STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335413	A. Building B. Wing	09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Washington Center for Rehab and Healthcare	Route 40 Argyle, NY 12809

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 conducted during the recertification and abbreviated survey (Case # 677094), the facility failed to ensure the residents' right to be free from neglect for one (1) (Resident #128) of six (6) residents reviewed for neglect. Specifically, Resident #128 was care planned for falls with intervention including the resident's bed being in the lower position, bolsters placed on both sides, and high-profile floor mats. On 02/12/2025, Certified Nurse Aide #2 left the resident unattended with the bed in a high position while providing care. The resident fell out of bed and sustained a hematoma (a localized pool of blood) on the head, and bruising in both knees. This resulted in actual harm to Resident #128 that was not Immediate Jeopardy. This is evidenced by:The facility policy titled, Abuse, last revised 07/18/2025, documented that the purpose was to prohibit the mistreatment, neglect, and abuse of residents/patients and misappropriation of resident/patient property by anyone, including but not limited to staff, family, friends, and residents of the facility. The policy further defines neglect as the failure of the facility, its employees, or service providers to provide goods and services necessary to avoid physical harm, pain, mental anguish, or distress.Resident #128 was admitted to the facility with diagnoses of dementia with behavioral disturbances (behavioral and psychological symptoms that accompany dementia, affecting a significant portion of those living with the condition), traumatic brain injury (a brain dysfunction caused by an outside force, usually a violent blow to the head), and major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). The Minimum Data Set (an assessment tool) dated 02/01/2025, documented that Resident #128 sometimes made themselves understood, sometimes understands others, and had severe cognitive impairment.The Comprehensive Care Plan for falls, initiated on 08/21/2021, documented that Resident #128 was at risk for falls and has had an actual fall related to deconditioning, psychotropic drug use, progression of aneurysm, did not seek assistance with transfers, and had declining health related to dialysis stopping. Interventions included the resident's bed being in the lower position, bolsters placed on both sides, and high-profile floor mats. The facility's Investigative Report dated 02/13/2025, documented that Resident #128 was observed on the floor next to their bed on 02/12/2025 at 7:45 PM. The bed was observed in an elevated position, and only one (1) bolster and no floor mats were in place. The resident had been incontinent on linens, so staff stepped into the hallway to obtain fresh linens from the cart that was just outside the resident's room. Upon returning to the room, the resident was observed on the floor next to their bed. A hematoma (a localized pool of blood) was reported on the head, and a bruise was reported on both knees. A review of progress notes dated 02/12/2025 documented that at 7:45 PM, Licensed Practical Nurse #4 on the unit heard a sound followed by Resident #128 yelling, ?I am on the floor.' Upon entering the resident's room, they noticed the bed in an elevated position, no fall mat or bolster in place on the left side of the bed, the right-side bolster and mat were in place. A review of progress notes dated 02/12/2025 documented that Registered Nurse #2 was called to the resident's room to assess their injuries after the fall. They observed Resident #128 lying on the floor, next to their bed, on their back. Resident with complaint of pain on the left side of their head and a hematoma (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	noted with bruising to their right and left knees.Nurse Practitioner #1's progress notes dated 02/13/2025 at 10:33 AM documented Resident #128 was evaluated for report of fall out of bed on 02/12/2025. Report hematoma left head but nothing visible at this time. No joint tenderness or swelling,Facility staff were educated on 02/13/2025 on care plan violation by Director of Nursing #1 and Assistant Director of Nursing #1. Education was conducted for all staff regarding understanding the importance of reading care cards and the potential consequences of not adhering to them.A review of investigation notes dated 02/13/2025 documented that Certified Nurse Aide #2 stated the resident was in bed getting changed when they had another bowel movement. They stated that they stepped out of the room to get a new pad, and upon returning, the resident was on the floor next to their bed. During an attempted phone interview on 09/11/2025 at 12:35 PM, Certified Nurse Aide #2 was contacted. A phone message was left, and no return phone call was received.During an interview on 09/11/2025 at 2:35 PM, Licensed Practical Nurse #5 stated they were working when they heard a noise from Resident #128's room, and the resident was found on the floor. They stated they observed the resident lying on their back on the floor with their head against the fall mat, and the bed was noted in an elevated position. They stated that they contacted the supervising nurse, who came down to assess the resident.During an interview on 09/12/2025 at 11:35 AM, Director of Nursing #1 stated they assessed the resident the day after the incident. They stated that the staff used a Hoyer lift to place the resident in bed on 02/12/2025 in the evening. They stated Certified Nurse Aide #2 was changing the resident when they became incontinent again and required a clean pad. They stated that the aide stepped out of the room across the hall to obtain a clean pad from the linen cart, and upon re-entering the room, the resident was lying on the floor next to their bed. Director of Nursing #1 stated that during the investigation, it was determined that the resident's bed was not in the lowest position, and only one (1) side floor mat and bolster was observed in place (to the side opposite of which resident fell out). They stated Registered Nurse #2 assessment findings of a hematoma to the forehead and bruising to both knees. They stated there was no skin abnormalities noted on their assessment on 02/13/2025.Based on the following corrective actions taken, there was sufficient evidence the facility corrected the noncompliance and was in substantial compliance with this specific regulatory requirement at the time of this survey: Completed a full house audit to determine what residents required floor mats to be placed and to determine compliance. Developed and implemented education on 02/13/2025 for entire facility associated with the following of care plans, specifically for residents with safety and fall care plans. Developed and implemented a plan to ensure all residents were safe and free of potential neglect for staff not following care plans. 