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	03/02/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews conducted during a Abbreviated Survey, the facility did not ensure that all alleged violations including injuries of unknown origin were reported to the Department of Health immediately, but not later than 2 hours after the allegation if the events that caused the allegation result in serious bodily injury, or not later than 24 hours if the event that cause the allegation do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey agency) in accordance with the State law through established procedures, and report the results of all investigations to other officials (including to the State Survey Agency), within 5 working days of the incident for one (Resident #4) of three Residents reviewed for injury of unknown origin. Specifically, 0n 1/21/2026, Resident #4 reported right knee pain during cares and was found with swelling to the right knee. A STAT Xray was completed. The radiology report dated 01/21/2026 documented an acute non-displaced fracture of the right tibial plateau. The injury (fracture) constituted a serious bodily injury, requiring immediate reporting within 2 hours. The incident was not reported to the New York State Department of Health until 01/22/2026, exceeding the 2-hour requirement. The 5-day investigative report was not submitted until 02/09/2026, exceeding the required 5-working-day timeframe. The findings are:Resident #4 was admitted to the facility with diagnoses including, but not limited to, anemia, dementia, and hypothyroidism The 10/24/2025 Annual Minimum Data Set documented that Resident #4 had severely impaired cognition, required supervision with bed mobility, and required substantial to maximal assistance with transfers, toileting, and showers. On 01/21/2026 at 12:46 PM, the physician's order documented that a right knee x-ray was to be completed related to muscle weakness, swelling, and pain for Resident #4.The Nursing Home Investigation Form dated 01/22/2026 and submitted to the Department of Health documented the date of incident as 01/22/2026 and documented that Resident #4 was identified with an injury.On 01/21/2026 at 01:26 PM, the nursing progress note by Registered Nurse Supervisor #2 documented that on 01/21/2026 at 11:00 AM, while being turned and positioned Resident #4 was observed guarding their right knee and complaining of pain. Swelling to the right knee was observed. The charge nurse was called to the room, and a stat x-ray of the right knee was ordered and completed.On 01/21/2026 at 07:55 PM, the radiology report documented that the right knee x-ray identified an acute nondisplaced fracture of the right tibial plateau for Resident #4.On 01/21/2026 at 08:37 PM, the nursing Situation, Background, Assessment, Recommendation (SBAR) note documented the x-ray result identified an acute nondisplaced fracture of the right tibial plateau and included a provider recommendation to transfer Resident #4 to the hospital for further evaluation.On 01/21/2026 at 10:03 PM, the nursing progress note by Registered Nurse Supervisor #1 documented that at 10:00 PM, the physician was notified that the x-ray revealed an acute nondisplaced fracture of the right knee. Resident #4 was assessed with right knee swelling and pain. The Director of Nursing was made aware, and Resident #4 was transferred via EMS to the hospital for further evaluation.The facility's hospital transfer form documented that on 01/21/2026 at 10:11 PM Resident #4 was transferred to the hospital for further evaluation.On 01/22/2026 at 02:18 AM, the hospital after-visit summary (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	document received by the facility upon the resident's return to the facility documented that four views of the right knee x-ray were completed and documented a questionable fracture of the lateral tibial plateau for Resident #4.On 01/22/2026 at 09:40 AM, the nursing progress note documented that Resident #4 returned from the hospital emergency department at approximately 09:20 AM. The A review of the facility submission report, the facility did not report the injury which was of unknown origin to the New York State Department of Health until 01/22/2026 at 1:20 PM more than two (2) hours after injury was identified.The facility was required to submit their investigative report to the New York State Department of Health on 01/28/2026 five working days after the injury was identified. Review of the New York State Department of Health Nursing Home Investigative Report Submission #22298 revealed the facility did not submit their investigative report of the unknown injury to the Department until 02/09/2026, thirteen (13) days after they identified the injury of unknown incident. During an interview on 02/12/2026 at 3:49 PM, the Director of Nursing stated that on 01/21/2026 Resident #4 complained of pain to the right knee, a stat x-ray was ordered and completed at the facility, and the radiology results identified an acute non-displaced fracture of the right tibial plateau. The Director of Nursing stated that the physician was notified of the x-ray results on 01/21/2026 and gave an order for Resident #4 to be transferred to the emergency room for further evaluation. Resident #4 was transferred to the hospital on [DATE] and returned to the facility on [DATE]. The Director of Nursing stated that the facility documented the date of incident as 01/22/2026, although the fracture was identified on 01/21/2026. The Director of Nursing stated that the facility initiated the incident report and investigative documentation upon Resident #4's return to the facility on [DATE]. The Director of Nursing stated that they were waiting for the New York State Department of Health to send confirmation of receipt of the facility's reporting of the injury. They didn't receive confirmation and sent the report of their investigation on 02/09/2026. 