changing needs for one (1) of six (6) residents (Resident #15) reviewed for accidents. Specifically, care plan interventions were not updated to reflect the hand-written note on the 03/28/2025 smoking evaluation that indicated Resident #15 must wear an apron at all times. The undated policy titled Resident Care Planning Procedure documented the care plan is updated according to resident needs, hospitalizations, illness, behavioral issues, nutritional needs, activity level, changes in activity of daily living status or any change in which the interdisciplinary team feels is a change in the resident's status. The unit nurses update the care plan as changes occur.1) Resident #15's diagnoses included unspecified dementia. A significant change Minimum Data Set (assessment tool) dated 12/08/2025 documented Resident #15 had severe cognitive impairment and was a tobacco user.A Care Plan for smoking dated 03/28/2025 documented allow resident to smoke in designated smoking area with supervision as needed, check clothing regularly for signs of unsafe smoking, and provide smoking apron as needed. A smoking evaluation kept at the front desk dated 03/28/2025 revealed a handwritten note which indicated Resident #15 must wear an apron at all times.When interviewed on 02/26/2026 at 12:20 p.m., the Director of Nursing stated new interventions should be added to care plans. They stated Administration Registered Nurse #8 wrote a note on the 03/28/2025 smoking evaluation that Resident #8 must wear an apron at all times. They stated Resident #15's care plan should have been updated immediately to reflect the new intervention. They stated assessments and care plans should match. When interviewed on 02/26/2026 at 12:53 p.m., Administration Registered Nurse #8 stated that on 04/02/2025 they wrote a note on the 03/28/2025 smoking evaluation, kept at the front desk that indicated the resident must wear an apron at all times. They stated they would have received information from either the smoking attendant or unit staff to prompt updating the care plan. They stated the Licensed Practical Nurse Manager would have been responsible for updating Resident #15's care plan and should have done so immediately. When interviewed on 02/26/2026 at 1:18 p.m. Licensed Practical Nurse Manager #4 stated they did not recall receiving a report from Administration Registered Nurse #8 that Resident #15 must wear an apron at all times on 04/02/2025. They stated they would have been responsible for updating Resident #15's care plan, however Administration Registered Nurse #8 could have also updated the care plan. They stated there should have been communication regarding this. 10 NYCRR 415.11

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	02/27/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview during the recertification and abbreviate survey (#2677034) the facility did not ensure that residents who were unable to carry out activities of daily living received the necessary services to maintain personal hygiene for three (3) of seven (7) residents (Resident #15, Resident #115, and Resident #18) reviewed for activities of daily living. Specifically, 1) Resident #15's resident representative stated they observed Resident #15 double briefed on 02/08/2026 2), Resident #115 was observed double briefed on 02/19/2026, and 3) Resident #18 was observed on multiple occasions with poor oral hygiene. The findings include: A policy titled Activities of Daily Living last reviewed 09/04/2025 documented the purpose to ensure that all residents receive safe, appropriate, and consistent assistance with Activities of Daily Living (ADLs) while preserving dignity, promoting independence, and following individualized care plans. Certified nurse aides shall provide assistance, setup, supervision, or complete care as required for toileting and incontinence care, hygiene and grooming tasks. 1) Resident #15's diagnoses included unspecified heart disease, unspecified dementia, unspecified severity, with anxiety, with psychotic disturbance, and chronic obstructive pulmonary disease. ^^ ^ A significant change Minimum Data Set (assessment tool) dated 12/08/2025 documented Resident #15 had severe cognitive impairment, required partial/moderate assistance with toileting, substantial/maximal assistance with dressing and hygiene, was occasionally incontinent of bladder and frequently incontinent of bowel. A Care Plan for activities of daily living dated 04/01/2025 documented assist with toileting as necessary to promote continence, encourage resident to participate in activities of daily living care and observe for any decline in the ability to participate with activities of daily living. During an interview on 02/19/2026 at 1:15 p.m., Resident #15's representative stated on 02/08/2026 at 3:13 PM during a visit they observed Resident #15 double briefed. They stated they rang the call bell and Certified Nurse Aide #11 stated Resident #15 was a heavy wetter and they used a pull-up brief over the standard brief because the standard type of brief tended to fall. They stated Resident #15 was bladder incontinent at times and had a history of urinary tract infections. ^ During an interview on 02/25/2026 at 4:37 p.m., and 02/27/2026 at 2:36 p.m., Licensed Practical Nurse Unit Manager #4 stated they were aware that Resident #15 was observed by the Resident Representative on 02/08/2026 to have 2 briefs on. They stated Certified Nurse Aide #11 was counselled regarding not double briefing residents. They stated there may have only been one aide assigned on 02/08/2026 and that there was no nurse assigned to the shift due to call outs until 10:30 p.m., on 02/08/2026. They stated Resident #15 had history of urinary tract infections and should not have been double briefed. They stated double briefing residents was against facility policy. ^^ During an interview on 02/27/2026 at 5:16 p.m., Certified Nurse Aide #11 stated they were assigned (continued on next page)

