STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335404	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Renaissance Rehabilitation and Nursing Care Center	4975 Albany Post Road Staatsburg, NY 12580

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observations, record review, and interviews conducted during an Abbreviated Survey (2579539), 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 one (1) of three (3) residents reviewed for activities of daily living. Specifically, Resident #3 was dependent on staff assistance for bathing and did not consistently receive showers twice per week per the resident's care plan and preference. The findings include: The policy and procedures on Activities of Daily Living/Maintain Abilities, revised 09/11/2024, stated that the facility was responsible for creating an environment that individualized each resident's quality of life. Staff across all shifts and departments were expected to understand and support principles of quality of life and honor each resident's preferences, choices, values, and beliefs. The facility also ensured residents were given appropriate treatment and services to maintain or improve their ability to perform activities of daily living. Resident #3 was admitted with diagnoses including cerebrovascular disease, dysarthria, and asthma. The admission Minimum Data Set assessment, dated 01/23/2025, documented the resident had intact cognition. For preferences for customary routine and activities, it was documented as very important for Resident #3 to choose between a tub bath, shower, bed bath, or sponge bath. Resident #3 was dependent on staff to complete bathing, and transfers for bathing and showering. The comprehensive care plan for activities of daily living dated 01/20/2025 documented interventions to provide showers twice per week as per the resident's preference. The 7/31/2025 Resident Nursing Instructions (care instructions for direct care staff) documented to shower on Tuesday and Friday evenings (initiated 01/24/2025). The July 2025 Certified Nurse Aide accountability documentation for the 3PM to 11PM shift, documented the resident received 5 of 9 showers for the month. The August 2025 Certified Nurse Aide accountability documentation for the 3PM to 11PM shift, documented the resident received 3 showers for the month. During an observation on 10/29/2025 at 11:50 AM, the resident was in bed not wearing a shirt and wearing an adult brief as the sheet was off the resident's body. The resident was interviewed during the observation and stated they did not always get showers when they should. During an interview on 10/30/2025 at 9:10 AM, the Staff Development Licensed Practical Nurse stated the resident usually told the staff when they wanted their shower, and the resident did not refuse their showers. During an interview on 10/30/2025 at 1:57 PM, Certified Nurse Aide #2 stated there was a time when the resident reported they did not receive a shower on the 3 PM-11 PM shift. During an interview on 10/30/2025 at 2:32 PM, the Director of Nursing stated they observed a pattern on the 3-11 and 11-7 shifts in which the Certified Nurse Aides were not documenting the care provided. The Director of Nursing stated the supervisor should review the Kiosk to confirm that documentation was completed. 10 NYCRR 415.12 (a)(3)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews during an abbreviated survey (2582016, 2579539, 2574633), the facility did not ensure residents received treatment and care in accordance with professional standards of quality for three of three residents (Residents #7, #6, and #4) reviewed for quality of care. Specifically, 1) Resident #7 was not assessed timely by a registered nurse after being observed with three open wounds on the left thigh; 2) there was no documented evidence that Resident #6 with complaint of pain was assessed by a registered nurse prior to being transferred from the floor to bed after an unwitnessed fall; and 3) there was no documented evidence that Resident #4 was assessed by a registered nurse prior to being transferred from the floor to bed after an unwitnessed fall. The findings include: An untitled policy dated 10/02/2024 revealed when it is determined that a resident has had an accident or incident according to policy definition the nurse must notify the nursing supervisor immediately of the unusual event. The nurse/nursing supervisor is responsible to evaluate the resident for injury to determine whether the resident may or may not be moved, if there is any suspicion for major injury which may be worsened/exacerbated by moving the resident, they must be stabilized and remain in place until emergency medical services arrive to assume care, with non-disruptive measures employed for comfort as practicable. If the nursing supervisor deems the resident may be moved, maximal support will be used, and the resident will be placed into bed for a full body audit and vitals collected. The attending physician will be notified to receive orders for treatment, in the event the attending physician cannot be reached, the medical director will be notified of the resident's condition. 