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	05/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on record review and interviews, the facility failed to ensure each resident was free from verbal and mental abuse. This was evident for one of three residents reviewed for abuse (Resident #1). Specifically, on 01/25/2026, Certified Nurse Assistant #1 used vulgar/foul language and screamed at Resident #1 while providing care. This incident caused Resident #1 to experience mental distress which resulted in actual harm to Resident #1 that was not Immediate Jeopardy.The undated facility policy titled Abuse, Neglect, Mistreatment and Misappropriation of Resident Property documented that an owner, licensee, administrator, licensed nurse, employee or volunteer of a nursing home shall not physically, mentally or emotionally abuse, mistreat or neglect a resident. Under abuse definition section ?A.' Abuse includes verbal abuse, sexual abuse, physical abuse and mental abuse. Verbal abuse is further defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, disability. Mental abuse includes but is not limited to humiliation, harassment, threats of punishment or deprivation. Resident #1 had diagnoses that included anoxic brain damage (a severe injury caused by a total lack of oxygen to the brain causing brain cells to die within minutes), hemiplegia (paralysis of one entire side of the body) following other cerebrovascular disease (problems with blood flow to the brain) affecting right dominant side, contracture of muscle right and left hand. The Quarterly Minimum Data Set (a resident assessment tool) dated 12/09/2025 documented Resident #1 had unclear speech, was sometimes understood, was cognitively intact and dependent on staff for all activities of daily living: eating, oral hygiene, toileting, showering and dressing upper and lower body. Resident #1 had a Care Plan dated 01/21/2025 entered by the social worker with a focus Potential for Victimization: Due to medical, cognitive, mood and/or behavioral status). Resident #1 has the potential to be a victim while a resident in a skilled nursing setting related to: medical status, diagnosis of traumatic brain injury, and other which is defined as unable to easily verbalize. The long-term goal was Resident #1 would be free of being a victim of abuse, neglect, or resident-to-resident incident throughout routines. Interventions were listed as Resident #1 will be encouraged to engage in daily routines, meaningful conversations, activities of preference, psych consultations, and hobbies to foster growth, healthy relationships, and positive engagement while a resident at the facility. The internal Accident and Incident report dated 01/25/2026 documented that at approximately 3:15 PM, Resident #1 was receiving care from Certified Nurse Assistant #1. They were witnessed by other staff members to be handling Resident #1 in a rough manner and vocalizing in loud tones characterized as screaming. Per Resident #1's report, Certified Nurse Assistant #1 used ice cold water to provide hygienic care. At the time of the occurrence, Resident #1's family was on the phone with an open line. The Registered Nurse Supervisor #1 reported to the scene and Certified Nurse Assistant #1 was removed from the environment immediately and care was provided by other staff. Certified Nurse Assistant #1 left the facility and was subsequently notified that they would be suspended pending the outcome of the investigation. A Registered Nurse assessment yielded data supporting emotional upset and anger; there was no indication of physical injury. The Medical Director was made aware of the incident and (continued on next page)

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

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	followed up with no new orders. A follow up skin check three days later yields no new injury, bruising, discoloration, report of pain or other negative psychical manifestation of the event. Statements collected from staff on duty support the allegation as stated by Resident #1 regarding being handled roughly and being subjected to loud, disruptive and agitated vocalizations. The allegation of abuse is substantiated. Review of a handwritten internal Accident and Incident statement dated 01/25/2026 at 3:15 PM by Registered Nurse #1 documented Resident #1 accused Certified Nurse Assistant #1 of abuse and reported that Certified Nurse Assistant #1 was physically rough when doing care, was screaming about having to do care, and used ice cold water. Registered Nurse #1 documented that they saw Certified Nurse Assistant #1 rolling Resident #1 back and forth roughly and that staff heard and saw Certified Nurse Assistant #1 yelling. There is a follow up undated, untimed typed page signed by Registered Nurse #1 included in the incident report. It documented that they were called to the unit shortly after 3:00 PM to address a certified nurse assistant screaming. They intervened and advised Certified Nurse Assistant #1 to exit Resident #1's room and to stop screaming. Certified Nurse Assistant #1 left the room, and they finished providing care to Resident #1. Resident #1's representative was on the phone during the entire exchange. Registered Nurse #1 stated that at about 5:00 PM, they went back to get a statement from Resident #1 and Resident #1 was still on the phone with Resident #1's representative. Registered Nurse #1 stated that Resident #1 told them that Certified Nurse Assistant #1 had come in the room, was loud and was in their face, that they used cold water to clean them, Certified Nurse Assistant #1 started yelling, and that they got upset and yelled back. There is no documented evidence that local law enforcement was called by the facility. Review of the handwritten statement by Certified Nurse Assistant #1 dated 01/25/2026, revealed that the nurse wanted them to change Resident #1, they said they would if the nurse went with them, and they said they would. They gathered the supplies and went into Resident #1's room. The Resident's representative was on the phone on speaker and asked Certified Nurse Assistant #1 why they were in the room, and Certified Nurse Assistant #1 replied that they were there to change Resident #1. Resident #1's representative told them that the resident did not want them in there and then verbally berated them. Certified Nurse Assistant #1 stepped out and called out to the nurse to come to the room and help them and the nurse replied they would, but they never did. In the written statement, Certified Nurse Assistant #1 documented that by the time they were almost done changing Resident #1, Certified Nurse Assistant #2, the nurse they expected would assist them, and another nurse all came to the room. When they were all there outside the room, Certified Nurse Assistant #1 documented in their statement that they all started in on them saying Resident #1 said for you to go. Certified Nurse Assistant #1 also wrote in their statement that they mentioned that Certified Nurse Assistant #2 had told them earlier that all certified nurse assistants were to take care of Resident #1 regardless of how Resident #1 behaves. Certified Nurse Assistant #1 further documented that in their defense the nurse should have come into the room with them when they first asked them then none of this would have happened. Review of the handwritten statement by Certified Nurse Assistant #2 dated 01/25/2026 documented as follows, on Sunday they were working on unit 1 during the 7:00 AM to 3:00PM shift floating to unit 2 for the 3:00 PM to 11:00 PM shift, before they even got up on the unit, the nurse texted stating can you go to unit 2, Certified Nurse Assistant #1 wants to go home. They went upstairs and heard screaming coming from Resident #1's room so they entered and told Certified Nurse Assistant #1 that they can leave because it was evident that they were very upset. They replied f*** you I ain't going, you said everyone is allowed to change them. Even though Resident #1 was scared and saying don't touch me get out of my room, they still continued to do care tossing the resident left to right as they put on a depend (adult brief), loudly cursing and arguing. Resident #1 was very shaken up by what was going on, the nurse (Registered Nurse Supervisor #1) tried to calm Certified Nurse Assistant #1, but they were still irate. They were arguing with Resident #1's representative that was on the phone, going back and forth, while trying to give care to Resident #1. They finally left very upset. Afterward, Resident #1 was very scared at the way they were treated (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	by Certified Nurse Assistant #1. After full chart review there is no documented evidence of a complete nursing assessment, psychiatric referral or follow-up with a medical provider after this incident occurred. During an interview on 04/29/2026 at 1:15 PM Resident #1's representative stated that day when they were on the phone, the aide (Certified Nurse Assistant #1) came in and they could tell on the phone that they had an attitude. They stated they heard a smack but did not know the location, and they heard the staff cursing. During an interview on 04/29/2026 at 1:16 PM, Resident #1 reported Certified Nurse Assistant #1) smacked them and used a racial slur. Resident #1 stated they have been nervous, and they jump when staff comes into the room. They stated there was no consultation afterwards. Resident #1 stated that sometimes when they receive care it is one aide and sometimes it is two. Resident #1 stated they do not feel safe in the facility. Sometimes they are scared, and they will call downstairs for someone to assist them. During a telephone interview on 04/29/2026 at 2:58 PM, Certified Nurse Assistant #1 they stated on that day they had to float but usually worked on unit 2, the Alzheimer's dementia unit. They stated they were