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	02/27/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to Resident #15 on 02/08/2026. They stated they did double brief Resident #15 with a standard adult brief and a pull-up type adult brief was placed to keep the standard adult brief in place.ˆ They stated they were aware the Resident Representative was concerned about the double briefing and that they should not have placed two adult briefs on Resident #15. They stated they observed other residents on units in the facility with a standard adult brief and pull-up style over it, so they thought it was acceptable. 2) Resident #115's diagnoses included unspecified dementia, unspecified retention of urine and urinary tract infection. ˆ The annual Minimum Data Set, dated [DATE] documented Resident #115 had severe cognitive impairment, was dependent on staff with all activities of daily living and was always bladder and bowel incontinent. A Care Plan for Elimination dated 02/21/2024 documented Resident #115 had impaired elimination patterns, was always incontinent and at risk for urinary tract infection. Provide access to toilet, bed pan, call bell and check and change every two (2) to four (4) hours and as needed.ˆˆ ˆ During an observation and interview on 02/19/2026 at 9:58 a.m., Resident #115 was receiving morning cares by Certified Nurse Aide #14. Resident #115 was observed wearing two wet adult briefs. Certified Nurse Aide #14 stated they were not aware why Resident #115 was double briefed. They stated they had not provided cares earlier in the shift and that Resident #115 may have been doubled briefed during the night shift. ˆ During an interview on 02/25/2026 at 1:51 p.m., Licensed Practical Nurse #6 stated Resident #115 was incontinent of bowel and bladder and had a history of urinary tract infections. They stated they were aware Resident #115 was observed double briefed 02/19/2026 and that double briefing was never allowed ˆ During an interview on 02/25/2026 at 4:37 p.m., Licensed Practical Nurse Unit Manager #4 stated that resident double briefing was unacceptable and not allowed by the facility. They stated they were not aware why Resident #115 had 2 briefs on, on 02/19/2026 except for possible staff laziness.ˆ They stated Resident #115 was at risk for urinary tract infections and was care planned for frequent check and change every two (2) to four (4) hours. During an interview on 02/25/2026 at 8:54 p.m., Certified Nurse Aide #19ˆstated they worked with Resident #115 during the 02//18/2025 11:00 p.m., to 7:00 a.m., shift. They stated they checked Resident #115 about 1:00 a.m., and 4:30 a.m., on 02/19/2025 and Resident #115 was dry and double briefed. Certified Nurse Aide #19 stated they did not double brief Resident #115 and that they did not change Resident #115 at all during the shift due to Resident #115 being dry and double briefed throughout the shift. They stated Resident #115 being dry throughout an entire shift was not typical (continued on next page)

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	02/27/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and they usually have to provide incontinence care at least once during a shift. Certified Nurse Aide #19 stated they did not report finding Resident #115 double briefed to nursing. They stated they were aware residents should not be double briefed. ^ 3)Resident #18's diagnosis included hemiplegia, dysphagia, and chronic gingivitis, plaque induced. The quarterly Minimum Data Set, dated [DATE] documented Resident #18 was cognitively intact and dependent on staff for all activities of daily living. A Care Plan for dental care initiated 02/19/2026 documented assist with or provide oral hygiene daily to prevent infection and cavities. During observations and interview on 2/19/2026 at 11:31 a.m., 02/26/2026 at 11:47 a.m., and 02/27/2026 at 9:29 a.m., Resident #18 was sitting in the wheelchair in the day room. Their teeth were coated in white buildup around the gums. They stated they had toothpaste in the drawer in their room, but no one helped brush their teeth. During an interview on 02/25/2026 at 12:12 p.m., Registered Nurse Unit Manager #17 stated Resident #18 refused cares at times, but not consistently. During an interview on 02/26/2026 at 11:54 a.m., Certified Nurse Aide #3 stated Resident #18 was already up in their wheelchair when they arrived that morning. Certified Nurse Aide #3 stated staff offered to brush Resident #18's teeth as a part of daily cares, but Resident #18 did not always want people to get close to them. Certified Nurse Aide #3 had been assigned to Resident #18 on 02/20/2026-02/22/2026, and 02/24/2026-02/27/2026. 10 NYCRR 415.12 (a)(3)

