STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335418	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northern Riverview Health Care, Inc	87 South Route 9w Haverstraw, NY 10927

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review and interviews conducted during the Abbreviated Survey (2622688), the facility did not ensure that the resident's family representative was notified of a change in condition for one (Resident #1) of three residents reviewed for notification of changes. Specifically, on 08/29/2025, Resident #1's family representative observed redness to Resident #1's right eye. The Family representative reported the observation to facility staff and was informed that the redness was due to an allergic reaction to medication the issue had already been addressed by the physician. There was no documented evidence that nursing staff identified or assessed the redness prior to the family representative' observation. There was no documented evidence that the resident's representatives were notified of the change in condition prior to the report from the family representative.The findings include: The facility policy titled Notification of Change, revised 07/07/2025, stated that the nurse will notify the resident, resident representative, and the resident's physician promptly of significant changes in condition, including the development of new symptoms or changes requiring treatment. Resident #1 was admitted with diagnoses including but not limited to dementia, anemia, and systemic lupus erythematosus. The 07/26/2025 Quarterly Minimum Data Set documented that Resident #1 had severe impaired cognition and the resident required extensive assist of one person with toileting, showering, and personal hygiene. Record review showed that on 08/29/2025, ciprofloxacin ophthalmic drops were ordered for Resident #1's right eye. There was no documented assessment to support the reason for the order, and no nursing documentation indicating when the redness was first observed or reported to the physician. During an interview on 10/29/2025 at 01:27 PM, the Assistant Director of Nursing stated that they were not aware of any documentation showing that the resident's family was notified of the red eye, and that staff should have observed and reported any changes in condition. During an interview on 10/29/2025 at 03:07 PM, the Regional Director of Nursing stated that if a resident with dementia is being assisted with daily care, staff should have observed and reported a change such as a red eye. The Regional Director of Nursing stated that the family should not have been the first to identify the change in condition that led to the initiation of ciprofloxacin ophthalmic drops (antibiotic eye drops). During an interview on 10/29/2025 at 03:28 PM, Registered Nurse Supervisor #1 stated that they were informed by a nurse that the family representative was upset regarding the appearance of Resident #1's right eye. Registered Nurse Supervisor #1 stated that when they spoke with the family representative, they were asking about an antibiotic for the eye that another nurse had told them was prescribed for the resident. Registered Nurse Supervisor #1 stated they were not aware of any redness or concerns with Resident #1's right eye prior to been contacted by the nurse. Registered Nurse Supervisor #1 stated they initiated the antibiotic order because the family representative was agitated, and they were attempting to address the concern. Registered Nurse Supervisor #1 stated they did not complete or document a nursing assessment of the resident prior to entering the order.During an interview on 10/29/2025 at 05:16 PM, the family representative stated that when they visited on 08/29/2025, they observed that Resident #1's right eye was red and reported this to the nurse. The family representative stated that the nurse informed them that the redness was already addressed, that the resident had an infection related to an allergic reaction to medication, and that the issue had been handled. The family representative stated that they had not been contacted by staff prior to their visit about any redness or change in the resident's condition. 10NYCRR 415.3

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review and interviews conducted during the Abbreviated Survey (2622688), the facility did not ensure that all alleged violations involving abuse and neglect are reported not immediately but not later than 2 hours after the allegation is made if the events that caused the allegation involve abuse or results in serious bodily injury, or not later than 24hours if the events that cause the allegation do not result in serious bodily injury to the administrator of the facility and to other officials including the State Survey Agency for one (1) resident (Resident #1) of three (3) reviewed for abuse. Specifically, on 09/12/2025, Resident #1's family representative informed the facility that Resident #1 had been punched in the face by another resident. The facility's investigation form and progress notes revealed that a report was received on 09/12/2025 from the family representative and an investigation was initiated on 09/13/2025. There was no documented evidence that the allegation was reported to the New York State Department of Health or local law enforcement. The Facility did not report the results of the investigation within 5 working days of the