arrested, and they are being falsely accused. Certified Nurse Assistant #1 stated that it is a public record they are falsely accused of striking Resident #1 in the face. They did not know they were being accused until the troopers came to their house. They stated they are not sure who made the accusation. They stated that they knew that Resident #1's representative was on the phone. Certified Nurse Assistant #1 stated that the facility never informed them of why they were terminated, that it was vague. They thought they were terminated because they said f*** you to the nurse after they made them go in the room to provide care alone. They stated that Resident #1's representative was on the phone but there was no video proof. It was the day of the blizzard there were only two aides and Resident #1 has been a problem since they got there. There was an incident before this of Resident #1 accusing a different aide of hitting them and they were not suspended. This other aide, who recently left the facility, contacted them when they saw the story on the news and offered to write a statement for them. They implemented a 2-aide policy because Resident #1 refused care from certain aides and then they were down to only one aide that could provide care to them. Certified Nurse Assistant #1 stated that on the day of the incident, Registered Nurse #1 had allowed the only other aide to leave the facility, during a snow emergency, to get food, and they stated that they were not going to provide care to Resident #1 by themselves. Certified Nurse Assistant #1 stated that they were told to get started and they (Registered Nurse #1) would come in to assist them. Certified Nurse Assistant #1 stated that they tried to get the nurse to come in and assist them with care because Resident #1's representative and Resident #1 were yelling. Certified Nurse Assistant #1 stated that Registered Nurse #1 snapped at them and told them to go in and provide care and that they would be in soon, and shortly thereafter multiple staff appeared and everyone started screaming at them. Certified Nurse Assistant #1 stated that they said f*** you to Registered Nurse #1 and to the aide that was supposed to assist them with care. Certified Nurse Assistant #1 stated that Resident #1 was frustrated because they had not been changed all day. During an interview on 04/29/2026 at 4:25 PM, Certified Nurse Assistant #2 stated Resident #1 has a controlling behavior on the phone, yelling, screaming, and cursing on the phone, and on the day of the incident, Resident #1 was acting like that with the certified nurse assistants. Certified Nurse Assistant #2 stated on the day of the incident, they were on unit 1 from 7:00 AM to 3:00 PM and were moved to unit 2 at 3:00 PM. Certified Nurse Assistant #2 stated that when they arrived on unit 2 they went to Resident #1's room and found Certified Nurse Assistant #1, Resident #1, and a person that was engaged in a phone call with Resident #1, all screaming at each other. Certified Nurse Assistant #2 stated they noted that Certified Nurse Assistant #1 was upset so they stated that they would finish providing care to Resident #1 and told Certified Nurse Assistant #1 that they could leave. Certified Nurse Assistant #1 was saying to Resident #1 I need to change you and Resident #1 was asking Certified Nurse Assistant #1 to get out their room. Certified Nurse Assistant #1 was midway through changing Resident #1 when other nursing staff arrived and Registered Nurse #1 told Certified Nurse Assistant #1 to leave Resident #1's room. Certified Nurse Assistant #1 complied and (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	left the room. Certified Nurse Assistant #2 stated that they were not sure if Resident #1 was seen by psychiatry after the incident. Certified Nurse Assistant #2 stated that the police were at the facility the next morning. Certified Nurse Assistant #2 stated they were surprised when the incident was reported on the news and that the report stated that Certified Nurse Assistant #1 had hit Resident #1. Certified Nurse Assistant #2 stated that they never saw Certified Nurse Assistant hit Resident #1 and Resident #1 never told them that Certified Nurse Assistant #1 had hit them. Certified Nurse Assistant #2 stated that after the incident they thoroughly checked Resident #1's body and did not find any visible marks. During an interview with Registered Nurse #1 on 05/01/2026 at 3:45 PM, they stated that they started as the Director of Nursing on 03/24/2026, but prior to that they were hired for infection control. They stated that since they live close, they would be willing to come in over the weekend. They stated they were there when the incident with Resident #1 occurred. Registered Nurse #1 stated that they saw Certified Nurse Assistant #1 being very unprofessional, they did not see a hit. Certified Nurse Assistant #1 was in the resident's room, Resident #1 was uncovered, and Certified Nuse Assistant #1 was rolling the resident back and forth. Registered Nurse #1 stated that from inside the room, Certified Nurse Assistant #1 was yelling out into the hallway I am already F-ing in here I am going to finish the F-in care. Registered Nurse #1 stated that they were trying to de-escalate the situation. They stated that another certified nurse assistant came into the room. Resident #1 was upset and was distraught and nervous. Registered Nurse #1 stated that this incident was their first time meeting Resident #1, and that Resident #1's representative was on the phone the whole time. Registered Nurse #1 talked with Resident #1's representative on the phone, and they said they heard the aide screaming and cursing and that Resident #1 had said to them on the phone that Certified Nurse Assistant #1 was being really rough and washing them with cold water. Registered Nurse #1 stated that they were not aware if Resident #1 was seen by psychiatry services yet, but that it should be evaluated as quickly as possible. Registered Nurse #1 stated they did know that the social worker saw Resident #1 to discuss the event and that they would consider that to be a mental health evaluation, not a psychiatric evaluation. Registered Nurse #1 did not recall if there were any changes to the care plan at that time. Registered Nurse #1 stated that the social worker would be the staff to update the care plan in the system. During a telephone interview with Registered Nurse #2 on 05/26/2026 at 2:30 PM they stated they knew Resident #1, that they were the Director of Nursing at the time of the incident, and that it had occurred during a snowstorm. They stated that what they knew was that no one had called them that evening, even though they were the Director of Nursing, they stated that the facility had since fired them claiming that they were unavailable. They stated that Registered Nurse #1 was the only registered nurse in the building because of the snow. Registered Nurse #2 stated they had heard that Resident #1 had said they were slapped but were unsure who they said it to. Registered Nurse #2 stated that they knew they had to report it. They stated that Resident #1 told the police, and they were not sure why no one else called the police, they were not sure if it was their family that had made the call, and they were unsure when the police showed up. Registered Nurse #2 stated that because Resident #1 said they had been slapped, they had to report it. Registered Nurse #2 stated that at the time neither they nor Registered #1 knew anything about the reporting system. They stated that Registered Nurse #1 called the Department of Health and made the report over the phone, and that they knew the incident was in the newspaper. Registered Nurse #2 stated that Registered Nurse #1 had assessed Resident #1 and that there was no psychiatrist to assess the resident. During a telephone interview with the Medical Director on 05/26/2026 at 3:48 PM, they stated that they did not get any call regarding the incident, but they heard about it randomly one day during rounding sometime the following week. They stated that Resident #1 was being followed by a different medical provider who saw the resident on 02/08/2026. The Medical Director stated that they think they should have been called and would have liked to have been notified of the incident. The Medical Director stated that they were not aware this incident made it to the local news. 10NYCRR 415.4(b)(1)(i)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews conducted during a Survey, the facility did not ensure for three of six residents (Resident #1, Resident #8, and Resident #9) that were reviewed for abuse and falls, that all alleged violations involving abuse and injuries were reported immediately, but not later than two hours after the allegation was made, if the events that caused the allegations involved abuse or resulted in serious bodily injury, to the administrator of the facility and to other officials, including to the State Survey agency, in accordance with State law through established procedures. Specifically, on 03/15/2025, Resident #9 while receiving assistance for bed mobility fell out of bed and sustained a fracture to their right hip. On 11/26/2025, Resident #8, who required close supervision for ambulation, walked unassisted and without monitoring and fell and sustained a fracture to their right hip. On 01/25/2026, Resident #1 while receiving care was subjected to vulgar/foul language and was screamed at by a certified nurse assistant. The facility's undated policy titled Abuse, Neglect, Mistreatment and Misappropriation of Resident Property defined mental abuse as including but not limited to humiliation, harassment, threats of punishment or deprivation and defined neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. According to their policy immediately means as soon as possible but ought not to exceed 24 hours after discovery of the