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	02/27/2026

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interview conducted during recertification and abbreviated survey (NY00622225) from 2/19/26 to 2/27/26, it was determined the facility did not ensure that they provided an ongoing program to support residents in their choice of activities based on the comprehensive assessment, care plan, and preferences of each resident, for one (1) of one (1) resident (#90) reviewed for activities. Specifically, Resident #90 was not provided with the opportunity to consistently attend activities of their choice or attend activities specified for residents with dementia. The findings includeResident #90 had diagnoses including Alzheimer's Disease, Anxiety, and Depression.The Care Plan for activity dated 02/10/2022 documented Resident #90 was able to make most needs known and make their own decisions on activity participation. Resident #90 was frequently confused and needed help to get from place to place. Identify previous activities and interests as possible, coordinate treatment routine to allow for activities, identify current choices of activities, offer alternate plan for activities as needed, invite, escort and transport to activity programs per choice and interest, encourage resident to participate as able in activity programs, provide one to one visit for socialization and reminiscence two (2) times per week, offer to provide materials for independent leisure activity, preferences will be met by: having information to read, listening to music, be around animals, keeping up with the news, doing things with groups of people, going outside to get fresh air, and participating in religious activities.The significant change Minimum Data Set (MDS) dated [DATE] documented Resident #90 had severely impaired cognition, their activities of choice included listening to music, being around groups of people, going outside for fresh air and participating in religious activities. The activities calendar dated 02/19/2026 documented catholic mass was at 10:00 a.m. on the lower level in the large activity room.When observed on 2/19/2026 at 10:02 a.m. and 3:15 p.m., Resident #90 was sitting at a table in the 2 East day room. Resident #90 was not facing the television, no music was playing, and activities were not being provided. The activity attendance sheet dated 02/21/2026-02/25/2026 Resident #90 was not involved in any activity on or off the unit.The music program attendance sheet dated 02/24/2026 documented Resident #90 was not in attendance.When observed on 02/24/2026 at 2:35 p.m., Resident #90 was sitting in the middle of the 2 East day room. Activities were not provided. Resident #90's Geri-aide was sitting at a table with other residents and was not engaging with Resident #90.When observed on 02/25/2026 at 9:44 a.m., Resident #90 in the day room sitting at table. Resident #90 could not watch the television, no music was playing, and activities were not being provided.When interviewed on 02/26/2026 at 10:03 a.m., the Director of Activities stated they have implemented music programs for 2 East residents with dementia. The Director of Activities stated they also do one to one visit with residents who have dementia but have no other activity programs at this time. They stated the nursing department has a quality-of-life program where they utilize Geri aides to sit with residents to do leisure activities such as ball toss or independent packets on 2 East, but this is not part of the activities department. They stated at times Geri aides bring residents with dementia down to programs provided in the large activity room. They stated they were currently waiting on puzzles and other items for independent packets that were requested recently from the nursing department. The Director of Activities stated they feel there are not many programs for residents with dementia.When interviewed on 02/26/2026 at 10:22 a.m., the Director of Nursing stated the quality-of-life program where they utilize Geri aides to do activities on 2 east in addition to regular activities. was run by the nursing department. They stated the quality-of-life program utilized Geri aides to sit with residents, go out with the smokers at night, and ambulate with residents. They stated the activity department provided education and materials for the Geri aides to use. The Director of Nursing stated the program was started prior to April 2025. They stated the unit manager should ensure that activities were being provided on the unit. The Director of Nursing stated they met with the Director of Activities and three (continued on next page)

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	02/27/2026

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(3) Geri aides about a month ago to go over activities for the program. They stated the Director of Activities was going to come up with a calendar, but they still do not have a calendar or attendance sheets for the quality-of-life program.10 NYCRR 415.15(f)(1)

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	02/27/2026

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interview during the recertification survey conducted from 02/19/2026 to 02/27/2026, the facility did not ensure that necessary services, and/or equipment were provided to assure that a resident with limited range of motion and mobility maintained or improved function based on the resident's clinical condition for one (1) of four (4) residents (Resident #44) reviewed for position and mobility. Specifically, Resident #44 was observed on three (3) occasions without the use of a right ankle-foot orthosis as per physician order.The policy and procedure titled Splinting/Bracing, reviewed on 05/01/2025, documented a valid physician order was required before the application of splints or braces. Therapy staff were responsible for evaluating fit, and position, and for establishing a schedule of wear. Residents were to receive care and monitoring to prevent avoidable harm. Resident #44 had diagnoses of muscle weakness, hemiplegia of the right dominant side (paralysis of the right side of the body), and paralytic gait.A physician order dated 5/23/2024 documented staff to apply a right ankle-foot orthosis in am and remove it in pm, and have nursing assess skin integrity.A physical therapy discharge summary for services dated 05/21/2024 through 07/20/2024 documented Resident #44 required maximum assistance for stand-pivot transfers while wearing the right ankle-foot orthosis due to poor balance.The significant change Minimum Data Set, dated [DATE] documented Resident #44 had severe cognitive impairment and was dependent on staff for activities of daily living and required a wheelchair for mobility.A Comprehensive Care Plan for activity of daily living function, last updated on 12/09/2025, documented the use of the right foot brace when the resident was out of bed and directed staff to apply stockinette to bilateral lower extremities to protect the skin from the brace.A Comprehensive Care Plan for skin integrity, last updated on 12/31/2025, documented staff were to apply the right ankle foot orthosis, and the nurse was to check skin integrity during the am and pm shifts.During observation on 02/24/2026 at 11:33 AM, 02/25/2026 at 10:33 AM, and 02/26/2026 at 08:00 AM, Resident #44 was observed seated in the second-floor dayroom without the right ankle foot orthosis in place.During an interview on 02/26/2026 at 08:30 AM, Licensed Practical Nurse #10 stated Resident #44 had an order for a brace. Licensed Practical Nurse #10 stated staff had been signing off on the brace; however, the resident had not been wearing the brace and had not worn the brace in several weeks. Licensed Practical Nurse #10 stated certified nurse aides were responsible for applying the brace and follow-up was required if they did not wear the brace. During an interview on 02/26/2026 at 08:53 AM, Registered Nurse Manager #11 stated Resident #44 was required to wear the brace per the physician's order and care plan. Registered Nurse Unit Manager #11 stated that if Resident #44 did not wear the brace, muscle weakness would occur, and their foot drop would worsen. Registered Nurse Unit Manager #11 stated staff was responsible for ensuring that residents had equipment ordered by the physician.During an interview on 02/26/2026 at 8:55 AM, Certified Nursing Aide #9 stated Resident #44 had not worn the brace in over one (1) month. Certified Nurse Aide #9 stated nursing staff and Registered Nurse Unit Manager #11 were aware that Resident #44 was not wearing the brace.During an interview on 02/26/2026 at 09:00 AM, the Director of Rehabilitation stated Resident #44 was required to wear braces to prevent foot drop. The Director of Rehabilitation stated if Resident #44 did not wear braces, muscle weakness would occur, and foot drop would worsen.10NYCRR: 415.12(e)(2)