incident.The findings include: The Facility's Abuse Policy revised on 07/18/2025 documented that the Administrator or Director of Nursing is required to notify the appropriate State Agency and local law enforcement immediately, no later than two hours after an allegation of abuse is identified. The policy also required that the legal guardian or responsible family member and the physician be notified without delay, and that an investigation be initiated, including completion of the facility's investigation form, interviews with the reporter and witnesses, review of the resident's record, and documentation of findings. The policy stated that the Administrator or Director of Nursing is responsible for ensuring that all alleged violations are fully investigated and that the results are reported to the proper authorities as required by State law. Resident #1 was admitted with diagnoses including but not limited to dementia, anemia, and systemic lupus erythematosus. The 07/26/2025 Quarterly Minimum Data Set (MDS) documented that Resident #1 had severe impaired cognition. Review of Resident #1's medical record, including progress notes and the facility's investigative form dated 09/13/2025, revealed that the facility first became aware of an allegation of resident-to-resident physical abuse involving Resident #1 on 09/12/2025 when the complainant reported that Resident #1 had been punched in the face by another resident. There was no documentation that the allegation was reported to the New York State Department of Health within 24 hours or at any time thereafter. The facility's Investigative Form dated 09/13/2025 documented that the incident was categorized as an allegation of resident-to-resident physical abuse. The form stated that the family representative reported that another resident had punched Resident #1 in the face, and that the allegation had been referred to the Assistant Director of Nursing. There was documentation on the form indicating the incident was reported to the State Survey Agency. No documentation was provided during the survey to show that any report was submitted to the New York State Health Department. During an interview on 10/29/2025 at 01:27 PM, the Assistant Director of Nursing stated that they were aware of the allegation of abuse made on 09/12/2025. The Assistant Director of Nursing stated that they were responsible for initiating the internal investigation and acknowledged that the incident should have been reported to the New York State Health Department. During an interview on 10/29/2025 at 05:01 PM, the Director of Nursing stated that all allegations of abuse are required to be reported to the Department of Health, and that the Administrator is responsible for submitting the report. The Director of Nursing stated that there was no documentation showing that the allegation involving Resident #1 was ever reported. During an interview on 10/29/2025 at 05:16 PM, the complainant stated that they notified the facility on 09/12/2025 that two residents had reported that Resident #1 was punched in the face by another resident. The complainant stated that they contacted law enforcement because they believed that Resident #1 was not safe, and that the facility did not report the allegation to the Department of Health. 10 NYCRR 415. 4(b)(1)(ii)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on record review and interviews conducted during an abbreviated survey (2622688), the facility did not report to the State Agency an alleged violation of abuse against a resident who is receiving care from the facility no later than 24hours if the events that cause the suspicion did not result in serious bodily injury for one(1) Resident #1 of three (3) residents reviewed for abuse. Specifically, on 09/12/2025, Resident #1's family representative informed the facility that Resident #1 was punched in the face by a peer. The facility's investigation form and progress notes revealed the report from the family representative was received on 09/12/2025 receiving the information from the family representative. The Facility provided documentation of an investigation initiated on 9/17/2025. There was no documented evidence that the allegation was reported to the New York State Department of Health or local law enforcement. The Facility did not report the results of the investigation within 5 working days of the incident.The findings include: The Facility's Abuse Policy revised on 07/18/2025 documented that the Administrator or Director of Nursing is required to notify the appropriate State Agency and local law enforcement immediately, no later than two hours after an allegation of abuse is identified. The policy also required that the legal guardian or responsible family member and the physician be notified without delay, and that an investigation be initiated, including completion of the facility's investigation form, interviews with the reporter and witnesses, review of the resident's record, and documentation of findings. The policy stated that the Administrator or Director of Nursing is responsible for ensuring that all alleged violations are fully investigated and that the results are reported to the proper authorities as required by State law. Resident #1 was admitted with diagnoses including but not limited to dementia, anemia, and systemic lupus erythematosus. The 07/26/2025 Quarterly Minimum Data Set (MDS) documented that Resident #1 