1) Resident #7's diagnoses included paranoid schizophrenia, neurocognitive disorder with Lewy bodies and hypertensive disorder. The 07/28/2025 quarterly Minimum Data Set documented Resident #7 had moderate cognitive impairment, was independent with eating, and self-propelled in a wheelchair. The 08/02/2025 Accident and Incident Report written by Licensed Practical Nurse #8 documented Certified Nurse Aide #11 reported Resident #7 was found with three open areas on the left hip (four (4) x thee (3) centimeters upper, five (5) x two (2) centimeters middle, and three (3) x three (3) centimeters lower). The physician was notified at 10:45 PM on 08/02/2025. The 08/02/2025 statement written by Licensed Practical Nurse #8 documented Resident #7 stated they burned themselves with hot black coffee a few days ago. The undated Post Accident Incident Pain and Skin Observation Report written by Registered Nurse #6 documented Resident #7 had three open areas on the left hip. There was no documented evidence in the electronic medical record or in the accident/incident report documenting that Resident #7 was assessed timely by a registered nurse after the open hip wounds were identified. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 08/03/2025 nursing progress note Licensed Practical Nurse #8 documented the resident was reported to have three (3) open areas on left hip, upper four (4) x three (3) centimeters, middle five (5) x two (2) centimeters and lower three (3) x three (3) centimeters. The physician was notified. The area was cleansed with normal saline, and triple antibiotic ointment and dry protective dressing were applied. The resident stated they burned themself with coffee a few days ago but did not recall when. The resident has been witnessed putting a cup with black hot coffee and no lid next to their body when in the wheelchair. The resident's sister was notified. Suggested obtaining a metal coffee mug with lid and cup holder for the wheelchair to prevent further incident. Review the staffing schedule documented no Registered Nurse was on duty from 08/02/2025 at 7:00 AM until 08/03/2025 7:00 PM. The 08/04/2025 nursing progress note written Licensed Practical Nurse #13 documented the resident was seen by the wound care physician for evaluation of the left hip burn. Silvadene and a dry protective dressing to be applied every day and as needed. During an interview and observation on 10/30/2025 at 9:36 AM, the Director of Nursing stated Licensed Practical Nurse Supervisor #8 was on duty when Resident #7's wounds were observed. They stated a Registered Nurse was not in the facility from 7:08 AM on 08/02/2025 until 5:44 PM on 08/03/2025. They stated the registered nurse who presented to the facility on [DATE] should have been informed of the wounds during verbal shift report and upon review of the supervisor report and should have immediately assessed Resident #7. During an interview on 10/30/2025 at 11:30 AM, Licensed Practical Nurse #8 stated they were working as a supervisor on 08/02/2025 from 7 PM to 7 AM and contacted the Director of Nursing, Regional Director of Nursing, Administrator, medical doctor and other supervisors via group text to report Resident # 7's wounds. During a follow-up interview on 10/30/2025 at 11:41 AM, the Director of Nursing stated they received a group text message on 08/03/2025 at 6:36 AM and 6:37 AM from Licensed Practical Nurse #8 informing the group of Resident #7's wounds. They stated they did not respond to the group text chat and that the only response to the text message was from the Administrator who stated they would order Resident #7 a coffee mug with a lid and holder for the wheelchair. They stated they should have responded to the text and followed up with a phone call to discuss the incident and provide an assessment. During an interview on 10/30/2025 at 1:55 PM the Administrator stated they received a group chat text message on 08/03/2025 at 6:36 AM from Licensed Practical Nurse #8 to report the incident involving Resident #7. They stated they responded at 7:23 AM indicating they would order a coffee mug with lid for Resident #7. The Administrator stated when a registered nurse was not present in the building during an incident, the expectation was that the Director of Nursing, a corporate registered nurse or a registered nurse from a nearby sister facility would be requested to report to the facility to assess resident/s. They stated that Resident #7 not being assessed by a registered nurse immediately was due to lack of clinical oversight. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/04/2025 at 4:25 PM, the Medical Director stated they were contacted by Licensed Practical Nurse #8 via group text on 08/03/2025 at 6:36 AM. The Medical Director stated the expectation was that video assessments be utilized when a registered nurse was not in the building to assess. They stated the video assessment could be completed by Director of Nursing or Medical Director. They stated they did not conduct a video assessment for Resident #7 on 08/02/2025 and was unaware if the Director of Nursing conducted a video assessment. 