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	02/27/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, record review and interview conducted during the recertification survey, the facility did not ensure each resident receives adequate supervision and or assistance devices consistent with resident needs to prevent accidents for one (1) of two (2) residents (Resident #103) reviewed for accidents. Specifically, after Resident #103 had a documented 05/19/2025 intact blister on the left hand second digit related to smoking, care plan interventions were not updated to reflect Resident #103 smoking cigarettes down to the butt and/or the use of a cigarette extender as per a 05/21/2025 hand-written note. Subsequently, Resident #103 was observed on 02/25/2026 smoking without the use of a cigarette extender. The findings includeThe policy titled Residents Smoking last reviewed 01/10/2025 documented the smoking plan of care is evaluated quarterly and revised as needed.Resident #103's diagnoses included unspecified psychosis, left femur fracture and post-traumatic stress disorder.A Care Plan for smoking dated 04/03/2025 documented Resident #103 was a dependent smoker and needed supervision while smoking. Potential for smoking related injury related to cognition/judgement history of non-compliance with smoking policy. Resident refuses to wear a smoking apron. No interest in smoking cessation interventions. Often smokes cigarettes down to the butt and refuses staff intervention to replace them, hence large skin discoloration of smoke to the right-hand middle finger. 04/03/2025 interventions included allow resident to smoke in designated smoking area with supervision as needed, resident needs assist to and from smoking area but no supervision while smoking, provide education on risks of smoking behavior, provide smoking apron as needed (resident usually refuses).A quarterly Assessment Packet dated 05/07/2025 with a 06/13/2025 completion date documented in the smoking evaluation section that Resident #103 had poor safety awareness, did not have a history of non-compliance with smoking policies, demonstrated accurate understanding of smoking policy or guidelines, and exhibited smoking activity was done in a safe manner. May smoke with supervision only. Staff to light the residents' cigarettes. A 05/19/2025 Care Plan note documented Resident #103 will smoke safely within the designated smoking area through the next review was not met. An intact blister on the residents left hand second digit was related to smoking. Interventions are ongoing and appropriate. A hand-written note dated 05/21/2025 was added to 02/12/2025 admission Assessment Packet which indicated the use of a cigarette extender. There was no documented evidence in the Care Plan to address the use of a cigarette extender.A quarterly Assessment Packet dated 08/07/2025 with an 08/16/2025 completion date documented in the smoking evaluation section that Resident #103 had poor safety awareness, a history of non-compliance with smoking policies, was able to light smoking materials independently with good safety awareness, demonstrated accurate understanding of smoking policy and guidelines, and may smoke with supervision only. An annual Minimum Data Set (assessment tool) dated 02/13/2026 documented Resident #103 had moderate cognitive impairment and was a current tobacco user.An annual Assessment Packet dated 02/06/2026 with a 02/10/2026 completion date documented Resident #103 had poor safety awareness and may smoke with supervision only. A 02/18/2026 picture identification sheet titled smoking residents who require supervision documented no below the picture of Resident #103. During an observation on 02/25/2026 at 10:05 a.m., Resident #103 was brought from the lobby to the smoking area. Resident #103 had a cigarette in their mouth in the lobby and after being brought to the smoking area, Geri Aide # 29 lit the resident's cigarette. No cigarette extender or smoking apron was offered or worn by Resident #103.During an interview on 02/25/2026 at 10:21 a.m., Geri Aide #29 stated Resident #103 did not need a smoking apron since a handwritten 2023 smoking assessment tool in the smoking book documented that a smoking apron is not applicable. Geri Aide #29 stated that smoking assessments were completed by the nursing staff, and any changes were told to the smoking area staff.During an interview on 02/25/2026, at 10:44 a.m., Resident #103 stated they choose to have one (1) cigarette after breakfast, lunch and dinner. (continued on next page)