10 NYCRR 415.4(b)(1)(i) and (ii), 415.4(b)(5)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews during an Abbreviated Survey, the facility failed to thoroughly investigate injuries of unknown origin for two(2) of four(4) sampled residents (Residents #1 and #4). Specifically: 1) Resident #1: Following the discovery of a forehead hematoma, the facility failed to provide a completed investigative report. Documentation lacked staff statements from those providing care prior to the injury and failed to include a detailed description of that care. Facility staff could not provide an explanation of how the injury occurred. 2) Resident #4: After an X-ray on 01/21/2026 revealed an acute right tibial plateau fracture, the facility's investigation was incomplete. Missing elements included staff descriptions of care at the time of the incident, details on how the resident was transferred, and a formal investigative conclusion or root cause. The findings are:The facility's policy titled Accident - Incidents, documented a review date of 06/01/2024, and that The Incident/Accident Statement Form must include a list of nursing staff caring for the resident at the time of the incident and one shift prior, and any witnesses must be listed by name and a statement completed. The policy further documented that the Incident/Accident Report Form must be completed and include the required information, including identification of staff involved, statements, and a complete investigation with conclusion. 1. Resident #1 was admitted with diagnoses included but not limited to anemia, dementia, and hypothyroidism. The Annual Minimum Data Set, dated [DATE] (an assessment tool used to assess residents) documented that Resident #1 had severely impaired cognition and required supervision with transfers and ambulation.The 12/10/2025 Nursing Home Facility Incident Report submitted to the Department of Health documented the following: Injury appears to be of unknown origin, as no staff witnessed an incident. On 12/10/2025, Resident #1 was transferred to the hospital emergency department for evaluation. During an interview on 01/29/2026 at 01:11 PM, Resident #3, roommate of Resident #1, stated that no staff member interviewed them regarding the incident in which Resident #1 was found with a hematoma to the forehead. Resident #3 stated that they were not asked to provide a written or verbal statement and were not questioned about what may have occurred. Review of the facility-provided investigation documentation did not include a statement from Resident #3, despite Resident #3 being present in the room during the timeframe in which Resident #1 was last observed prior to being found with hematoma. Additionally, the documentation did not include determination as to whether abuse, neglect, or mistreatment was considered or ruled out as part of the investigation.During an interview on 01/29/2026 at 03:49 PM, the Administrator stated that he was not the individual who initiated or completed the investigation and reported that the prior Director of Nursing was responsible for completing the investigation. The Administrator further stated that he did not review the investigation and was unable to state whether the investigation provided to the surveyor was complete. During an interview on 01/30/2026 at 02:10 PM, Director of Nursing #2 stated that the facility determined the hematoma to Resident #1's forehead identified on 12/10/2025 was an injury of unknown origin. The Director of Nursing stated that the facility's investigation consisted of statements obtained from staff working the shift during which the hematoma was identified. The Director of Nursing stated that statements were obtained from staff working that shift and that statements were not obtained from staff working prior shifts. The Director of Nursing stated that they trusted that staff would have reported if an incident had occurred prior to the injury being identified. The Director of Nursing further stated that although they held the Director of Nursing position at the time, they had recently started in the role and were still receiving orientation with the previous Director of Nursing (Director of Nursing #1) and was not responsible for initiating the investigation or submitting the final report to the New York State Department of Health. When asked to provide the completed investigation, Director of Nursing #2 stated that there was no additional documentation related to the investigation on file at the facility. The only documentation was what was submitted to the Department of Health. t 2. Resident #4 was admitted with diagnoses (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	