2) Resident #6 diagnoses included metabolic encephalopathy (a neurological condition,) Dysphagia (difficulty swallowing), and Lupus (an autoimmune disorder). The admission Minimum Data Set (an assessment tool) dated 07/22/2025 documented Resident #6 had moderately impaired cognition and was dependent on staff for all activities of daily living. The resident had one (1) fall documented. The 07/20/2025 Accident and Incident Report written by Licensed Practical Nurse #8 documented the resident was found on the floor next to their bed. Resident # 6 complained of hip pain. Medical Doctor was notified, and x-rays were ordered. The 07/20/2025 at 7:00 AM progress note written by Licensed Practical Nurse #8 documented the resident was reported to be on the floor next to their bed. Medical Doctor was notified, x-rays were ordered, and Tylenol was administered for pain. There was no documented evidence in the 07/20/2025 through 07/24/2025 nurse progress notes that an assessment was done by a registered nurse after the 07/20/2025 fall. The staffing schedule dated 7/20/2025 documented there was not a Registered Nurse working from 7 AM on 7/19/25 until 7 AM on 7/20/25. During an observation and interview on 10/30/2025 at 10:45 AM Resident #6 was in bed with two (2) staff providing incontinence care. Resident #6 was alert but did not recall the fall. During an Interview on 10/30/2025 at 11:40 AM, Licensed Practical Nurse #8 stated if there was no registered nurse in the building they could facetime the Director of Nursing. They stated they did not remember specifics but stated they would not get the resident off the floor without a registered nurse assessment. They stated they completed the Accident and Incident Report and were unsure why there was no documentation of a registered nurse assessment. During an interview on10/30/25 at 12:56 PM the Director of Nursing stated they usually completed the investigation for unwitnessed falls. They stated they did not recall this specific event and were unsure if a registered nurse assessed the resident prior to them being returned to bed. They stated if a registered nurse assessed the resident a note should have been written. They stated a supervisor should have written a note, and a registered nurse assessment should have been completed. They stated nurses should have written notes for three (3) days after the fall. They did not know why this was not done. 3) Resident #4 had diagnoses that included dementia, depression and anxiety. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 07/07/2025 quarterly Minimum Data Set documented Resident #4 had severe cognitive impairment and received maximal assistance for bed mobility and transfers. The 05/19/2025 care plan titled Fall Risk documented keep items in reach, gripper socks to feet at bedtime, keep room well-lit and clutter free, keep resident in areas of increased visibility, bed in lowest position. The 07/19/2025 Accident/Incident Report documented the resident was observed lying on the floor on the left side along the right side of the bed with what appeared to be blood coming from the left nostril. The resident was assisted off the floor and transferred to bed with staff assistance of two persons. The physician and family were notified at 6:00 PM. Follow up for 72 hours and observe for signs and symptoms of injury such as ecchymosis, pain, swelling and a change in mentation or behavior. There was no documented evidence in the nursing progress notes from 07/19/2025 through 07/29/2025 that a registered nurse assessed Resident #4 prior to the resident being transferred from the floor to the bed. There was no documented evidence that 72-hour post fall monitoring was conducted and/or treatment was put in place to address Resident #4's bloody nose. The staffing dated 7/19/25, documented on the second floor Licensed Practical Nurse #12 worked 7 AM -7 PM, Licensed Practical Nurse #13 worked 7 AM to 2 PM and Licensed Practical Nurse#14 worked 7 PM -11PM. Licensed Practical Nurse Supervisor #8 worked 7 PM on 7/19/25 to 7 AM on 7/20/25. There were no Registered Nurses scheduled to work from 7 AM on 7/19/25 until 7 AM on 7/20/25. During this time Resident#4 was found on the floor in their room on 7/19/25 at 6 PM with a bloody nose. During an interview on 11/6/25 at 10:20AM, Certified Nurse Aide #11 stated they found the resident on the floor. They stated they knew they could not move the resident and told Licensed Practical Nurse #12. They stated the resident was transferred back to bed by Licensed Practical Nurse #12 and Licensed Practical Nurse #8. They stated there were no other nurses that came to see the resident. During an interview on 10/30/25 at 11:55AM, Licensed Practical Nurse #12 stated the process was to call the Director of Nursing. Licensed Practical Nurse #12 stated they did not recall speaking with the director of nursing regarding Resident #4's fall. They stated they often communicated with the Director of Nursing via text. They stated they had not seen the Director of Nursing come to the facility to assess residents after fall/s. During an interview on 10/30/25 at 11:31AM, Licensed Practical Nurse Supervisor #8 stated they were working at the time of Resident #4's fall. They stated the process was to call the Director of Nursing, the Medical Director, and corporate nurse if there was a fall in the building after hours. They stated many times there were no registered nurses working at the facility when residents had falls. They stated they did not remember a registered nurse being in the building to conduct an assessment at the time of Resident #4's fall. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/29/2025 at 11:38AM, the Director of Nursing stated they were the backup when there were no registered nurses in the building. They stated they did not come to the facility to assess residents, instead the nurses called them with problems, and they provide guidance and support over the phone. They stated they did not write notes after speaking to nurses about incidents. They stated they were not aware of Resident #4's 07/19/2025 fall until 07/21/2025. They stated they had an in-service with the nurses to remind them they needed to call them about falls in the facility. During a follow up interview on 10/30/2025 at 12:56 PM the Director of Nursing stated they now remembered being notified by the nurse about the fall. They stated they did not write a note or an assessment because they had a lot of things on their mind. 10NYCRR 415.12

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review conducted during the abbreviated survey (2574633), the facility did not ensure each resident received adequate supervision consistent with resident's needs to prevent accidents for one (1) of three (3) residents (Resident #7) reviewed for accidents. Specifically, Resident #7 sustained an upper left lateral thigh burn on 04/12/2025 after they spilled a hot beverage. The facility did not thoroughly investigate the accident and implement interventions to prevent reoccurrence. Subsequently, Resident #7 sustained second degree burns on the left upper thigh on 08/04/2025 after placing their hot cup of coffee next to their thigh while self-propelling in their wheelchair. Additionally, the facility did not report either burn incident to the New York State Department of Health.The findings included:An untitled facility policy last dated 10/02/2024 documented: It is the policy of the Facility to promote and maintain a safe environment, and to maintain reports and surveillance of all resident's accidents and incidents. The purpose is to investigate and document all accidents and incidents and develop corrective measures to prevent reoccurrence. The Director of Nursing/designee is to review initial information with Administrator to determine if there had been a care plan violation or other criteria to prompt a report to Department of Health such as suspicion of abuse, with appropriate follow-through per prevailing regulation and best practice. Nursing will review the completed report with the Interdisciplinary team in Morning Report and discuss outcomes of investigation including causative/contributory factors, efforts to prevent recurrence, care plan updates and any necessary resident or employee education needs.1) Resident #7's diagnoses included paranoid schizophrenia, neurocognitive disorder with Lewy bodies and hypertensive disorder.An Annual Minimum Data Set completed 04/28/2025 documented Resident #7 had moderate cognitive impairment, required set-up/clean up assistance with eating, and self-propelled in a wheelchair. An Accident and Incident report dated 04/12/2025 completed by Licensed Practical Nurse Supervisor #15 documented Resident #7 was found with two blisters on left thigh which Resident #7 stated they received when they spilled hot chocolate on 04/11/2025.The nursing progress note completed by Licensed Practical Nurse #15 dated 04/12/2025 at 6:55 PM, documented they were notified by Licensed Practical Nurse #16 that Resident #7 had blisters to left lateral upper thigh. The resident stated I spilled hot cocoa on myself during dinner last night and I didn't tell anyone. The Nurse Practitioner was notified and wound care notified. New orders included vitals every shift for three (3) days and to cleanse area with DermaKlenz (wound cleanser), apply Silvadene (cream to prevent and treat infection) to blisters and cover with boarder gauze daily. Certified Nurse Aide #14's written statement dated 4/12/2025 documented while doing morning cares on Resident #7, they noticed two blisters on the resident's left thigh. They stated the resident told them it happened yesterday (4/11/2025) while drinking hot chocolate. Certified Nurse Aide #14 documented they notified the nurse. A Post-Incident Skin assessment dated [DATE] by Registered Nurse #6 documented a burn blister on left thigh. The 04/12/2025 Accident / Incident report was signed off by the Director of Nursing on 4/14/2025 and documented the resident had poor safety awareness, was educated on appropriate safe handling of hot beverages and there was no evidence of abuse/neglect. The report did not include an investigation to determine how abuse was ruled out or a root cause analysis to prevent further recurrence. Additionally, there was no documented evidence the burns were reported to the New York State Department of Health.The resident comprehensive care plan was updated on 04/14/2025 documented a blister to the left hip. Interventions included to refer for follow-up with the wound care team, perform wound care rounds weekly, assess characteristics of ulcer daily during treatment care and document findings weekly, apply local treatments as ordered by physician, monitor food consumption, and dietary education regarding use of hot chocolate cup, dietary referral. A dietary note dated 04/14/2025 completed by the Registered Dietician documented they were informed by nursing that