incident. Their policy further documented that if the injury is unexplained (i.e., fracture), and if the findings of abuse are substantiated (physical, verbal, sexual, financial exploitation), and if there is caregiver neglect (i.e., care plan not followed resulting in resident injury), or if a therapeutic error results in injury a report must be made to the facility designated State Agency within 24 hours (or per state guidelines) of the initial findings. Resident #9 was admitted with diagnoses of fusion of spine site unspecified, personal history of healed traumatic fracture, and chronic pain syndrome. Resident #9 had an annual minimum data set (a resident assessment tool) dated 02/17/2025 that documented that the resident was cognitively intact. Resident #9 had functional ability limitations documented as being dependent on staff for most/all activities of daily living like: toileting, showering, upper and lower body dressing. According to the Centers for Medicare & Medicaid Services (CMS) coding guidelines, an activity is defined as Dependent (Code 01) if: A caregiver must complete the entire activity for the resident (total staff assistance); or the assistance of two or more helpers is required to safely complete the activity (multiple helpers).Resident #9's Care Plan with focus Fall Risk entered 10/26/2023: Resident is at increased risk for fall related to (r/t): sympathetic dystrophy (an older term for Complex Regional Pain Syndrome - a rare, chronic, and severe neurological condition characterized by intense burning or aching pain, swelling, and changes in the skin, bones, and joints of an affected limb). Goals: Resident will have no serious injury related to falls entered on 01/12/2025. Interventions entered 10/27/2022: call bell in reach at all times, keep needed items in reach, keep room well lit and clutter free, remind and encourage resident to call for assistance. A note attached to this care plan dated 02/19/2023 documented care plan reviewed, no negative outcome no fall since last quarter, continue Plan of Care (POC).Review of an untitled, undated and unsigned page in the packet provided by the facility as part of the internal incident report documented the date of the incident as 03/15/2025 at 9:00 PM. The summary of the incident documented that Certified Nurse Assistant #7 was rendering care and turned Resident #9 on their left side facing the door to adjust the pad underneath the resident, their legs were parallel (right leg was on top of the left leg), while Certified Nurse Assistant #7 was adjusting the pad the resident's right leg jerked with spastic movement which pulled resident's body weight to dangle off the bed causing resident to slid off the bed and fall onto the floor. certified nurse assistant documentation showed that resident required total assist by two person in bed mobility and toilet care. Certified Nurse Assistant #7 acknowledged (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not following the plan of care requiring two person assist. An x-Ray was done on 03/16/2025 and revealed resident sustained moderate arthritic changes of the knee with distal femur fracture (broken leg bone just above the knee joint). Conclusion: Resident was transferred to a hospital for further evaluation and was admitted for right femur fracture. Certified Nurse Assistant #7 was given a disciplinary notice and education to follow plan of care.Review of chart indicates this incident was never reported to the New York State Department of Health.Resident # 8 was admitted with diagnoses of history of falling, primary generalized (osteo) arthritis and chronic pain.The Minimum Data Set, dated [DATE] indicates that for sit to stand and for walking 10 feet, further defined as the ability to walk at least 10 feet in a room, corridor or similar space, Resident #8 required supervision or touching assistance, further defined as helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity, and the assistance may be provided throughout the activity or intermittently.Review of Fall Risk Care Plans with active effective date of 08/04/2022 documented Resident #8 is at increased risk for fall related to: muscle weakness, 06/10/2024 status post fall no injury. 09/19/2024 status post fall laceration to forehead. 10/09/2024 status post fall, and 11/26/2025 status post fall. Goals were listed as follows: Resident will have no falls, and resident will have no fall related injuries.The facility Investigative Synopsis typed up on letterhead, undated and untimed, documented that on 11/26/2025, the facility received report that Resident #8 was found on the floor in the north hallway of unit 2. The event was reported by Licensed Practical Nurse #2, who discovered the resident on the floor at approximately 5:00 PM. Nursing administration was notified immediately. According to the initial incident report, the resident was found on the floor near the north hallway after apparently losing their balance while ambulating. The fall was unwitnessed. The resident was able to verbalize what happened, reporting that they were going to the dining room and slipped and fell. An injury assessment was performed, and the resident complained of pain in both hips. X-ray orders were placed according to the provider notification. The event is documented as being discovered by Licensed Practical Nurse #2 and their narrative is they turned and found the resident on the floor in the north hallway, they saw the resident on the floor and paged the supervisor and got vitals. This document further indicated that the resident's [NAME] fall risk evaluation prior to the fall was 19, indicating they were a high risk for falls. The contributing factors included intermittent confusion, balance impairment, prior falls and medications affecting stability. The conclusion documented that based on the facts gathered, the evidence does not support abuse, neglect, mistreatment, or misappropriation of property and the rationale is that the fall was unwitnessed, but all available evidence was consistent with the resident losing their balance while ambulating independently. The administrator at the time of the event signed this document with the conclusion that the investigation supports that this incident was an accidental fall related to the resident's impaired balance and high fall risk, not the result of abuse, neglect or mistreatment. During an interview on 05/20/2026 at 11:39 AM the Director of Rehabilitation stated that before Resident #8 fell, they were getting Occupational Therapy and Physical Therapy. They stated that Resident #8's function prior to the fall was indicated to be contact guard handheld assist, they were very confused, and they would try to self-transfer. The Director of Rehabilitation stated that Resident #8 should not have been walking around by themself. The Director of Rehabilitation stated that to communicate the details of the abilities and limitations of the residents to the units, they fill out a rehabilitation recommendation form that is given to the Director of Nursing and this would be linked to the certified nurse assistant documentation, so they can see what residents can do and cannot do. Director of Rehabilitation stated that at the time of the incident, the rehabilitation recommendation was given to the Director of Nursing, and they would record the residents' ability levels. The Director of Rehabilitation stated that they have no way of making sure that nursing is following their recommendations and recording the residents' ability levels. The Director of Rehabilitation stated that residents with dementia or advanced dementia would not use a walker appropriately. The Director of Rehabilitation stated that when Resident #8 was in the dining room and stood up, someone should (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	have redirected them, and if they felt like walking someone should have held their hand and walked with them, they should not have walked alone. The Director of Rehabilitation stated that they have seen a decline in Resident #8's abilities. Review of chart indicates this incident was never reported to the New York State Department of Health.Resident #1 had diagnoses that included anoxic brain damage (a severe injury caused by a total lack of oxygen to the brain causing brain cells to die within minutes), hemiplegia (paralysis of one entire side of the body) following other cerebrovascular disease (problems with blood flow to the brain) affecting right dominant side, contracture of muscle right and left hand. The Quarterly Minimum Data Set (a resident assessment tool) dated 12/09/2025 documented Resident #1 had unclear speech, was sometimes understood, was cognitively intact and dependent on staff for all activities of daily living: eating, oral hygiene, toileting, showering and dressing upper and lower body. Resident #1 had a Care Plan dated 01/21/2025 entered by the social worker with a focus Potential for Victimization: Due to medical, cognitive, mood and/or behavioral status. Resident #1 has the potential to be a victim while a resident in a skilled nursing setting related to: medical status, diagnosis of traumatic brain injury, and other, which is defined as unable to easily verbalize. The long-term goal was Resident #1 would be free of being a victim of abuse, neglect, or resident-to-resident incident throughout routines. Interventions were listed as Resident #1 will be encouraged to engage in daily routines, meaningful conversations, activities of preference, psych consultations, and hobbies to foster growth, healthy relationships, and positive engagement while a resident at the facility. The internal Accident and Incident report dated 01/25/2026 documented that at approximately 3:15 PM, Resident #1 was receiving care from Certified Nurse Assistant #1. They were witnessed by other staff members to be handling Resident #1 in a rough manner and vocalizing in loud