including, but not limited to, anemia, dementia, and peripheral vascular disease. The Annual Minimum Data Set, dated [DATE] documented that Resident #4 had moderately impaired cognition, required supervision with bed mobility, was dependent on staff for toileting and showering, and required substantial to maximal assistance with transfers. The facility's investigation report dated 01/22/2026 documented on 01/21/2026 during AM care, Resident #4 was noted to guard body during turning and positioning and complained of pain. The charge nurse was called to the room and swelling of the right knee was identified. A STAT right knee x-ray was ordered and completed, which revealed an acute non-displaced fracture of the right tibial plateau. Per physician's order, Resident #4 was transferred to the hospital for further evaluation. Physician's order dated 1/21/26 documented that a right knee x-ray was to be completed one time on 01/21/2026 at 12:46 p.m. related to muscle weakness, swelling, and pain. The radiology report dated 01/21/2026 for the right knee x-ray performed at the facility documented an acute non-displaced fracture of the right tibial plateau for Resident #4. The Hospital After Visit Summary dated 01/21/2026 documented that the reason for visit was leg injury and the diagnoses included knee pain and tibial plateau fracture. Review of the Accident/Incident Statement Forms completed by Certified Nurse Aide #5 documented that care was provided to Resident #4 and that Certified Nurse Aide #5 was assigned to Resident #4. The statements further documented that no incident was witnessed and identified one witness by name.The statements did not document the type of care provided to Resident #4, including how Resident #4 was transferred or assisted with activities of daily living at the time of the occurrence. Further review of the Accident/Incident Statement Forms showed that two statements completed by Certified Nurse Aide #5 were missing required identifying information and detail. One statement lacked the name, title, and date of the individual completing the form, and an additional statement lacked a date. Both statements did not include the shift and/or time Certified Nurse Aide #5 was assigned to Resident #4, despite indicating assignment to Resident #4. In addition, while the statements indicated that care was provided, they did not include sufficient detail to identify the specific care provided or the circumstances surrounding the injury. Review of the Accident/Incident Statement Form completed by Certified Nurse Aide #6 showed that within the section of the form that asks whether the aide was assigned to the resident and whether care was provided, Certified Nurse Aide #6 indicated no to being assigned to Resident #4 and no to providing care. However, in another section of the same form, Certified Nurse Aide #6 documented assigned aide for appointment on 01/20/2026 - yes During an interview, Certified Nurse Aide #6 stated that assistance was provided with completion of dressing and transfer of Resident #4 to the wheelchair using stand and pivot method in preparation for the outside medical appointment. Review of the Accident/Incident Statement Form completed by Certified Nurse Aide #6 showed the form did not include a description of the care or assistance provided to Resident #4, did not identify the role of Certified Nurse Aide #6 during the outside medical appointment, and did not include a description of how Resident #4 was prepared or transferred at the time of the occurrence During an interview on 02/12/2026 at 01:41 PM, Certified Nurse Aide #5 stated that on 01/20/2026, morning care was provided to Resident #4 to prepare Resident #4 to go out to an outside medical appointment with Certified Nurse Aide #6. Certified Nurse Aide #5 stated that Certified Nurse Aide #6 assisted with completion of care and transfer of Resident #4 into the wheelchair via Hoyer lift. Certified Nurse Aide #5 stated that during care there were no issues or concerns, and Resident #4 reported no pain. Certified Nurse Aide #5 stated that when Resident #4 returned from the outside medical appointment, Certified Nurse Aide #5 and Certified Nurse Aide #7 transferred Resident #4 back into bed using a Hoyer lift without incident and Resident #4 did not voice any complaints. Certified Nurse Aide #5 stated that on the following day, 01/21/2026, when assigned to Resident #4 and providing morning care, Resident #4 was guarding the right knee and complained of pain, and the complaint was immediately reported to the nurse. The Facility's Accident/Incident investigation did not include review of Resident #4's care plan related to transfer requirements, did not include an evaluation of the Hoyer lift transfer performed, and (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	did not include interviews with staff from all shifts involved in Resident #4's care and transfer. The investigation record did not identify the transfer requirements for Resident #4 at the time of the occurrence, did not identify the staff involved in the transfer across shifts, and did not identify the circumstances surrounding the transfer to determine how the injury occurred. During an interview on 02/12/2026 at 04:47 PM, Certified Nurse Aide #6 