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	02/27/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When smoking, cigarette extenders and smoking aprons were not offered, and they did not want to use them. Resident #103 stated they never burned themselves or dropped a cigarette.During an interview and observation on 02/26/2026 at 10:11 a.m., Receptionist #30 stated the residents' smoking materials were kept in a portable safe at the reception desk. Three (3) cigarette extenders were observed in an envelope in the safe. Each of the cigarette extenders was a different model, different colors and each was about two (2) inches long. Receptionist #30 stated no one used cigarette extenders. They stated smoking assessments were kept at the smoking area locked up and the assessments stated which residents needed a smoking apron. During a follow up interview on 02/26/2026 at 10:35 a.m., Geri Aide #29 stated Resident #103 does not use a cigarette extender. They stated they watch Resident #103 to ensure they did not smoke the cigarette all the way down to the butt. Geri Aide #29 stated Resident #103 used the cigarette extender in the past but did not use it now. They stated they last saw the resident use it a few months ago. They stated they gave cigarettes with the extender on it to Resident #103 and saw them remove the cigarette from the extender. They stated now the staff did not offer the cigarette extender but monitored the resident while smoking to stop them before the cigarette gets too close to the butt. They stated for any changes to smoking assessments, the unit nurses will inform the smoking staff.During an interview on 02/26/2026 at 10:51 a.m., the Administrator stated smoking assessments were completed quarterly by the Registered Nurse Managers. They stated any issues or burns were brought to the attention of the Unit Manager, Director of Nursing and Administrator. They stated they expect staff to follow the assessments and care plans and to update the care plan as needed when changes occur.During an interview on 02/26/2026 at 11:25 a.m., Licensed Practical Nurse Manager #4 stated smoking assessments were done quarterly. Licensed Practical Nurses collect the information, and the Registered Nurses complete the assessments. They stated there was a note in the smoking care plan for a blister on the residents' left hand second finger and it was reasonable to believe the resident smoked the cigarette down to the butt which caused a blister. Licensed Practical Nurse Manager #4 stated they were not aware that cigarette extenders had arrived and were available at the facility. They stated Resident #103 must be monitored by staff to ensure safety but there were no care plan interventions to address monitoring their smoking cigarettes down to the butt or use of a cigarette extender. During an interview on 02/26/2026 at 12:20 p.m., the Director of Nursing stated that care plan interventions, care plan notes and smoking assessments were expected to all be the same. They stated as something changes, they expect interventions to be updated. They stated Resident #103 did not use a cigarette extender. They stated they believe staff take one cigarette away for another, so Resident #103 did not smoke the cigarette all the way down. They stated staff should give reports to each other on changes to smoking assessments. They stated the smoking assessments in the smoking book were not the latest ones. During an interview on 02/26/2026 at 12:52 p.m., Administration Registered Nurse #8 stated they did not complete the assessments, they only annotate written remarks and printed out the assessments for the smoking book. They stated they expected the unit managers to update care plans.10 NYCRR 415.12

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	02/27/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review conducted during the recertification survey from 2/19/2026 to 2/27/2026, the facility did not ensure care consistent with professional standards of practice, was provided for one (1) of one (Resident #5) reviewed for respiratory care. Specifically, Resident #5 was administered oxygen without a valid medical order from 01/29/2026 to 02/19/2026.The findings include:The policy titled Oxygen, last reviewed on 10/29/2025, documented oxygen is a medication and a specific physician's order is necessary to administer the same. Resident #5's diagnoses included lung cancer, pulmonary embolism, and acute respiratory failure. The significant Change Minimum Data Set (a resident assessment tool) dated 12/19/2025 documented Resident #5 had moderate cognitive impairment and had shortness of breath when lying flat.A nursing progress note dated 01/29/2026 documented Resident #5 returned from the hospital and was admitted back into the facility while receiving oxygen at two (2) liters per minute via a nasal canula.A nursing progress note dated 02/03/2026 documented the Resident #5 went to an appointment and had an oxygen saturation of 91% while receiving oxygen at two (2) liters per minute.During observation on 02/19/2026 at 4:13 p.m., Resident #5's nasal cannula was on the floor, and the oxygen concentrator was running. Licensed Practical Nurse #25 was informed of the residents' nasal canula on the floor and they immediately replaced the nasal canula.During observation on 02/19/2026 at 4:30 p.m., Resident #5 's was receiving oxygen via nasal cannula at a flow rate set at 0 liter per minute.There was no documented evidence in the electronic health record for a physician order to address administration of oxygen from 01/29/2026-02/19/2026.During an interview on 02/19/2026 at 4:50 p.m., Licensed Practical Nurse #25 stated the resident was receiving oxygen at two (2) liters per minute and they could not locate a physician order for oxygen administration to the resident. Licensed Practical Nurse #25 was informed of the observation of the resident's oxygen concentrator at zero (0) liters per minute oxygen flow rate and went into the resident's room and stated the oxygen concentrator flow rate was on zero (0) or one (1) liter per minute. During an interview on 02/19/2026 at 4:55 p.m., Registered Nurse Unit Manager #24 stated they will contact the medical doctor to see what needs to be done for the resident regarding obtaining an order for the oxygen administration. When interviewed via telephone on 02/27/2026 at 10:28 a.m., Medical Doctor #2 stated when Resident #5 returned to the facility on [DATE] they were receiving oxygen. They stated the oxygen was continued. On 02/19/2026, Medical Doctor #2 was contacted by the nursing staff and an order for three (3) liters per minute continuously via nasal cannula was entered for the resident. They stated there was no previous physician order for the oxygen but administering oxygen was proper and clinically indicated for the resident. 10 NYCRR 415.12(k)(6)