tones characterized as screaming. Per Resident #1's report, Certified Nurse Assistant #1 used ice cold water to provide hygienic care. At the time of the occurrence, Resident #1's family was on the phone with an open line. The Registered Nurse Supervisor #1 reported to the scene and Certified Nurse Assistant #1 was removed from the environment immediately and care was provided by other staff. Certified Nurse Assistant #1 left the facility and was subsequently notified that they would be suspended pending the outcome of the investigation. A Registered Nurse assessment yielded data supporting emotional upset and anger; there was no indication of physical injury. The Medical Director was made aware of the incident and followed up with no new orders. A follow up skin check three days later yields no new injury, bruising, discoloration, report of pain or other negative psychical manifestation of the event. Statements collected from staff on duty support the allegation as stated by Resident #1 regarding being handled roughly and being subjected to loud, disruptive and agitated vocalizations. The allegation of abuse is substantiated. Review of the chart and the incident report revealed that the Nurse Supervisor on the day of the incident called a phone number to report the incident. However, it is indicated in iQIES that the phone number called was to the Justice Center, and the Nurse Supervisor left a message but did not leave a return phone number. The review also revealed that the facility never called local law enforcement, and that local law enforcements' arrival at the facility on the day following the incident was because the Resident #1's representative had called them. 10 New York Codes, Rules, and Regulations 415.4(b)(1)(i)

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	05/26/2026

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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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 record reviews and interviews conducted during a Survey the facility did not revise or update a resident care plan after a significant change was noted in the resident's psychosocial and physical wellbeing. This was noted for three of three residents (Resident #9, Resident #4, and Resident #1) reviewed for care planning. Specifically, on 02/02/2025 Resident #9 had a fall from bed and care plan for falls was never updated; on 11/20/2025 at 5:24pm Physical Therapist #1 documented that Resident #4 was voicing suicidal ideation upon evaluation, and this information was never addressed and there was no update to the care plan for Psychosocial well-being; and on 01/25/2026 after an incident of abuse Resident #1 voiced that they did not feel safe, and there was no update to the potential for victimization care plan. The facility policy titled Comprehensive Care Plan Policy last reviewed/revised defined significant change in condition as a decline or improvement requiring an updated assessment and care plan revision. This policy further documented that the care plan must be updated when risk increases or new problems arise, and following falls, hospitalization, skin issues, behaviors, infections, or adverse events.Resident #4 was re-admitted with diagnoses that included, but were not limited to, unspecified fracture of right femur, peripheral vascular disease and anxiety disorder. An admission minimum data set (a resident assessment tool) dated 10/29/2025 documented the resident had a brief interview of mental status score of 15, indicating no cognitive impairment. Progress note dated 11/20/2025 at 5:48pm written by Physical Therapist #1 documented resident.voicing suicial ideations upon evaluation. Social Worker and Director of Rehabilitation made aware. Resident also noted with left heel erythema. Nurse made aware and heel booties applied to both heels after optimal positioning in bed. Physician's History and Physical dated 11/21/2025 indicted psychiatric normal. No further documentation noted regarding depression or suicidal ideations.Review of care plans with focus of observe for changes in behavior due to alteration of self-image revised effective date of 11/10/2025. Review of care plan for psychosocial well-being listed problem as changes in lifestyle/daily routine in community with an active effective date of 11/09/2025. Review of care plan for psychotropic drug use: anxiety, state resident is on alprazolam: related to diagnosis of anxiety with an active effective date of 10/20/2025. There are no care plans for depression, or for suicidal ideation.During an interview with the Director of Social Work on 05/01/2026 at 9:01am they stated they have a role in psychosocial admission assessment. They stated they can do some of the nurse related items in a care plan meeting. When talking about Resident #4 they stated they remembered a care plan for delusions, and that if they had known about the statement they would have talked with Resident #4.During an interview on 05/01/2026 at 3:45pm with the current Director of Nursing they stated they did not know about the suicidal comment made by Resident #4, but had they known the next step would be to do a Patient Health Questionnaire-9 (PHQ9 is a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression) and a Generalized Anxiety Disorder (GAD) follow up and then update the emotional well being care plan. Resident #9 was admitted with diagnoses that include fusion of spine site unspecified, personal history of healed traumatic fracture, and chronic pain syndrome. The Annual Minimum Data Set (a resident assessment tool) dated 02/17/2025 documented that Resident #9 was cognitively intact. Resident #9 had functional ability limitations documented as being dependent on staff for most/all activities of daily living like: toileting, showering, upper and lower body dressing. According to the Centers for Medicare & Medicaid Services (CMS) coding guidelines, an activity is defined as Dependent (Code 01) if: A caregiver must complete the entire activity for the resident (total staff assistance); or the assistance of two or more helpers is required to safely complete the activity (multiple helpers). Review of the facility's internal Accident and Incident report dated 03/15/2025 by Certified Nurse Assistant #7 on their handwritten employee investigative statement documented that they were doing patient care on Resident #9, they turned them on their left side to (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	adjust the pad underneath Resident #9 and rolled them on their left side. While they were adjusting the pad, Resident 9's right leg jerked forward and pulled their body weight forward off the bed and onto the floor. They informed the charge nurse and supervisor of the fall. Review of an untitled, undated and unsigned page in the packet provided by the facility as part of the internal incident report documented the date of the incident as 03/15/2025 at 9:00 PM. The summary of the incident documented that Certified Nurse Assistant #7 was rendering care and turned Resident #9 on their left side facing the door to adjust the pad underneath the resident, their legs were parallel (right leg was on top of the left leg), while Certified Nurse Assistant #7 was adjusting the pad the resident's right leg jerked with spastic movement which pulled resident's body weight to dangle off the bed causing resident to slide off the bed and fall onto the floor. The certified nurse assistant documentation revealed that the resident required total assist by two person in bed mobility and toilet care. Certified Nurse Assistant #7 acknowledged not following the plan of care requiring two-person assist. An x-Ray was done on 03/16/2025 and revealed resident moderate arthritic changes of the knee with distal femur fracture (broken leg bone just above the knee joint). Conclusion: Resident was transferred to a hospital for further evaluation and was admitted for right femur fracture. Certified Nurse Assistant #7 was given disciplinary notice and education to follow plan of care. Resident #9's Care Plan with focus Activities of Daily Living (ADL)s: bathing, dressing, personal hygiene, toileting, and feeding, date entered 10/27/2022, documented that resident required assistance of one staff with activities of daily living as follows: bathing, dressing, toileting, personal hygiene, and feeding. Goals: resident will have these needs met as evidenced by neat clean well-groomed appearance daily. Interventions: assist with bathing, dressing, grooming, toileting needs, provide privacy. Assist with feeding needs at all meals, monitor and record intakes. Resident #9's Care Plan with focus Fall Risk entered 10/26/2023: Resident is at increased risk for fall related to: sympathetic dystrophy (an older term for Complex Regional Pain Syndrome - a rare, chronic, and severe neurological condition characterized by intense burning or aching pain, swelling, and changes in the skin, bones, and joints of an affected limb). Goals: Resident will have no serious injury related to falls entered on 01/12/2025. Interventions entered 10/27/2022: call bell in reach at all times, keep needed items in reach, keep room well-lit and clutter free, remind and encourage resident to call for assistance. A note attached to this care plan dated 02/19/2023 documented care plan reviewed, no negative outcome no fall since last quarter, continue Plan of Care (POC).During an interview on 05/26/2026 at 1:13pm with The Medical Director they stated they do not normally attend care plan meetings, they occur in the afternoons, and they are usually there in the mornings to do their rounds. They stated if there is something they need to sign, or if they receive notice, they can speak with the family, or if there are some concerns, they can be involved in the care plan meetings. They stated the social workers arranged the meetings. The Medical Director stated daily care is