had severe impaired cognition. Review of Resident #1's medical record, including progress notes and the facility's investigative form dated 09/13/2025, revealed that the facility first became aware of an allegation of resident-to-resident physical abuse involving Resident #1 on 09/12/2025 when the complainant reported that Resident #1 had been punched in the face by another resident. There was no documentation that the allegation was reported to the New York State Department of Health within 24 hours or at any time thereafter. The facility's Investigative Form dated 09/13/2025 documented that the incident was categorized as an allegation of resident-to-resident physical abuse. The form stated that the family representative reported that another resident had punched Resident #1 in the face, and that the allegation had been referred to the Assistant Director of Nursing. There was documentation of the form indicating the incident was reported to the State Survey Agency. No documentation was provided during the survey to show that any report was submitted to the New York State Health Department. During an interview on 10/29/2025 at 01:27 PM, the Assistant Director of Nursing stated that they were aware of the allegation of abuse made on 09/12/2025. The Assistant Director of Nursing stated that they were responsible for initiating the internal investigation and acknowledged that the incident should have been reported to the New York State Health Department. During an interview on 10/29/2025 at 05:01 PM, the Director of Nursing stated that all allegations of abuse are required to be reported to the Department of Health, and that the Administrator is responsible for submitting the report. The Director of Nursing stated that there was no documentation showing that the allegation involving Resident #1 was ever reported. During an interview on 10/29/2025 at 05:16 PM, the complainant stated that they notified the facility on 09/12/2025 that two residents had reported that Resident #1 was punched in the face by another resident. The complainant stated that they contacted law enforcement because they believed that Resident #1 was not safe, and that the facility did not report the allegation to the Department of Health. 10 NYCRR 415.4(b)(1)(ii)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews conducted during the Abbreviated Survey (2622688), the facility did not ensure that Resident #1's Comprehensive Care Plan was revised to include measurable, resident-specific interventions specifically reflecting a change in condition involving right-eye redness that resulted in the initiation of antibiotic eye drops. Specifically, Ciprofloxacin(antibiotic) ophthalmic drops were ordered on 08/29/2025 and initiated on 08/30/2025 for the resident's right-eye redness. The Comprehensive Care Plan was not revised to include interventions related to the new treatment and the change in condition. Resident #1's comprehensive care plan interventions was last update 01/23/2025 which addressed a prior influenza related infection. There was no documented evidence of the current condition reported on 08/29/2025. The findings are: The facility's policy titled Care Plans - Comprehensive (revised 10/2019 and reviewed 08/02/2024) documented, Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change. Resident #1 was admitted with diagnoses including but not limited to dementia, anemia, and systemic lupus erythematosus. The Quarterly Minimum Data Set, dated [DATE] documented that Resident #1 had severe impaired cognition. The Physician's order dated 08/29/2025 documented that Resident #1 was to receive Ciprofloxacin ophthalmic drops for right-eye redness, to begin on 08/30/2025. There were no nursing progress notes, no nursing assessments, no physician's assessment indicating the necessity for these eye drops until 09/04/2025. The Comprehensive Care Plan documented a focus entry dated 08/29/2025 indicating, Resident has an actual infection (redness of the right eye), start on eye drop Cipro x 5 days, The care plan was not revised to include measurable goals or individualized interventions specific to the resident's right-eye redness and did not identify the nursing actions required to address the condition. All goals and interventions on the comprehensive care plan remained those established on 01/23/2025, which addressed influenza-related concerns. The resident's current condition and treatment needs/goals/interventions were not reflected in the Comprehensive Care Plan. During an interview on 10/29/2025 at 1:27 PM, the Assistant Director of Nursing stated that charge nurses complete the care plans. The Assistant Director of Nursing stated that care plans should be updated and reviewed quarterly and as needed. The Assistant Director of Nursing stated that there was no charge nurse on the first floor at the time the incident with Resident #1's right-eye redness was observed. The unit did not have a charge nurse for a long time. When the surveyor asked whose responsibility, it was to update residents' care plans in the absence of a charge nurse, the Assistant Director of Nursing stated that they did not want to answer and directed the surveyor to ask administration. During an interview on 10/29/2025 at 2:19 PM, the Director of Nursing stated that it is the responsibility of the charge nurse to update and revise care plans. The Director of Nursing stated that on 08/29/2025 when