Resident #7 spilled hot chocolate on themselves over the weekend. They encouraged the resident to consume all hot liquids during meals or ensure hot liquids had a lid to reduce risk of spills. No further updates were made to the resident's care plan with interventions to prevent reoccurrence. The Certified Nurse Aide Kardex (care instructions) did not document any instructions for hot beverage management or increased supervision with hot beverages.An Accident and Incident report dated 08/02/2025, completed by Licensed Practical Nurse #8 documented Certified Nurse Aide #11 reported Resident #7 was found with three open areas on left hip. Resident #7 stated they burned themself with hot coffee a few days ago. The Accident/Incident report documented the 3 open areas measured 4 X 3 centimeters, 5 x 2 centimeters, and 3

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observations, record review, and interviews conducted during an Abbreviated Survey (2579539) from 10/28/2025 to 10/30/2025, the facility did not ensure that residents were provided with appropriate treatment and services to achieve or maintain as much bladder and bowel function as possible for one (1) (Resident #3) of three (3) residents reviewed for activities of daily living. Specifically, Resident #3 was admitted with occasional incontinence of urine and bowel, was not provided services to maintain or improve incontinence. The resident expressed their preference not to wear adult briefs, was not trialed on a toileting program, and their incontinence episodes increased. The findings include: The policy and procedures on Activities of Daily Living/Maintain Abilities, revised 09/11/2024, stated that the facility was responsible for creating an environment that individualized each resident's quality of life. Staff across all shifts and departments were expected to understand and support principles of quality of life and honor each resident's preferences, choices, values, and beliefs. The facility also ensured residents were given appropriate treatment and services to maintain or improve their ability to perform activities of daily living. Resident #3 was admitted with diagnoses including cerebrovascular disease, dysarthria, and asthma. The admission Minimum Data Set assessment tool, dated 01/23/2025, documented the resident had intact cognition and was dependent on staff to complete toileting hygiene, bathing, and transfers for bathing and showering. The resident had an external catheter, was occasionally incontinent of urine (less than 7 episodes of incontinence during the 7-day look back period) and occasionally incontinent of bowel (one episode of bowel incontinence). The comprehensive care plan for urinary incontinence dated 01/20/2025 documented goals included the resident would be maintained on a toileting program to promote dignity and prevent skin breakdown. Interventions included to monitor for redness or skin breakdown during toileting or diaper changes every 2 to 4 hours. The care plan for Incontinence Prevention dated 01/20/2025 documented the resident was at risk for episodes of incontinence. Goals included the resident would maintain continence to ability with interventions. Interventions included utilize clothing that is easily removed to facilitate toileting, physical therapy/occupational evaluation and treatment as needed, and provide incontinence briefs. There were no updates to the care plan for continence after 1/20/2025. The quarterly Minimum Data Set assessment tool, dated 07/21/2025, documented the resident had intact cognition and was dependent on staff for toilet transfers. The resident had no urinary appliance, was frequently incontinent of urine (7 or more episodes of urinary incontinence, but at least one episode of continent voiding) and always incontinent of bowel (no episodes of continent bowel movements). The Minimum Data Set also documented a trial of a toileting program had not been attempted on admission/entry or reentry or since urinary incontinence was noted. The 7/31/2025 Resident Nursing Instructions (care instructions for direct care staff) documented the resident was incontinent and interventions were incontinence briefs, urinal, condom catheter initiated on 1/20/2025 with no updates. For Bowel Continence it documented continent with no updates since 1/20/2025. Toilet Use was documented as the resident was total dependence with one person assist, was incontinent of urine (starting 1/20/25) and incontinent of bowel (changed on 3/1/25), toilet type was bedpan or incontinence briefs. The care card was updated on 7/28/2025 to assist with toileting needs and provide incontinent care every 3 to 4 hours and as needed. During an observation on 10/29/2025 at 9:10 AM, the resident was observed in bed while Certified Nurse Aide #2 was providing care. During a telephone interview on 10/29/2025 at 10:23 AM, Resident #3's family member stated the resident wore adult briefs and it was not good for their skin. The family member stated the resident was assisted to the toilet when the resident was out on pass with the family. During an observation on 10/29/2025 at 11:50 AM, the resident was in bed not wearing any shirt and wearing an adult brief as the sheet was off the resident's body. The resident was interviewed during the observation they stated