not brought to their attentionResident #1 had diagnoses that included anoxic brain damage (a severe injury caused by a total lack of oxygen to the brain causing brain cells to die within minutes), hemiplegia (paralysis of one entire side of the body) following other cerebrovascular disease (problems with blood flow to the brain) affecting right dominant side, contracture of muscle right and left hand. The Quarterly Minimum Data Set (a resident assessment tool) dated 12/09/2025 documented Resident #1 had unclear speech, was sometimes understood, was cognitively intact and dependent on staff for all activities of daily living: eating, oral hygiene, toileting, showering and dressing upper and lower body.Resident #1 had a Care Plan dated 01/21/2025 entered by the social worker with a focus Potential for Victimization: Due to medical, cognitive, mood and/or behavioral status. Resident #1 has the potential to be a victim while a resident in a skilled nursing setting related to: medical status, diagnosis of traumatic brain injury, and other, which is defined as unable to easily verbalize. The long-term goal was Resident #1 would be free of being a victim of abuse, neglect, or resident-to-resident incident throughout routines. Interventions were listed as Resident #1 will be encouraged to engage in daily routines, meaningful conversations, activities of preference, psych consultations, and hobbies to foster growth, healthy relationships, and (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	positive engagement while a resident at the facility.The internal Accident and Incident report dated 01/25/2026 documented that at approximately 3:15 PM, Resident #1 was receiving care from Certified Nurse Assistant #1. They were witnessed by other staff members to be handling Resident #1 in a rough manner and vocalizing in loud tones characterized as screaming. Per Resident #1's report, Certified Nurse Assistant #1 used ice cold water to provide hygienic care. At the time of the occurrence, Resident #1's family was on the phone with an open line. The Registered Nurse Supervisor #1 reported to the scene and Certified Nurse Assistant #1 was removed from the environment immediately and care was provided by other staff. Certified Nurse Assistant #1 left the facility and was subsequently notified that they would be suspended pending the outcome of the investigation. A Registered Nurse assessment yielded data supporting emotional upset and anger; there was no indication of physical injury. The Medical Director was made aware of the incident and followed up with no new orders. A follow up skin check three days later yields no new injury, bruising, discoloration, report of pain or other negative psychical manifestation of the event. Statements collected from staff on duty support the allegation as stated by Resident #1 regarding being handled roughly and being subjected to loud, disruptive and agitated vocalizations. The allegation of abuse is substantiated.During an interview on 05/01/2026 at 3:45pm with the current Director of Nursing they stated they know that the Social Worker met with Resident #1. The Director of Nursing stated that they would consider that meeting to be a mental health evaluation not a psychiatric evaluation. The Director of Nursing stated that they do not recall if there were any changes made to the care plan at that time. The Director of Nursing stated that the social worker would be the staff to update the care plan in the system. The Director of Nursing also stated that the social worker may have put a care plan in place requiring that two certified nurse assistants provide care to Resident #1. 10NYCRR 415.11(c)(2)(i-iii)

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	335404	A. Building B. Wing	05/26/2026

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interviews conducted during survey, the facility failed to ensure adequate supervision and implementation of an identified intervention for two of three residents (Resident #9 and Resident #8) reviewed for accidents. Specifically, on 03/15/2025, Resident #9 who required two-person assistance for bed mobility was provided with one staff assist by a certified nurse assistant which resulted in a fall from bed and Resident #9 sustained a fracture to their right hip. On 11/26/2025, Resident #8, who was severely cognitively impaired and required close supervision for ambulation, walked unassisted and without monitoring and fell and fractured their right hip. These incidents resulted in actual harm to Resident #9 and Resident #8 that was not Immediate Jeopardy.The facility assessment last reviewed 12/12/2025 documented in a chart addressing resident support/care needs on page five for activities of daily living that the goal is to foster a dignified environment that maximizes residents' autonomy, enhances their quality of life, and ensures their safety and comfort during these essential activities. In the same assessment, related to mobility and fall/fall with injury prevention the facility assessment documented that the facility implemented comprehensive care practices aimed at contracture prevention and management, ensuring that residents retain their range of motion and physical comfort.The undated facility policy titled Abuse, Neglect Mistreatment and Misappropriation of Resident Property under Section ?G' defined what constitutes an injury of unknown origin. An injury should be classified as an injury of unknown source when both of the following conditions are met: The source of the injury was not observed by any person, or the source of the injury could not be explained by the resident.The undated facility policy Accident/Incident Prevention and Management documented that 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. On page one, this policy defines an avoidable accident as an accident that occurred because the facility failed: to implement interventions, including adequate supervision, consistent with a resident's needs, goals, plan of care, and current standards of practice in order to reduce the risk of an accident.Resident #9 was admitted with diagnoses that include fusion of spine site unspecified, personal history of healed traumatic fracture, and chronic pain syndrome.The Annual Minimum Data Set (a resident assessment tool) dated 02/17/2025 documented that Resident #9 was cognitively intact. Resident #9 had functional ability limitations documented as being dependent on staff for most/all activities of daily living like: toileting, showering, upper and lower body dressing. According to the Centers for Medicare & Medicaid Services (CMS) coding guidelines, an activity is defined as Dependent (Code 01) if: A caregiver must complete the entire activity for the resident (total staff assistance); or the assistance of two or more helpers is required to safely complete the activity (multiple helpers).Resident #9's Care Plan with focus Activities of Daily Living (ADL)s: bathing, dressing, personal hygiene, toileting, and feeding, date entered 10/27/2022, documented that resident required assistance of one staff with activities of daily living as follows: bathing, dressing, toileting, personal hygiene, and feeding. Goals: resident will have these needs met as evidenced by neat clean well-groomed appearance daily. Interventions: assist with bathing, dressing, grooming, toileting needs, provide privacy. Assist with feeding needs at all meals, monitor and record intakes.Resident #9's Care Plan with focus Fall Risk entered 10/26/2023: Resident is at increased risk for fall related to: sympathetic dystrophy (an older term for Complex Regional Pain Syndrome - a rare, chronic, and severe neurological condition characterized by intense burning or aching pain, swelling, and changes in the skin, bones, and joints of an affected limb). Goals: Resident will have no serious injury related to falls entered on 01/12/2025. Interventions entered 10/27/2022: call bell in reach at all times, keep needed items in reach, keep room well-lit and clutter free, remind and encourage resident to call for assistance. A note attached to this care plan dated 02/19/2023 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	documented care plan reviewed, no negative outcome no fall since last quarter, continue Plan of Care (POC).Resident #9's Care Plan with focus Activities of Daily Living (ADL)s: transfers, bed mobility, ambulation devices and equipment: Geri chair transfers: total dependence of two, Hoyer lift, Bed Mobility: total dependence of two Ambulation: non ambulatory, total dependence of one Geri chair on and off unit. Active effective date 10/27/2022 entered on 03/26/2025 by Director of Physical Therapy. Goals: Resident will maintain maximum comfort and positioning while in bed. Interventions: Assist with transfers ambulation, and bed mobility as recommended. Encourage participation in activities of daily living care. Praise and provide positive reinforcement for completed task. Use task segmentation (specify).Review of the facility's internal Accident and Incident report dated 03/15/2025 by Certified Nurse Assistant #7 on their handwritten employee investigative statement documented that they were doing patient care on Resident #9, they turned them on their left side to adjust the pad underneath Resident #9 and rolled them on their left side. While they were adjusting the pad, Resident 9's right leg jerked forward and pulled their body weight forward off the bed and onto the floor. They informed the charge nurse and supervisor of the fall.Review of an untitled, undated and unsigned page in the packet provided by the facility as part of the internal incident report documented the date of the incident as 03/15/2025 at 9:00 PM. The summary of the incident documented that Certified Nurse Assistant #7 was rendering care and turned Resident #9 on their left side facing the door to adjust the pad underneath the resident, their legs