stated assignment included escorting Resident #4 to an outside medical appointment. Certified Nurse Aide #6 stated upon entering the room, Certified Nurse Aide #5 assisted Resident 4 with dressing and Resident #4 was partially dressed. Certified Nurse Aide #6 stated assistance was provided to complete dressing and to transfer Resident #4 into a wheelchair. Certified Nurse Aide #6 demonstrated the transfer was completed using a stand and pivot method and stated a Hoyer lift was not used. Certified Nurse Aide #6 stated Resident #4 did not complain of pain at that time and Resident #4 was transported to and from the appointment in a wheelchair. Certified Nurse Aide #6 stated that during the medical appointment Resident #4 remained in the wheelchair and was not transferred in or out of the wheelchair and stated that during transport in the ambulette there were no incidents.During a follow up interview on 02/12/2026 at 05:13 PM, Certified Nurse Aide #5 stated that a mistake was made and that during the original interview there was confusion regarding when the Hoyer lift was used. Certified Nurse Aide #5 stated that Resident #4 was not transferred into the wheelchair via Hoyer lift prior to leaving for the outside medical appointment and that the transfer to the wheelchair was completed without the use of a Hoyer lift. Certified Nurse Aide #5 stated that the Hoyer lift was used upon return from the outside medical appointment to transfer Resident #4 back into bed because Resident #4 reported being tired. Certified Nurse Aide #5 stated that Resident #4 is not a Hoyer lift resident and stated being aware that at the time of the transfer Resident #4 was not identified as requiring a Hoyer lift.During an interview on 02/12/2026, the Director of Nursing stated that Resident #4 reported right knee pain on 01/21/2026 and an X-ray revealed an acute non-displaced fracture of the right tibial plateau. The Director of Nursing stated that no staff reported any incident during care or transfer and that Resident #4 returned from the outside medical appointment on 01/20/2026 without reported issues. The Director of Nursing stated that Certified Nurse Aide #5 and Certified Nurse Aide #7 reported Resident #4 was transferred with two staff using a Hoyer lift; however, the reason the Hoyer lift was used was not known. The Director of Nursing stated follow-up with staff was needed and that the Accident/Incident Statement Forms did not include the specific care provided to Resident #4. 10 NYCRR 415.12 (c)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, record review, and interviews conducted during the Abbreviated Survey (2695368), the facility did not ensure adequate supervision and implementation of an identified intervention for one (Resident #1) of three residents reviewed for injury of unknown origin. Specifically, Resident #1, who resided on a secure unit, required supervision with ambulation and had a history of wandering and falls, was found on 12/10/2025 with a hematoma to the forehead of unknown origin. Following the incident, enhanced monitoring for safety was initiated on 12/10/2025, however, the facility was unable to demonstrate consistent implementation of the enhanced monitoring intervention. The facility provided incomplete enhanced monitoring documentation from 12/15/2025 through 01/10/2026 which contained missing staff signatures and lacked supervisory review.The findings are:The facility policy titled Safety and Supervision of Residents, revised on 02/01/2024, documented that facility-oriented and resident-oriented approaches to safety are used together to implement a systems approach to safety, which considers the hazards identified in the environment and individual resident risk factors. The policy further documented that the Interdisciplinary Team (IDT) will develop targeted interventions to reduce individual resident risk factors related to identified hazards in the environment, including adequate supervision and assistive devices.Resident #1 was admitted with diagnoses including, but not limited to, anemia, dementia, and hypothyroidism.The 10/24/2025 Annual Minimum Data Set documented that Resident #1 had severely impaired cognition and required supervision with transfers and ambulation.The risk for falls care plan documented that Resident #1 was at risk for falls related to confusion, gait and balance problems, incontinence, and vertigo. Interventions included enhanced monitoring for safety initiated on 12/10/2025. The Enhanced Monitoring Rounding Tool required staff to document monitoring of the resident each shift (day, evening, and night) including the date, the identified concern, and the initials of the staff that verify that monitoring was completed.The Accident/Incident Statement Form (Involved Party) dated 12/10/2025 documented that Certified Nurse Aide #4 last provided care to Resident #1 at approximately 5:30 PM and last observed the resident in bed at approximately 6:30 PM; however, Resident #1 was later observed with a hematoma to the forehead at approximately 7:30 PM, and staff were unable to identify when or how the injury occurred.The 12/10/2025 Nursing Home Facility Incident Report submitted to the Department of Health documented the following: Injury appears to be of unknown origin, as no staff