when they needed help, they yelled for staff to assist by calling, nurse! nurse! Staff did not answer, and they would be incontinent. They did not like wearing the brief and would like to be assisted to the toilet. They stated that when they went to visit their family, they did not wear adult briefs and used the toilet. The resident stated the staff were aware of their preference to be assisted to the toilet; they had told the certified nurse aides and nurses, but they did not listen to them. During an interview on 10/30/2025 at 1:08 PM, Certified Nurse Aide #2 stated that the resident transferred with two assistants, could stand and was capable of being toileted. They also stated at times they did not have the staff to assist the resident. During an interview on 10/30/2025 at 1:27 PM, Registered Nurse #6 stated that the resident had not been on a toileting program. During an interview on 10/30/2025 at 1:57 PM

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	335404	A. Building B. Wing	11/19/2025

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Renaissance Rehabilitation and Nursing Care Center	4975 Albany Post Road Staatsburg, NY 12580

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. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews during an abbreviated survey (2582016, 2579539, 2574633), the facility did not ensure sufficient nursing staffing to attain or maintain the well-being of each resident. Specifically, upon review of the staffing schedule for multiple days on all three shifts and for each floor for July and August 2025, the facility did not provide adequate numbers of Certified Nurse Aides to meet the needs of the residents.The findings are: The undated facility Staffing Policy documented the facility shall have sufficient staff to provide nursing and related services to attain or maintain the highest practicable, physical, mental and psychosocial well-being of each resident. The facility shall further assure that staffing levels enable each resident to receive treatments, medications, diets and other health services in accordance with individual care plans. The Facility assessment dated [DATE], and last reviewed by the Quality Assurance and Improvement Committee on 8/22/24 documented the staffing plan. The Staffing Plan- Staffing Guidelines documented there would be a minimum of 11 Certified Nurse Aides for the day and evening shifts, and a minimum of six (6) Certified Nurse Aides for the night shift. A review of the staffing schedules for July 2025 and August 2025 documented the facility did not meet the minimum of 11 Certified Nurse Aides on day or evening shifts for 62 of 62 days, and did not meet the minimum of six (6) Certified Nurse Aides on the night shift for 58 of 62 days. During an observation on 10/29/25 at 9:55 AM on second floor foul odors were noted coming from residents' rooms. There were approximately eight residents in the day room at tables. There was no staff supervising or interacting with residents. During an observation on 10/30/25 at 10:26 AM, in the first floor dining room, no staff were present and six residents were unsupervised.During an observation on 10/30/25 at 10:30 AM, there was a strong smell of urine on second floor and twenty residents were observed in bed. During an interview on 10/29/25 at 10:17AM, Resident #1 stated call bells went off all the time and it took a long time to get a bell answered. They stated on the weekend bells rang constantly, meals were always cold, and they did not get showers regularly. They stated the Charge Nurses were aware and did not do anything about it. They stated that sometimes there were no nurses on the second floor and a nurse would have to come up from another unit to give out medications. During an interview on 10/28/25 at 10:15 AM, Certified Nurse Aide #2, working on the second floor, stated there were five (5) Certified Nurse Aides working today but there were times when there were three (3) Certified Nurse Aides or less and that was not enough to get the work done. They stated residents had to stay bed longer or not get out of bed when short staffed. They stated they had two residents to shower today and would try hard to get it done but was not sure it would happen. They stated the facility was aware that there was a staffing problem. During an interview on 10/29/25 at 9:57 AM, Certified Nurse Aide#10, who was working on the second floor, stated today there were four (4) Certified Nurse Aides, and they were taking care of about 12-13 residents each. They stated they had two showers to give but had not given them as they had four residents to feed. They stated they used to have seven (7) Certified Nurse Aides on the schedule and that was what they needed to get residents out of bed, complete all cares and have a Certified Nurse Aide to supervise the day room. When there was not enough Certified Nurse Aides on the unit it limited the number of residents they were able to get out of bed, shower, and take to activities. When they had only two Certified Nurse Aides, residents were stuck in their rooms, and it was impossible to get the residents into chairs for activities. They stated it also took a long time to feed everyone. During an interview on 10/29/25 at 10:37 AM Certified Nurse Aide #3 stated when staffing was lower than five (5), they could not complete their assigned work. They stated it was hard to do showers, answer call bells, and find help for transfers requiring a mechanical lift. During a follow up interview on 10/30/25 at 10:30 AM, Certified Nurse Aide#3 stated there were only three Certified Nurse Aides working on the unit. The plan was to work with the other Certified Nurse Aide to get residents ready for the day. At this time, they were still getting residents out of bed and making the toileting changes that were started at 7:00 AM. They stated they had eight (8) residents that required a mechanical lift for transfers and one (1) or two (2) more showers to give.During an interview on 10/30/25 at 10:36AM, Registered Nurse#6 stated they were giving meds on two sides today. They stated they were also assisting the Certified Nurse Aides as there were three (3) working. They stated they were constantly stopped and asked for help to get residents out of bed or to help with turning. They stated they could not get the medications passed out in a timely manner and residents got their medications late. They stated they were unable to get assessments done and care plans were often left incomplete. They stated some days there

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review conducted on an abbreviated survey (2582016, 2579539, 2574633), the facility did not ensure that a Registered Nurse was on duty for at least 8 consecutive hours a day, 7 days a week for four (4) of nine (9) weekends reviewed from 07/01/25 through August 31,2025. Specifically, no Registered Nurse worked during the 24-hour period on the following weekends 7/5/25 to 7/6/25, 7/12/25 to 7/13/25, 7/19/25 to 7/20/25 and 8/2/25 to 8/3/25. Additionally, during the times when no Registered Nurse was scheduled, two (2) residents (Resident #4 and #6) fell, another sustained a burn (Resident #7), and they were not assessed by qualified staff (registered nurse, physician or nurse practitioner) (See F684).Findings included:The undated facility Staffing Policy documented the facility will have sufficient staff to provide nursing and related services to attain or maintain the highest practicable physical mental and psychosocial well-being of each resident. The facility shall further assure that staffing levels enable each resident to receive treatments, medications, diets and other health services in accordance with individual care plans.The Facility assessment dated [DATE] documented staffing goals which included the Director of Nursing as a full-time Registered Nurse, two full-time Registered Nurse Managers, three (3) full-time Registered Nurse Supervisors for evenings and weekends, and six (6) Licensed Practical Nurses for day shift, five (5) for evening shift and (3) three for night shift.The facility staffing was reviewed from 7/1/2025 through 8/31/25. During this time there was no documentation of a Registered Nurse on duty for at least 8 consecutive hours a day on the weekends of 7/5/25 to 7/6/2025, 7/12/25 to 7/14/25, 7/19/25 to 7/20/25, and 8/2/25 to 8/3/25. On these weekends, the facility had no registered nurse in the building for periods of 36 to 48 hours. Review of the facility Accident/Incident log documented on 7/19/2025, Resident #4 fell out of bed, sustained a bloody nose, and was put back to bed without being assessed by a Registered Nurse. On 7/19/2025 Resident #6 fell out of bed, complained of hip pain and was not assessed. On 8/2/2025, Resident #7 was observed with a burn on their thigh and was not assessed by qualified staff until 8/4/2025 when seen by the wound care physician. During an interview on 10/29/25 at 11:21 AM the Staffing Coordinator stated they did not have the staff to meet the goal of the Facility Assessment. There were times when there was no Registered Nurse scheduled in a twenty-four-hour period and the Director of Nursing was made aware of the situation. The Director of Nursing would be available to cover any day where a Registered Nurse was needed. The staffing Coordinator stated that the weekend dates of 7/7/25, 7/6/25, 7/9/25, 7/12/25, 7/19/25 and 8/2/25 would be covered by the Director of Nursing. They did not keep a record of days the Director of Nursing was in the facility filling in for Registered Nurses or have documentation the Director of Nursing was added to the weekend schedule.During an interview on 10/29/25 at 11:38 AM the Director of Nursing stated they were the back up when a Registered Nurse was not scheduled. When there was not a Registered Nurse, the Licensed Practical Nurse would call them when there was a problem, and they would offer guidance over the phone. They stated they did not write notes and did not not have any other documentation they were on duty during this time. During an interview on 10/30/25 at 1:55 PM the Administrator stated when a Registered Nurse was not present in the building during an incident, the expectation was that the Director of Nursing or a Corporate Registered Nurse would report to the facility as soon as possible to assess resident. They also stated that a nurse from sister facility nearby could also be requested to go to the facility to assess a resident. The Administrator stated they were aware that there were days when a Registered Nurse was not available to work in the facility, especially on weekends or night shift and was working to increase Registered Nurses at the facility. 