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	02/27/2026

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 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview conducted during a recertification survey conducted from 02/19/2026 to 02/27/2026, the facility did not ensure that medical supervision was provided for one (1) resident of five (5) residents reviewed for drug regimen review. Specifically, the pharmacy consultant recommended discontinuation of the drug Megace, an appetite stimulant, due to the resident's weight of 415 pounds. The physician agreed to discontinue the medication; however, the nurse practitioner reordered the medication, and the resident continued to receive the medication. The findings include The policy and procedure titled Medication Administration, revised 08/11/2025, documented the consultant pharmacist provided drug information and conducted monthly drug regimen reviews. The consultant pharmacist flagged or addressed unnecessary medications with the medical director. The facility established standards for physician countersignatures on orders and ensured they were completed promptly. Collaboration with the Quality Assurance and Performance Improvement program for medication safety. Resident #7 had diagnoses including schizoaffective disorder, Type 2 diabetes mellitus, and morbid obesity. The medication regimen review dated 10/02/2025 documented long-term use of Megestrol beyond 30 days could increase the risk of blood clots. The consultant pharmacist recommended discontinuation or clarification of the clinical indication if Megestrol continued. The medication regimen review response dated 11/21/2025 documented discontinue Megace. No GLP1 (Medication to treat Type 2 diabetes and Obesity) until resident # 7 is monitored off Megace. The physician order (renewal) documented 12/04/2025 Megestrol 400mg/10ml once daily. The December 2025 medication administration record documented Megestrol was administered 12/05/2025-12/11/2025, 12/15/2025, 12/16/2025, 12/18/2025, 12/19/2025, 12/22/2025, and 12/25/2025-12/31/2025. The quarterly Minimum Data Set, dated [DATE] documented Resident #7 had intact cognition, a height of 64 inches, a body mass index of 71.223 and weighed 413 pounds. The physician order (admission) dated 01/09/2026 documented Megestrol 400 mg/10ml once daily for benign endometrial hyperplasia (non-cancerous thickening of the lining of the uterus caused by extra cell growth) The January 2026 medication administration record documented Megestrol was administered 1/01/2026-01/08/2026, 01/11/2026-11/13/2026, 01/15/2026- 01/20/2026, 01/23/2026-01/25/2026, 01/29/2026- 01/31/2026, 02/01/2026, 02/02/2026, 02/04/2026 through 02/15/2026, 02/19/2026 through 02/24/2026 and 02/25/2026. The February 2026 medication administration record documented Megestrol was administered 02/01/2026, 02/02/2026, 02/05/2026-02/07/2026, 02/09/2026-02/25/2026, and 02/19/2026-02/24/2026. During an interview conducted on 02/26/2026 at 3:41 PM, the Medical Director stated the pharmacist's recommendations regarding the resident's medications had been reviewed. The Medical Director confirmed that the pharmacist recommended discontinuing Megestrol and agreed with the recommendation. The Medical Director stated an order was given to discontinue the medication. The Medical Director stated the resident was new to their care. The Medical Director stated that the resident weighed approximately 415 pounds and that a discussion had occurred regarding initiating a GLP-1 medication to assist with appetite suppression and weight management. The Medical Director stated that GLP-1 medications were not generally preferred; however, consideration was given to their use in this case to help reduce appetite. The Medical Director stated the gynecologist originally initiated Megestrol due to bleeding concerns; however, the resident was not currently experiencing bleeding. For that reason, they agreed with the pharmacist's recommendation to discontinue Megestrol. When informed, the resident continued to receive Megestrol. The Medical Director stated that Megestrol was not intended to remain active and reiterated that the medication was supposed to have been discontinued. During a follow-up interview on 02/26/2026 at 2:12 PM, the Medical Director stated Megestrol had been discontinued, and the Nurse Practitioner reordered the medication. The Medical Director stated Megestrol was not intended (continued on next page)

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	02/27/2026

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 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to remain active for the resident. During an interview with the Director of Nursing on 02/27/2026 at 2:10 PM, the Director of Nursing stated Megestrol had been discontinued and later reordered by the Nurse Practitioner. The Director of Nursing was unable to produce the order. During an interview on 02/27/2026 at 2:28 PM, the consultant pharmacist stated a recommendation had been made to discontinue Megestrol. The consultant pharmacist stated the physician was expected to address the recommendation; however, the issue was not addressed during the following month. The consultant pharmacist further stated the resident was not receiving Megestrol as an appetite stimulant, and Megestrol had been prescribed for endometrial hyperplasia. 10 NYCRR 415.15(b)(1)(i)(ii)