Ciprofloxacin(antibiotic) ophthalmic drops were ordered for Resident #1's right eye redness, the facility did not have a charge nurse and had not had one for several months. The Director of Nursing stated that as of 10/29/2025, the facility has hired a charge nurse for the unit. The Director of Nursing stated that care plans should always be updated and revised with any change in condition or any change in the plan of care. During an interview on 10/29/2025 at 3:07 PM, the Regional Director of Nursing stated that care plans are reviewed and revised at least quarterly and as needed. The Regional Director of Nursing stated that the resident's change in condition related to right-eye redness, and the initiation of eye drops, should have resulted in updated interventions being added to the care plan. During an interview on 10/29/2025 at 3:28 PM, Registered Nurse Supervisor #1 stated that they initiated the order for ciprofloxacin ophthalmic antibiotic eye drops on 08/29/2025 for Resident #1's right-eye redness without completing a nursing assessment or documenting any evaluation or assessment of the resident's condition. Registered Nurse Supervisor #1 stated that there were no clinical indications documented to support why the resident would need antibiotic eye drops. When asked where the care plan interventions were for the Resident #1's right-eye redness, Registered Nurse Supervisor #1 stated that they were probably rushing to complete an admission and that interventions should have been added on the care plan. Registered Nurse Supervisor #1 stated that every time there is a change in condition, the care plan should be updated to reflect new interventions and appropriate goals. 10 NYCRR 415.11(c)(1)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews conducted during the Abbreviated Survey (# 2622688), the facility did not ensure that necessary care and services were provided to maintain the resident's highest practicable physical well-being for one (Resident #1) of three (3) residents reviewed for abuse. Specifically, on 08/29/2025, Resident #1's family representative reported redness to Resident #1's right eye to nursing staff. The family representative stated that nursing staff told them the condition was already addressed. Record review revealed was no documented nursing assessment, a change-in-condition evaluation or a physician notification. There was no documentation that staff identified the redness prior to the family representative report. Ciprofloxacin ophthalmic (antibiotic) eye drop was ordered on 08/29/2025 and initiated on 08/30/2025 with no documented clinical rationale for the treatment. There was no registered nurse assessment or a physician evaluation at the time the order was placed. Resident #1 was not evaluated by a medical provider until 09/04/2025(six days after redness was discovered) and was diagnosed with subconjunctival hemorrhageThe findings include: Resident #1 was admitted with diagnoses including but not limited to dementia, anemia, and systemic lupus erythematosus. The Quarterly Minimum Data Set, dated [DATE] documented that Resident #1 had severe impaired cognition. Review of Resident #1's medical record showed no documented Registered Nurse assessment, and no nursing progress note on or after 08/29/2025(after notification from family representative of redness in the right eye) that the facility identified a change in condition, evaluated the eye, or notified the physician. Review of the physician's orders dated 08/29/2025 revealed ciprofloxacin ophthalmic (antibiotic) eye drops were ordered on 08/29/2025 to begin on 08/30/2025 for right eye redness. The order was created by Registered Nurse Supervisor #1 and there was no corresponding nursing assessment or documentation supporting the need for treatment. There was no documentation that a physician was contacted at the time the order was entered. Review of the Medication Administration Record revealed that the first dose of ciprofloxacin ophthalmic drops was administered on 08/30/2025. The medical progress note dated 09/05/2025 by Nurse Practitioner #1 documented that Resident #1 was evaluated on 09/04/2025 and diagnosed with a right subconjunctival hemorrhage. This was the first documented medical provider assessment following the reported change in condition on 08/29/2025. During an interview on 10/29/2025 at 03:28 PM, Registered Nurse Supervisor #1 stated they were notified on 08/29/2025 by a nurse that the family representative for Resident #1 reported redness to resident's right eye. Registered Nurse Supervisor #1 stated they sent a text message to the provider to obtain an order for eye drops but did not document an assessment of the resident's eye and did not document the physician notification. Registered Nurse Supervisor #1 stated they could not recall the appearance of the Resident#1's right eye at the time they received the report and notified the physician. During an interview on 10/29/2025 at 01:27 PM, the Assistant Director of Nursing stated they were not notified of any redness to Resident #1's right eye on 08/29/2025 and were not aware of any documentation reflecting that staff assessed the resident on that date. During an interview on 10/29/2025 at 02:56 PM, the Medical Director stated that when a resident has a change in condition, a provider should be notified, an assessment should be completed, and documentation should reflect these