were parallel (right leg was on top of the left leg), while Certified Nurse Assistant #7 was adjusting the pad the resident's right leg jerked with spastic movement which pulled resident's body weight to dangle off the bed causing resident to slide off the bed and fall onto the floor. The certified nurse assistant documentation revealed that the resident required total assist by two person in bed mobility and toilet care. Certified Nurse Assistant #7 acknowledged not following the plan of care requiring two-person assist. An x-Ray was done on 03/16/2025 and revealed resident moderate arthritic changes of the knee with distal femur fracture (broken leg bone just above the knee joint). Conclusion: Resident was transferred to a hospital for further evaluation and was admitted for right femur fracture. Certified Nurse Assistant #7 was given disciplinary notice and education to follow plan of care.Review of the note written by Physical Therapist #1 on 02/22/2025 at 1:59 PM documented late entry for 02/11/2025 Interdisciplinary Quarterly Screen for Physical Therapy: patient screened by physical therapy and does not demonstrate any decline from baseline levels. Patient refuses to get out of bed most days. Bilateral Shepard's hooks required for bed mobility. Bed Mobility: total dependance of two. Transfers: total dependence by Hoyer. Ambulation: non-ambulatory. Locomotion on/off unit: total dependence by Geri Chair. No physical therapy evaluation required at this time.The standard monthly progress note started on 03/04/2025 and entered on 03/30/2025 written by the Medical Director documented history of present illness (HPI): Resident #9 with past medical history (PMHx) (listing all the resident's current diagnoses), Patient was seen today for monthly medication renewal. No complaints on examination. History of change since last assessment: Over the past month no falls, hospitalization. Started on famotidine (a histamine H2-receptor blocker that reduces stomach acid production). Change in Mobility: No. The note continues with the review of systems.Review of a nursing note dated 03/15/2025 at 10:58 PM Resident #9 was reported to have rolled out of bed onto the floor while being changed around 9:00 PM. Resident with complaint of severe pain to their right knee. Nurse on unit 2 administered Tylenol 650mg as ordered right now for pain with moderate relief. No other visible injuries and no other complaints of pain. Nurse Practitioner notified and ordered x-ray of the right knee. Vital signs every shift for three days and skin assessment every shift for three days. Review of nursing note dated 03/16/2025 at 2:43 AM Resident #9 alert and verbal; makes needs known, pupils equal and reactive to light, vital signs stable, hematoma noted on right forehead and front of forehead, supervisor made aware, supervisor stated doctor was made aware. Call light in reach.Review of a nursing note dated 03/16/2025 at 2:56 AM documented resident complains of right knee pain, ice applied with some relief. Resident alert and verbal.Review of a nursing note dated (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	03/16/2025 at 2:55 PM neurological checks and skull x-ray per Nurse Practitioner.Review of a nursing note dated 03/16/2025 at 11:28 PM type: correction. Resident x-ray shows R (right) femur fracture. Resident will be transferred to emergency room, family made aware.During an interview with the Administrator on 05/20/2026 at 3:15 PM, they stated there are challenges with staffing and some days they are okay. The Administrator stated in the 30 days of the month of November 2025, there were 19 falls The Administrator stated they are working to find reasons for the falls, ways to prevent them, and are trying to determine what times of day they occur. The Administrator stated that the staff are trained with the yearly mandatory training. The Administrator stated that they do not believe the falls are related to low staffing but stated sometimes more staffing could help. The Administrator stated that they need to work on ensuring that call lights are answered promptly, and toileting is done as necessary.During a telephone interview with the Medical Director on 05/26/2026 at 3:48 PM, they stated that they did not have details of how or why Resident #9 fell, just that they had wound up with a hip fracture and there was an order for the resident to be transferred to the hospital. They stated that Resident #9 could not walk at all, and they did not know how they had fallen. They stated Resident #9 was very unsteady on their feet. The Medical Director stated that they usually want to know if they need to be evaluated in the emergency room, their goal is to get them to the hospital. They stated to prevent future falls; the details would be important. The Medical Director stated that they did not know if it was a care plan violation.Resident # 8 was admitted with diagnoses of history of falling, primary generalized (osteo) arthritis (protective cartilage that cushions the ends of the bones wears down over time) and chronic pain.The Minimum Data Set, dated [DATE] indicates that for sit to stand and for walking 10 feet, further defined as the ability to walk at least 10 feet in a room, corridor or similar space. Resident #8 required supervision or touching assistance, further defined as helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity, and the assistance may be provided throughout the activity or intermittently.Review of Fall Risk Care Plans with active effective date of 08/04/2022 documented Resident #8 is at increased risk for fall related to: muscle weakness, 06/10/2024 status post fall no injury. 09/19/2024 status post fall laceration to forehead. 10/09/2024 status post fall, and 11/26/2025 status post fall. Goals were listed as follows: Resident will have no falls, and resident will have no fall related injuries. Interventions dated 08/04/2022 included: call bell in reach at all times, keep needed items in reach, gripper socks to feet at HS (hour of sleep), keep room well-lit and clutter free, remind and encourage resident to call for assistance, and keep resident in areas of increased visibility. The list of interventions continues. A new intervention added on 12/26/2022 was round on the resident at 7:00 PM to see if needs are met. More interventions added and/or updated on 06/10/2024 included monitor for decreases in vision, monitor for episodes of restlessness agitation or increase in unsafe behaviors, and maintain safe environment at all times. After each fall there are updates to the care plan. On 06/10/2024 status post fall, redirect resident from standing in front of the elevator. On 07/17/2024 status post fall transfer to hospital to rule out head injury, laceration to side of forehead, and neurological checks as per protocol. On 09/18/2024 status post fall, close monitoring by staff when resident is out of bed. Interventions added on 10/10/2024 included offer nap times after breakfast and get resident up before lunch served. Last intervention noted with effective date 11/28/2025 documented 11/26/2025 status post fall, neurological checks as per protocol, vital signs every shift for three days, stat (immediate) bilateral hip x-ray per doctor, keep in bed until x-ray result arrives, rehabilitation screen, pain management as ordered. A note was attached to the care plan documenting, after the last fall to assess resident on the floor, sitting position, complaints of pain on lower extremity hips, no external rotation noted, notified Medical Director, ordered bilateral hip x-rays, Tylenol given for pain, notified family, left message to call back.Review of the internal facility Accident and Incident report dated 11/26/2025 revealed the first page is a check-off list with 25 items, none of which are marked. The second page of this unnumbered packet indicated the resident name (for Resident #8), time of 4:30 PM, location of event is hallway, that resident baseline prior to (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	event was ambulatory and wheelchair, and the event is described as resident got up from wheelchair and walked in hallway, lost balance and fell to floor. Safety/Preventative devices in place at time of incident per Care Plan: marked off as no and Safety/Preventative devices present at time of event: handwritten as no. The charge nurse that signed this page is signed by Licensed Practical Nurse #2 and Certified Nurse Assistant #5. Resident representative was notified at 5:10 PM and Medical Director notified at 5:14 PM. The provider instructions were listed as x-rays of bilateral hips, the entry is signed by a nurse supervisor, but the signature is illegible. The third page contained no resident name, documented the resident's most current mental status and diagnoses and indicated that the resident had a cognitive deficit as well as perceptual impairment noted as impaired sense of balance and poor safety awareness. The last time Resident #8 was observed was in the dining room at 4:00 PM, they were sitting in their wheelchair, indicating the resident got up walked into hallway lost balance fell. Witness statement by Licensed Practical Nurse #2 documented that they last saw Resident #8 at lunch, that the resident was on their assignment and that at the time of the incident, they heard a thud from the north hallway, saw the resident on floor, paged the supervisor and got vitals. Certified Nurse Assistant #5 documented in their witness statement that when they last saw Resident #8 it was afternoon, that the resident was on their assignment and that they were later informed of the accident/fall by a nurse.The facility Investigative Synopsis typed up on letterhead, undated and untimed, documented that on 11/26/2025, the facility received report that Resident #8 was found on the floor in the north hallway of Unit 2. The event was reported by Licensed Practical Nurse #2, who