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	02/27/2026

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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility did not ensure that residents with dementia were receiving the appropriate treatment and services to attain and maintain their highest practicable physical, mental, and psychosocial well-being for one (1) of two (2) residents reviewed for dignity. Specifically, Resident #28 was observed soiled and in the same clothing on consecutive days. The resident had a history of refusals of care and poor hygiene. The activities of daily living and behavior care plans both contained interventions including a referral to social services as needed for evaluation and follow-up but that was never completed. The findings included:Resident #28 had diagnoses that included bipolar disorder, dementia, and major depressive disorder. The Activities of Daily Living Care Plan effective 12/13/2025 documented that Resident #28 has compromised status and at risk for decline and/or lack of improvement related to congestive heart failure with edema, difficulty walking, mood disorder, cerebellar ataxia, and resistance to participate in activities of daily living. Interventions included, but not limited to, encourage participation in activities of daily living care, observe for any decline in ability to participate, and refer to social services regarding discharge planning, family support, non-compliance, or cognitive changes.The Behavioral Symptoms Care Plan effective 12/13/2025 documented that resident has history of refusal of assistance with activities of daily living. Interventions included but not limited to monitor for signs of illness that may exacerbate behavioral issues, monitor behaviors to determine if any threat to self or others and notify registered nurse for intervention, and social service evaluation and follow up. The Five-Day Minimum Data Set assessment dated [DATE] documented resident with moderately impaired cognition with disorganized thinking and inattention, no behaviors including refusals of care, and maximal assistance required from staff with toileting hygiene.The Social Work Progress note dated 12/17/2025 documented that resident was admitted for short term placement, was present for meeting, and resident/resident representative in agreement with plan of care.The Nursing Progress Notes dated 01/08/2026, 01/20/2026, 01/23/2026, 01/30/2026, 01/31/2026, 02/02/2026, 02/10/2026, 02/18/2026, and 02/24/2026 documented resident refusal of cares.There was no documented evidence of any social work progress notes related to refusals of care or follow-up after the 12/17/2025 care plan meeting. The Psychological Consultation Note dated 02/07/2026 documented visit referral for anxiety and depression, impaired social judgement, episodic verbal aggression with staff, frequent noncompliance with hygiene practice, and adjustment challenges. Continued psychotherapy recommended. During an observation on 02/20/2026 at 9:40 AM, Resident #28 was sitting up in a wheelchair, self-propelling, stains observed on their shirt. Shoes partially on feet with dirt marks all over the fabric and sides of the soles.During an observation on 02/24/2026 at 11:57 AM, Resident #28 was sitting up in a wheelchair in the common area on the unit. They had a stained area on their bright blue shirt approximately 4-6 inches in diameter near the lower portion of the shirt by their waist band. Pants appear soiled with some spots and orange sneakers were visibly dirty. During an observation on 02/24/2026 at 12:20 PM, Resident #28 left the dining table during lunch. Their shirt was pulled up above waist exposing their stomach.During an observation on 02/25/2026 at 9:21 AM until 02/25/2026 at 11:00AM, Resident #28 was observed sitting up in a wheelchair, with the same bright blue shirt as yesterday. A large partially wet stain was present on the bottom portion of their shirt. They were wearing black sweatpants that were dirty and dusty with some white stains. Resident #28 was wearing orange sneakers that had dirt all over the fabric and sides of soles. A urine smell was emanating from Resident #28, and their hair was greasy and uncombed. During an interview on 02/26/2026 at 3:40 PM Certified Nurse Aide #36, they stated that Resident #28 refuses care often. They try to reapproach them when they refuse. They do take themselves to the bathroom often. They will change their clothing, but on their time. Any time they refuse care, they report it to the nurse. (continued on next page)

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	02/27/2026

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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/26/2026 at 3:45 PM Certified Nurse Aide #37 stated that Resident #28's mood varies. Sometimes they are receptive to care, other times they are not. Resident #28 can be odorous at times if care is refused. They reapproach and reattempt to provide care when this happens, and it occurs often. Nurses are informed when they refuse care. During an interview on 02/26/2026 at 3:51 PM, Registered Nurse Unit Manager #24 stated that Resident #28 does refuse care. There are behavior sheets that they provided documenting refusal of care and agitation. The staff does report the refusals of care. Resident #28 will permit showers most of the time. Psychology does follow them now. Social Work can discuss the refusals as needed but they were not able to say whether they were aware. During an interview on 02/27/2026 at 1:56 PM, the Director of Social Work stated they cover all the residents in the building, including Resident #28. The nursing staff does reach out to social work for assistance with dignity or other resident care issues as needed, but they have not been notified of any issues with refusals of care for Resident #28. They have been in touch with the family and would have discussed that, but they were not aware. They stated they will follow up with the unit staff. 10NYCRR 415.12