10NYCRR 415.13(b)(1)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review conducted during an abbreviated survey (2582016) the facility did not ensure that pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing and administering of all drugs and biologicals) met the needs of each resident for one (1) (Resident #1) of three (3) residents reviewed for medications., Specifically, Resident #1 was not administered six (6) doses of eszopiclone to treat insomnia. The finding include:Resident #1 had diagnoses that included bipolar disorder, Lupus anticoagulation syndrome, and insomnia.An admission Minimum Data Set, (an assessment tool) dated 08/08/2025 documented the resident's cognition was intact. The resident received hypnotic medication daily.The policy titled Administering Medications dated 03/2025, documented if a medication is missing / unavailable, the overflow/extra medication supply storage in the med room should be checked. if it is not there, the emergency box should be checked to see if it is present. If it is not present the nurse should call the Medical Doctor/Nurse Practitioner for a hold order, document and call the pharmacy on the whereabouts and when the delivery will be, or an alternative that is available as stock or in the emergency drug box inventory. Monitor for potential effects of medication not given based on diagnoses being treated. Report all unusual events to nursing management promptly. A Physician order dated 09/15/2025 documented eszopiclone three (3) milligrams, one (1) tablet daily at bedtime for insomnia.The October 2025 Medication Administrator Record documented eszopiclone was not administered on 10/11/2025-10/16/2025. The nurse documented in the comment section of the Medication Administration Record on order on 10/11/2025-10/13/2025, on 10/15/2025 it was documented as unavailable on 10/14/2025 and 10/16/2025 the medication administration record had no documentation. The nurse progress notes from 10/11/2025-10/16/2025 did not document the sleeping medication was unavailable or not given.A Grievance report dated 10/17/2025, included an undated letter, addressed to the Director of Nursing, from the resident documenting they had not received their sleep medication. The Director of Nursing met with the resident regarding their concern and explained to the resident why the medication was not available for six (6) nights. The medication required prior insurance authorization. The insurance authorization had been obtained on 10/16/2025 for the medication and the medication was dispensed to the facility on [DATE]During an interview on 10/29/2025 at 9:25 AM, Resident #1 stated they were unable to get eszopiclone (sleep medication) for almost a week. They were unaware if the physician was notified but were told they had no sleep medication in the emergency medication box.During an interview on 10/29/2025 at 10:55 AM, Licensed Practical Nurse # 1 stated Resident #1 had a physician order for eszopiclone three (3) milligrams every night at bedtime for insomnia. The medication was unavailable in the facility. They notified the supervisor. They did not attempt to call the medical provider or the pharmacy to obtain the medication or obtain an order for an alternative sleep medication. During an interview on 10/29/2025 at 11:30 AM, the Director of Nursing stated the resident told them about not receiving eszopiclone for several days. A grievance was filed, and an investigation was conducted, and shared with the resident. The pharmacist advised the Director of Nursing the medication was not sent as it required prior approval from the insurance company. The Director of Nursing had called the Medical Provider who offered the resident Trazadone after the fifth missed dose, which the resident declined. The Director of Nursing stated they spoke with the pharmacy consultant and the pharmacy obtained the insurance approval, and the medication was delivered on 10/17/2025. They stated the medication nurse should have called the medical provider and or the pharmacy to obtain an alternative medication to help the resident sleep. They did not recall the pharmacy informing them of the need to obtain insurance approval and were unaware the medication would not have been delivered to the facility. The Director of Nursing stated they had not obtained prior approval in the past and thought it was the pharmacy's responsibility. During an interview with on 10/29/2025 at 12:03PM, the Nurse Practitioner stated if a medication was unavailable, they would expect either the nurse or the pharmacy to notify them. They were away in October during this time so they would have expected a medical provider would have been called.During an interview on 10/29/2025 at 2:15 PM, the physician stated they were made aware the resident did not get eszopiclone as ordered after six (6) doses were missed. They stated if they had been notified when the medication ran out, they could have ordered the resident an alternative sleep medication. During an interview on 10/30/2025 at 1:45 PM, the pharmacy representative stated the Director of Nursing notified them the resident had not received eszopiclone from 10/11/2025-10/16/2025. They stated they thought the pharmacy had notified the