discovered the resident on the floor at approximately 5:00 PM. Nursing administration was notified immediately. According to the initial incident report, the resident was found on the floor near the north hallway after apparently losing their balance while ambulating. The fall was unwitnessed. The resident was able to verbalize what happened, reporting that they were going to the dining room and slipped and fell. An injury assessment was performed, and the resident complained of pain in both hips. X-ray orders were placed according to the provider notification. The event is documented as being discovered by Licensed Practical Nurse #2 and their narrative is they turned and found the resident on the floor in the north hallway, they saw the resident on the floor and paged the supervisor and got vitals. This document further indicated that the resident's [NAME] fall risk evaluation prior to the fall was 19, indicating they were a high risk for falls. The contributing factors included intermittent confusion, balance impairment, prior falls and medications affecting stability. The conclusion documented that based on the facts gathered, the evidence does not support abuse, neglect, mistreatment, or misappropriation of property and the rationale is that the fall was unwitnessed, but all available evidence was consistent with the resident losing their balance while ambulating independently. The administrator at the time of the event signed this document with the conclusion that the investigation supports that this incident was an accidental fall related to the resident's impaired balance and high fall risk, not the result of abuse, neglect or mistreatment.An interview on 05/20/2026 at 11:23 AM with Licensed Practical Nurse #2, stated on 11/26/2025, Resident #8 was walking and fell. They were coming out of the community room and fell in the hallway. It was after dinner and they thought the resident had already eaten. They were walking, they were not given a walker. They had a wheelchair, because they needed something to sit in. They repeated that Resident #8 did not have a walker, they were not sure if they had fallen prior, and they did not know when the last fall occurred. Licensed Practical Nurse #2 stated that Resident #8 would always walk, does not know about their care plans. Licensed Practical Nurse #2 does not normally work on unit 2. When they called the supervisor on the day of the incident, they advised that they had found Resident #8 on the floor, but they did not see them fall. Licensed Practical Nurse #2 stated that Resident #8 is not capable of telling you what caused their fall, they have dementia. Licensed Practical Nurse #2 stated that the fall was unwitnessed. Licensed Practical Nurse #2 was not sure that on that day during change of shift they were made aware of who can and cannot walk alone. Licensed Practical Nurse #2 stated that close supervision means that if Resident #8 is in the dayroom (continued on next page)

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	335404	A. Building B. Wing	05/26/2026

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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F 0689 Level of Harm - Actual harm Residents Affected - Few	a staff person should be with them so that if they try and get up and walk they can be assisted back to the wheelchair or staff can walk with them. Licensed Practical Nurse #2 stated they did not know Resident #8's care plan said this, and they were not sure if there had been someone in the day room. Licensed Practical Nurse #2 stated they were in the hallway, Resident #8 did not walk past them. They heard a noise when Resident #8 fell to the floor, they turned and looked down the hall and saw Resident #8 on the floor.An interview on 05/20/2026 at 11:39 AM with the Director of Rehabilitation, they revealed that before Resident #8 fell, they were getting Occupational Therapy and Physical Therapy. They stated that Resident #8's function prior to the fall, was indicated to be contact guard handheld assist, they were very confused, and they would try to self-transfer. The Director of Rehabilitation stated that Resident #8 should not have been walking around by themself. The Director of Rehabilitation stated that to communicate the details of the abilities and limitations of the residents to the units, they fill out a rehabilitation recommendation form that is given to the Director of Nursing and this would be linked to the certified nurse assistant documentation, so they can see what residents can do and cannot do. The Director of Rehabilitation stated that at the time of the incident, the rehabilitation recommendation was given to the Director of Nursing, and they would record the residents' ability levels. The Director of Rehabilitation stated that they have no way of making sure that nursing is following their recommendations and recording the residents' ability levels. The Director of Rehabilitation stated that residents with dementia or advanced dementia would not use a walker appropriately. The Director of Rehabilitation stated that when Resident #8 was in the dining room and stood up, someone should have redirected them, and if they felt like walking someone should have held their hand and walked with them, they should not have walked alone. The Director of Rehabilitation stated that they have seen a decline in Resident #8's abilities.During an interview on 05/20/2026 at 12:03 PM with Certified Nurse Assistant #5, they stated they did not know Resident #8 well prior to the fall. They stated that Resident #8 needs a lot of assistance with everything, such as feeding and getting dressed, and once on their feet, they are very unsteady and can only walk short distances. Certified Nurse Assistant #5 stated when Resident #8 wanders around they know that they need to be with them, so they ask someone to get Resident #8's wheelchair. Certified Nurse Assistant #5 stated there are times when Resident #8 will get out of bed, leave their room, and walk down the hallway. They stated, when this happens, I walk them back to their room, or I will get a chair, or a wheelchair, and sometimes they have Resident #8 sit by the nurses' station. Certified Nurse Assistant #5 stated they know that they have to monitor Resident #8, as the last thing they want is for them to fall. Certified Nurse Assistant #5 stated they are aware of which residents should not walk by themselves, it is in their care plans, they see it on Sigma (electronic medical record), and since the unit usually has the same staff, staff know the residents' abilities. Certified Nurse Assistant #5 stated there are still days Resident #8 has the strength and enough willpower to get up and start walking.During a telephone interview with the Medical Director on 05/26/2026 at 3:48 PM, they stated they knew about Resident #8's fractured hip because they got a call on the weekend and they had the facility send the resident to the hospital because of the fall and the report that the resident had a shortened leg. The Medical Director stated they were not given the details of what led to the fall. The Medical Director stated that to determine how well a resident can ambulate, normally a Physical Therapy assessment is conducted to identify the abilities and limitations of the resident. The Medical Director stated that a resident that requires supervision should not be walking alone, and someone should be next to them. The Medical Director stated that they were not told that Resident #8 often stood up on their own and at times would walk down the hall. The Medical Director stated that if they had known and were aware of all regarding Resident #8, further evaluation might have been needed to determine if closer supervision was warranted, and they might have considered one-to-one supervision.10 NYCRR 415.4(b)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. Based on record reviews and interviews conducted during a Survey (2809204), the facility did not ensure that two of three residents reviewed for behavioral health (Resident #4 and Resident #1) were assessed and provided necessary services after making a suicidal statement and having a traumatic incident. Specifically, on 11/20/2025 at 5:24pm Physical Therapist #1 documented that Resident #4 was voicing suicidal ideation upon evaluation; and on 01/25/2026 Resident #1 experienced a situation and voiced that they did not feel safe.In the facility assessment last revision dated 11/17/2025 under Mental Health and Behavior it documented that the facility is dedicated to effectively managing medical conditions and medication-related issues that may contribute to psychiatric symptoms and behavioral challenges. This involved thorough assessment and ongoing monitoring to identify underlying factors influencing residents' mental health. The facility assessment further documented that to ensure the delivery of high-quality, safe, and effective care at all times that the facility is equipped with a diverse array of resources and further lists Behavioral and Mental Health Providers.In the facility policy titled Psychiatry and Psychology Services last revision 5/2025 documented that the facility would provide, arrange for or refer residents to psychiatric and psychological services sufficient to meet the mental and psychological needs identified through comprehensive assessment. This policy defines a psychiatrist as a physician licensed in New York State with specialty training in psychiatry, and a psychologist is an individual licensed by the New York state Education Department under article 153 of the education law. Resident #4 was re-admitted with diagnoses that included, but were not limited to, unspecified fracture of right femur, peripheral vascular disease, and anxiety disorder. An admission minimum data set (a resident assessment tool) dated 10/29/2025 documented the resident had a brief interview of mental status