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	02/27/2026

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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation, and interview during the recertification survey conducted 02/19/2026 through 02/27/2026, the facility did not ensure proper disposal of garbage and refuse. Specifically, 1) the recycle dumpster lid was broken, unable to be completely closed and left open which allowed cardboard boxes to spill over the top, 2) the compactor had food debris puddled in front of the compactor door, and litter on the ground between the compactor and the dumpster.The findings are:The policy titled Waste Handling issued 3/2024 documented, the facility will maintain a clean, safe, and sanitary environment by ensuring that all garbage, recyclable materials are properly disposed of in compliance with regulatory requirements. During an observation of the garbage area on 02/19/2026 at 10:03 AM with the Food Service Director, the recycle dumpster was open with cardboard boxes spilling over the top. There were boxes and other litter on the ground surrounding the dumpster and trapped under it. The waste management company arrived during this time to empty the dumpster. Once completed it was observed that the dumpster lid was broken on the right side.During the observation of the compactor at that time there was observed food debris that had spilled down the front of the door and was puddled at the base of the compactor to the ground. There was observed used gloves, cups, empty milk carton, and an empty bag of instant potatoes on the ground surrounding the compactor extending to the area of the recycle dumpster.During an interview on 02/19/2026 at 10:05 AM, the Food Service Director stated the lid on the recycle dumpster was broken and never fully closed because the right side of the lid was missing. They stated the garbage area was used by the whole facility, and everyone was responsible for keeping the area clean. During an interview on 02/25/2026 at 4:55 PM the facility Administrator stated they did not have a policy for garbage/recycling disposal. They stated they had a schedule for the waste management company to pick up and keep the area clean.10 NYCRR 415.14(h)

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	02/27/2026

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 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review conducted during the recertification and abbreviated surveys on 02/19/2026 to 02/27/2026, the facility did not ensure that rehabilitative services were provided for two (2) of two (Resident #79 and Resident #10) reviewed for Rehabilitation. 1) Specifically, an occupational therapy screen was not completed for Resident #79 as per physician order and 2) an occupational screen was not completed to evaluate and treat leaning to the right side for Resident #10 as per physician order. The findings included The facility policy titled Rehab Evaluation revised 04/02/2022 documented the evaluation must occur following admission with physician orders for evaluation. The evaluation should be performed within 48 hours following the physician order. 1)Resident #79 was admitted to the facility on [DATE] with diagnoses including unspecified dementia. The admission Minimum Data Set (a resident assessment tool) dated 12/30/2025 documented Resident #79 had moderate cognitive impairment, required substantial/moderate assistance with bathing and dressing, supervision/touching assistance with transfers, and did not have an occupational therapy screen over the last seven (7) days. A physician order dated 12/27/2025 documented occupational therapy screen, evaluation and treat.^^ ^A rehabilitation care plan was not observed in the electronic medical record for Resident #79. During observations on 02/19/2026 at 9:40 AM, 02/19/2026 at 4:28 PM,^02/20/2026 at 8:45 AM and 1:01 PM and 02/27/2025 at 10:50 AM, Resident #79 was in bed. During an interview on 02/20/2026 at 11:41 AM, the Resident Representative stated Resident #79 had not received therapy services since admission and spends most of their time lying in bed. During an interview on 02/26/2026 at 10:27 AM, the Director of Rehabilitation^reviewed the electronic medical record for Resident #79 and stated Resident #79 did not have an occupational therapy evaluation/screen or services since admission on [DATE]. They stated they were not aware why the occupational therapy evaluation did not take place and that residents were should always be screened by occupational therapy upon admission. During an interview on 02/27/2026 at 8:54 AM, Occupational Therapist #5 stated they did not screen Resident #79 upon admission. They stated they had a heavy workload and the screen/evaluation fell by the wayside.^They stated they were aware there was a physician order to screen/evaluate/treat Resident #79. They stated the Director of Rehabilitation was aware of their heavy workload and that some assessments were not being completed.^They stated they did not report the missed physician ordered screen/evaluation for Resident #79 to the Director of Rehabilitation. They stated they had 14-16 residents a day and there was no time left to catch up with assessments.^^ ^2) Resident 10 had diagnosis including unspecified dementia, schizophrenia, diabetes and mild contractures. (continued on next page)

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	02/27/2026

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 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 12/12/2025 Annual Minimum Data Set assessment documented Resident #10 had intact cognition, was dependent on staff for all cares, required a mechanical lift for transfer. A physician order dated 12/11/2025 documented occupational therapy, evaluate and treat for leaning to the right in bed and in the Geri chair. During observations on 02/19/2026 at 11:05 AM, 02/20/2026 at 9:02 AM, and 02/24/2026 at 11:38 AM and 2:24 PM Resident #10 was observed in bed with their head leaning to the right shoulder. On 02/26/2026 at 11:07 AM Resident #10 was observed in the Geri chair leaning to the right. During an interview on 02/26/2026 at 4:26 PM the Director of Rehabilitation stated nursing staff entered orders for therapy to screen and evaluate residents. They stated therapy would see the referral in the system and complete the screen. They stated they were not sure why there was no progress note for the evaluation affiliated with the physician order dated 12/11/2025. During an interview on 02/27/2026 at 8:50 AM Occupational Therapist #5 stated they did not see the 12/11/2025 physician order for Resident #10 to be screened by occupational therapy. They stated they usually only screened and evaluated new admissions, re admissions and referral requests. They stated they did not complete quarterly evaluations. Occupational Therapist #5 stated the Rehabilitation Director was aware they were unable to complete all referrals due to a heavy case load. They stated their priority was treatment of managed care residents. 10 NYCRR 415.16(a)