10 New York Codes, Rules and Regulations 415.4(b)(1)(i)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on record review and interviews conducted during the recertification survey, the facility did not ensure each resident was treated with respect and dignity in a manner and environment that promoted maintenance or enhancement of their quality of life for one (1) (Resident #22) of six (6) residents reviewed. Specifically, Resident #22 reported that some staff did not treat them with respect, they were impolite and mean to them. The resident expressed concern over being treated worse if they talked about it. This is evidenced by: The Policy and Procedure titled, Quality of Life/Dignity, revised 5/28/2024, documented each resident would be cared for in a manner that promoted or enhanced quality of life, dignity, respect and individuality. Residents would be treated with dignity and respect at all times. Treated with dignity meant the resident would be assisted in maintaining and enhancing their self-esteem and self-worth. Resident #22 was admitted to the facility with diagnoses of cerebral infarction (ischemic stroke and occurs because of disrupted blood flow to the brain) chronic diastolic (congestive) heart failure (heart does not fill with blood adequately), edema (swelling that occurs when fluid builds up in the body's tissues). The Minimum Data Set (an assessment tool) dated 07/06/2025, documented the resident had severe cognitive impairment, could be understood, and understand others. During an interview on 09/08/2025 at 1:49 PM, Resident #82 stated some staff were ?short and abrupt' especially with Resident #22. Resident #82 stated they were concerned for Resident #22 because the resident was afraid to speak up. Resident #82 stated some residents could not speak for themselves and emphasized the need for respectful treatment. During an interview on 09/08/2025 at 3:18 PM, Resident #22 stated some staff did not treat them with respect and were impolite and mean. They stated they did feared being treated worse if they reported their concerns and that care was not always provided timely. During an interview on 09/12/2025 at 10:37 AM, Licensed Practical Nurse #2 stated they had been told by Social Work Director #1 the prior week that Resident #82 had concerns about the treatment of Resident #22, who at the time reported no concerns. Licensed Practical Nurse #2 stated the expectation was for staff to treat residents respectfully and politely, asking residents what they wanted and respecting their choices. During an interview on 9/12/2025 1:17 PM, Director of Nursing #1 stated all staff were trained on treating residents with dignity and respect. They stated Licensed Practical Nurse #2 had spoken to Resident #22 and Resident #22 reported no concerns. 10 New York Code of Rules and Regulations 415.5(a)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observations, record review, and interviews conducted during a recertification survey, the facility did not ensure that a resident who needed respiratory care was provided such care consistent with professional standards of practice and the comprehensive person-centered care plan for one (1) (Resident #2) of two (2) residents reviewed for respiratory care. Specifically, for Resident #2, the facility did not ensure the physician's order for oxygen administration was followed. This is evidenced by: The Policy and Procedure titled, Oxygen - concentrators, dated 8/14/2025, documented that oxygen equipment would be checked daily for the correct flow and concentration. The Policy and Procedure titled, Oxygen Policy, dated 8/13/2025, stated the oxygen flow rate must be adjusted by a Licensed Practical Nurse and administered according to the physician order. Resident #2 was admitted to the facility with the diagnoses of chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), type two (2) diabetes mellitus (a chronic condition in which the body does not use insulin effectively or does not produce enough insulin to regulate blood sugar levels), and rheumatoid arthritis (a chronic inflammatory disorder usually affecting small joints in the hands and feet). The Minimum Data Set (an assessment tool) dated 08/07/2025 documented the resident was able to be understood, to understand others and was cognitively intact. The Physician's order dated 06/22/2025 documented the resident was to receive three (3) liters of oxygen per minute via nasal cannula to maintain oxygen saturation greater than 88 percent. During an observation on 09/09/2025 at 9:30 AM, Resident #2 was observed on oxygen. The oxygen concentrator was set to two (2) liters per minute. During an observation on 9/11/2025 at 12:10 PM, the oxygen concentrator in Resident #2's room was running with the flow meter set to two (2) liters per minute. Resident #2 was not in the room. When Licensed Practical Nurse #3 was alerted, they turned the concentrator off. During an observation on 9/11/2025 at 1:50 PM, Licensed Practical Nurse #3 turned on the oxygen concentrator for demonstration to the surveyor without the resident present. The oxygen rate was observed to be two (2) liters per minute. During an interview on 9/11/2025 at 1:50 PM, Licensed Practical Nurse #3 stated it was reasonable to assume the resident had been receiving the wrong liter per minute of oxygen when in bed, as the concentrator had still been running. During an interview on 9/11/2025 at 2:30 PM, Director of Nursing #1 stated that oxygen should only be administered by nurses and at the rate prescribed by the provider. 10 New York Codes, Rules, and Regulation 415.12(k)(6)

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation and staff interview conducted during the recertification survey, the facility did not dispose of garbage and refuse properly. Specifically, the trash compactor was leaking and the area around was not clean. This is evidenced by: During observations on 09/08/2025 at 11:25 AM, a white and yellow fluid and a black fluid were leaking from the trash compactor. A food decomposition odor was detected in the area surrounding the compactor. During an interview on 09/08/2025 at 11:26 AM, Food Service Director #1 stated that they would place a work order with the maintenance department to contact the vendor to have the compactor replaced or repaired and to have the area cleaned. New York Codes, Rules, and Regulations Title 10 S415.14(h)