actions. The Medical Director stated that the nurse likely contacted a provider and may have forgotten to document because staff can become busy. The Medical Director stated they could not explain why there was no nursing assessment or documentation of provider notification related to the 08/29/2025 report of right-eye redness. The Medical Director stated they were driving during the interview and did not have access to the resident's medical record to clarify what occurred. During an interview on 10/29/2025 at 05:01 PM, the Director of Nursing stated they were not employed at the facility when the redness to Resident #1's right eye was first reported on 08/29/2025. The Director of Nursing was unable to provide documented evidence of any nursing assessment, provider notification, or clinical rationale supporting the initiation of ciprofloxacin ophthalmic eye drops for the reported right-eye redness of Resident #1. During an interview on 10/29/2025 at 04:40 PM, Physician #1 stated they were aware that ciprofloxacin ophthalmic drops were ordered for Resident #1 on 08/30/2025 but did not assess the resident at that time. Physician #1 stated they first evaluated the resident on 09/13/2025 and relied on the diagnosis of subconjunctival hemorrhage previously documented by the nurse practitioner on 09/04/2025. Physician #1 stated they did not know why no assessment or clinical documentation was not completed when the redness was first reported on 08/29/2025. During an interview on 10/29/2025 at 05:16 PM, the family representative

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews conducted during an Abbreviated Survey (2622688), the facility did not ensure physician supervision oversight of medical care for one (Resident #1) of (3) three residents reviewed for physician services. Specifically, an order for ciprofloxacin(antibiotic) eye drops was ordered for Resident #1's right eye on 08/29/2025 after redness was reported by family representative. There was no documented physician assessment or nursing assessment at the time the order was entered. The treatment began 08/30/2025, and Resident #1 was not evaluated by a medical provider until 09/04/2025 six days after the change in condition was identified and after treatment had already been initiated.The findings include:The facility policy titled Physician Services, revised 05/2019 documented that a physician shall review and document orders for the care and treatment of residents and shall evaluate residents as clinically indicated. The policy also stated that all verbal orders must be authenticated by the physician. Resident #1 was admitted with diagnoses including dementia, anemia, and cardiac arrhythmias. The Minimum Data Set, dated [DATE] documented that the resident had severe impaired cognition and required extensive assistance of one staff for toileting, personal hygiene, and bathing. Record review of the physician's orders dated 08/29/2025 documented that ciprofloxacin 0.3% ophthalmic drops, one drop to the right eye three times daily was created by Registered Nurse Supervisor #1 with a start date of 08/30/2025. The order did not contain documentation of physician notification or assessment of the resident's change in condition. The medication administration record showed the eye drops was first administered on 08/30/2025. An initial Optum visit progress note dated 09/04/2025 at 11:06 AM documented that the resident was evaluated by a nurse practitioner and diagnosed with a subconjunctival hemorrhage to the right eye. The note did not reference the prior order for antibiotic eye drops. The note did not document response to treatment, and did not include an assessment of the resident at the time the antibiotic eye drops was initiated. During an interview on 10/29/2025 at 03:28 PM, Registered Nurse Supervisor #1 stated that ciprofloxacin(antibiotic) eye drops were ordered after a nurse notified them that the family representative for Resident #1 reported that the resident's eye appeared red. Registered Nurse Supervisor #1 stated they contacted the physician by text message to obtain the order but did not complete or document a nursing assessment of the resident and did not document physician notification in the medical record. Registered Nurse Supervisor #1 stated they could not recall the appearance of the resident's eye at the time the order was entered. During an interview on 10/29/2025 at 02:56 PM, the Medical Director stated that physicians may not evaluate a resident immediately if they are unavailable or on vacation and that the covering provider may also be busy. When asked whether a resident receiving antibiotic eye drops should be assessed by a medical provider, the Medical Director stated they were unaware that six days had passed between when the order was first initiated and the first provider evaluation. During an interview on 10/29/2025 at 04:40 PM, Physician #1 stated that nurse practitioners are in the facility every day and that they generally expect residents with a change in condition to be seen within two days. Physician #1 confirmed there was no documented evaluation of Resident #1 between 08/29/2025 and 09/04/2025 and stated that they had instructed staff to refer the resident to an ophthalmologist, but did not know whether the resident was ever seen. No documentation of an ophthalmology referral or visit was found in the medical record. 10 NYCRR 415.15(b)(1)(i)-(ii)