witnessed an incident. On 12/10/2025, Resident #1 was transferred to the hospital emergency department for evaluation.On 12/11/2025 at 5:43 AM, a nurse's progress note by a Registered Nurse documented that Resident #1 returned to the facility at approximately 5:35 AM following evaluation at the hospital emergency department. The progress note documented that imaging studies completed in the emergency department included a computed tomography scan of the cervical spine without contrast, a computed tomography scan of the head without contrast, X-rays of the left knee (front and side views), X-rays of the right knee (front and side views), and an X-ray of the pelvis, with no abnormalities identified. The note further documented that no new orders were received and that the resident continued on neurological checks.During an interview on 01/30/2026 at 01:03 PM, Certified Nurse Aide #1 stated that Resident #1 frequently walks around the unit and enters other residents' rooms. Certified Nurse Aide #1 stated that staff attempt to keep an eye on Resident #1, however, Resident #1 moves around the unit independently and is not continuously monitored. Certified Nurse Aide #1 stated that when staff attempt to redirect Resident #1, the resident becomes upset and resists redirection. Certified Nurse Aide #1 stated remembering that Resident #1 had a knot on the head and was unsure how the injury occurred.During an interview on 01/29/2026 at 01:08 PM, Certified Nurse Aide #2 stated that Resident #1 walks around frequently and goes into other residents' rooms. Certified Nurse Aide #2 stated that Resident #1 does not like to stay in bed and is frequently out of their room.During an interview on 01/29/2026 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 01:11 PM, Resident #3, roommate of Resident #1, stated that Resident #1 wanders in and out of the room. Resident #3 stated that they are a light sleeper and prefer the door to their room is always closed. Staff always close the door to their room after Resident #1 is placed back in bed. Resident #3 stated that as quickly as Resident #1 is placed in bed, Resident #1 gets back out of bed. Resident #3 stated that on the evening of 12/10/2025, no loud noise, thump, or sound was heard inside of the room that would indicate a fall or impact involving Resident #1.During an interview on 01/29/2026 at 01:18 PM, Licensed Practical Nurse #1 stated that Resident #1 is a wanderer and goes from room to room, and stated that Resident #1 is not on enhanced monitoring checks for safety, and is only on a wandering checklist that is signed once per shift.During an interview on 01/30/2026 at 01:46 PM, Certified Nurse Aide #4 stated that on 12/10/2025, Resident #1 was observed sleeping in the dining room and was asked if the resident wanted to go to bed. Certified Nurse Aide #4 stated the nurse placed Resident #1 back into bed; however, Resident #1 got back up shortly after being placed in bed. Certified Nurse Aide #4 stated that Resident #1 sleeps during the day because Resident #1 is up during the night and frequently walks around the unit and enters other residents' rooms. Certified Nurse Aide #4 stated that it is difficult to redirect Resident #1 when the resident goes into other residents' rooms because Resident #1 becomes upset and resists redirection.During an interview on 01/30/2026 at 02:10 PM, the Director of Nursing stated that Resident #1 ambulates independently on the unit and that no staff witnessed the incident on 12/10/2025 in which Resident #1 was found with a hematoma to the forehead of unknown origin while residing on a secured unit. The Director of Nursing stated that Resident #1 walks around the unit independently and is not accompanied by staff. During the interview, the surveyor discussed an observation in which Resident #1 was seated in the dining room with the resident's head down and forehead resting against the edge of the table while appearing to be asleep. The Director of Nursing stated that staff do not place Resident #1 in bed when the resident falls asleep in the dining room because Resident #1 does not remain in bed. The Director of Nursing reviewed the care plan with the surveyor and stated that enhanced monitoring for safety was initiated on 12/10/2025 following the incident. The Director of Nursing further stated that the investigation related to the injury of unknown origin was conducted under the previous Director of Nursing. Resident #1's record was reviewed with the Director of Nursing during the interview. Review of the care plan documented that Resident #1 required supervision with ambulation and that enhanced monitoring for safety was initiated on 12/10/2025 following the incident in which Resident #1 was found with a hematoma to the forehead.The Director of Nursing provided enhanced monitoring intervention documentation for Resident #1 from 12/15/2025 through 01/10/2026. Review of the Enhanced Monitoring Rounding Tool identified multiple instances where required staff initials were missing and the Unit Manager/Supervisor signature line located at the bottom of the monitoring tool was blank, which demonstrated that the facility was inconsistent in utilizing and verifying the completion of the enhanced monitoring intervention for Resident #1. 10 NYCRR 415.12(h)