score of 15, indicating no cognitive impairment. Progress note dated 11/20/2025 at 5:48pm written by Physical Therapist #1 documented resident.voicing suicial ideations upon evaluation. Social Worker and Director of Rehabilitation made aware. Resident also noted with left heel erythema. Nurse made aware and heel booties applied to both heels after optimal positioning in bed. Physician's History and Physical dated 11/21/2025 indicted psychiatric normal. No further documentation noted regarding suiciadal ideations. Medication orders were as follows: alprazolam 0.5mg give 1 tablet by mouth four times a day start date 11/19/2025 for diagnosis anxiety disorder due to known physiological condition. Order written by Medical Director;escitalopram 5mg give 1 tablet by mouth once daily start date 11/19/2025 for diagnosis major depressive disorder, single episode, mild. Order written by Medical Director;mirtazapine 15mg give 7.5mg by mouth once dialy start date 03/27/2026 for diagnosis depression, unspecified and anxiety disorder unspecified. Order written by Medical Director. Review of care plans Observe for changes in behavior due to alteration of self image revised effective date of 11/10/2025. Review of care plan for psychosocial well being listed problem as changes in lifestyle/daily routine in community with an active effective date of 11/09/2025. Review of care plan for psychotropic drug use: anxiety state resident is on alprazolam: related to diagnosis of anxiety with an active effective date of 10/20/2025. There are no care plans for depression, or for suicidal ideation. During an interview on 04/30/2026 at 2:56pm with Registered Nurse #3 they stated that were hired to be the unit manager for unit 1, but that at the moment they are covering both units and float all over. They stated they were never told about the suicial statement that Resident #4 made but that if a resident makes a statement the protocol is to take away any belt and or shoe laces and provide a tap bell. Registered Nurse #3 stated that a nurse and a doctor need to be made aware. During an interview on 05/01/2026 at 10:58am with Physical Therapist #1 they reviewed and read their note about Resident #4. They explained that DOR is Director of Rehabilitation and SW is Social Worker. They stated that they did not tell a nurse on the unit about the statement Resident #4 made because they cannot always find a nurse. They explained that they sometimes seek staff at a higher (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	level, and then they usually find someone to tell. Physical Therapist #1 stated that Resident #4 stated that basically they didn't want to live anymore. Physical Therapist #1 stated that the resident had pulmonary issues, anxiety, and depression, and it was holding them back in their rehabilitation, and they were afraid. They stated Resident #4 is doing so much better walking 10 feet now, and they have been in rehabilitation for a long time. When Resident #4 made the comment Physical Therapist #1 stated they listened and told them that things are going to get better. They stated that they see them almost every day and ask how they are feeling. Physical Therapist #1 stated Resident #4 has been weepy with them off and on and that they try and listen and encourage them. Physical Therapist #1 was not sure if they were at the facility the next day to follow up, but they told their director. They stated that they did not try to tell the Director of Nursing because they are not always available, they do not have their email, and they understood that the Director of Rehabilitation would inform the Director of Nursing. Physical Therapist #1 stated that when Resident #4 made the statement they didn't think they were going to do anything, adding that if someone feels that low, they want them to get the help they need, and Resident #4 struggles with a lot of depression and anxiety. Physical Therapist #1 stated if someone had seen or assessed Resident #4, they would have expected to find a note, but they did not recall specifically looking for a note about Resident #4's comment. They were not aware if there was a psychiatric provider at the facility in November. Physical Therapist #1 stated they do not do suicide assessments, and the protocol is to tell a supervisor or social worker, and they will notify the appropriate staff. Review of chart for Resident #4 revealed that no staff member ever did a psychiatric assessment before or after Resident #4 made the commemt. During an interview with the Administrator on 05/20/2026 at 3:15pm they were told that the Medical Director was doing medication gradual dose reduections and they believed they would also be doing any necessary psychiatric assessment, but they were not sure what information was provided to the Medical Director. The Administrator stated that if there were a psychaitric emergency they would send Resident #4 out to hospital. The Administrator stated they have been without a psyciatric provider for approximately 7 to 8 months. Resident #1 had diagnoses that included anoxic brain damage (a severe injury caused by a total lack of oxygen to the brain causing brain cells to die within minutes), hemiplegia (paralysis of one entire side of the body) following other cerebrovascular disease (problems with blood flow to the brain) affecting right dominant side, contracture of muscle right and left hand. The Quarterly Minimum Data Set (a resident assessment tool) dated 12/09/2025 documented Resident #1 had unclear speech, was sometimes understood, was cognitively intact and dependent on staff for all activities of daily living: eating, oral hygiene, toileting, showering and dressing upper and lower body. Resident #1 had a Care Plan dated 01/21/2025 entered by the social worker with a focus Potential for Victimization: Due to medical, cognitive, mood and/or behavioral status. Resident #1 has the potential to be a victim while a resident in a skilled nursing setting related to: medical status, diagnosis of traumatic brain injury, and other, which is defined as unable to easily verbalize. The long-term goal was Resident #1 would be free of being a victim of abuse, neglect, or resident-to-resident incident throughout routines. Interventions were listed as Resident #1 will be encouraged to engage in daily routines, meaningful conversations, activities of preference, psych consultations, and hobbies to foster growth, healthy relationships, and positive engagement while a resident at the facility. The internal Accident and Incident report dated 01/25/2026 documented that at approximately 3:15 PM, Resident #1 was receiving care from Certified Nurse Assistant #1. They were witnessed by other staff members to be handling Resident #1 in a rough manner and vocalizing in loud tones characterized as screaming. Per Resident #1's report, Certified Nurse Assistant #1 used ice cold water to provide hygienic care. At the time of the occurrence, Resident #1's family was on the phone with an open line. The Registered Nurse Supervisor #1 reported to the scene and Certified Nurse Assistant #1 was removed from the environment immediately and care was provided by other staff. Certified Nurse Assistant #1 left the facility and was subsequently notified that they would be suspended pending the outcome of the investigation. A Registered Nurse assessment yielded data (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	supporting emotional upset and anger; there was no indication of physical injury. The Medical Director was made aware of the incident and followed up with no new orders. A follow up skin check three days later yields no new injury, bruising, discoloration, report of pain or other negative psychical manifestation of the event. Statements collected from staff on duty support the allegation as stated by Resident #1 regarding being handled roughly and being subjected to loud, disruptive and agitated vocalizations. The allegation of abuse is substantiated. Review of chart revealed that there was no psychiatric assessment for Resident #1 after the incident. Resident # 1 did have psychiatric assessments in their chart. On 01/23/2025, was the first assessment and it noted no change in medication regime. On 03/10/2025 the same provider assessed the resident and suggested Resident #1 start Lexapro 5mg for generalized anxiety disorder and also increase their melatonin for sleep. The same provider did a follows up assessment on 03/21/2025 with no new recommendations, and saw Resident #1 on 06/10/2025, and again on 07/04/2025. At the end of the 07/04/2025 assessment the provider indicated that Resident #1 should have another follow up assessment in 4 to 6 weeks. That next follow up assessment did not occur. A new provider started and saw Resident #1 on 04/20/2026. During an interview on 04/29/2026 at 1:16pm Resident #1 reported the aide smacked them and called them a nigger. Resident #1 stated they have been nervous, and they jump when staff comes into the room. They stated there was no consultation afterwards. Resident #1 stated that sometimes when they receive care it is provided by one aide and sometimes it is provided by two aides. Resident #1 stated sometimes they are scared, and they will call downstairs for someone to assist them. Resident #1 stated they do not feel safe in the facility. During a telephone interview with the Medical Director on 05/26/2026 at 3:48 PM, they stated that they did not get any call regarding the incident, but they heard about it randomly one day during rounding sometime the following week. They stated that Resident #1 was being followed by a different medical provider who saw the resident on 02/08/2026. The Medical Director stated that they think they should have been called and would have liked to have been notified of the incident. The Medical Director stated that they were not aware this incident made it to the local news. 10NYCRR 415.15(b)(2)(iii)