STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335421	A. Building B. Wing	09/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tarrytown Hall Care Center	20 Wood Court Tarrytown, NY 10591

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45478 Based on observation, record review, and interview conducted during the recertification and abbreviated surveys (NY 00342701) from 9/24/24 to 9/28/24, the facility did not ensure that a resident's right to privacy was respected for 1 of 3 (Resident #80) residents reviewed for Dignity. Specifically, Resident #80's bathroom light was not working and they were told to leave the door open to create light while using the bathroom. The findings are: Resident #80 was admitted to the facility on [DATE] with diagnoses of hyperlipidemia, Alzheimer's Disease, and Non-Alzheimer's Dementia. The Quarterly Minimum Data Set assessment dated [DATE] documented the resident had severe cognitive deficits and needed partial to moderate assist for toileting and showering, and supervision for transfers. When interviewed on 9/24/24 at 1:51 PM, Resident #80's family member stated Resident #80 was told about 2 months ago to leave the door open for light while using the bathroom because the bathroom light was not working. The family member stated they had to call maintenance and, because they were not available over the weekend, it did not get fixed until Monday. There was no documented evidence in the 1/3/24 through 9/25/24 work order logbook of a request for the bathroom light to be fixed in Resident #80's room. When interviewed on 9/27/24 at 9:28 AM, Certified Nurse Aide #21 stated whenever anything was broken they would tell maintenance to fix it. They did not recall the light being broken in Resident #80's bathroom. When interviewed on 9/27/24 at 9:47 AM, the Director of Maintenance stated they were unsure why the facility did not call to make them aware the residents bathroom light was not working, since the family made the facilty aware in the middle of the day on Friday. The Director of Maintenance stated nobody called them over the weekend to inform them the light in Resident #80's bathroom was not working. The Director of Maintenance stated they could come in on weekends to fix things, as long as they were made aware. They further stated they should have been called or staff should have brought Resident #80 to another bathroom. (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: 335421	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/28/2024

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NY CRR 415.3(d)(1)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 43478 Based on record review and interviews conducted during the recertification survey from 9/24/24 to 9/28/24, the facility did not ensure that each resident's screen for a mental disorder or intellectual disability was completed for 2 of 24 (Residents #31 and #48) residents reviewed for Pre Admission Screening and Resident Review. Specially, there was no documented evidence of pre-admission screening and resident review assessments for Residents #31 and #48. The findings are: The facility policy, Pre-Admission Screening and Resident Review dated 11/25/23 documented all residents have the required pre-admission screen prior to admission to the facility, and any time there is a significant change that has a bearing on the resident's specialized service needs. 1. Resident #31 had diagnoses which included mild cognitive impairment, depression, and seizure disorder. Resident #31's electronic medical record revealed there was no documented evidence that a pre-admission screen and resident review assessment was completed. On 9/26/24 at 3:05 PM during an interview with the Director of Social Work and the Administrator, they stated Resident #31 was admitted in 2016, and Resident #31's pre-admission screen and resident review assessment from that time must not have been scanned into Resident #31's electronic medical record, and the original document was not in the facility. They stated they were responsible to check if all residents in the building had pre-admission screen and resident review assessments on file. 2. Resident #48 with Diagnosis of unspecified sequelae of cerebral vascular accident, Hemiplegia, and hypertension Resident #48's electronic medical record revealed there was no documented evidence that a pre admission screen and resident review assessment was completed. On 9/27/24 at 3:05 PM during an interview with the Director of Social Work stated Resident #48's pre-admission screen and resident review assessment must not have been scanned into Resident #48's electronic medical record, and the original document was not in the facility. They stated they were responsible to check if all residents in the building had pre-admission screen and resident review assessments on file. 10NYCRR 415.11 (e) 47626

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 47626 Based on observation, record review, and interview during the recertification survey from 9/24/2024 to 9/28/2024, the facility did not ensure residents at risk for pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote wound healing, prevent infection, and prevent new ulcers from developing for 1 of 2 residents (Residents #48) reviewed for Pressure Ulcers. Specifically, for Resident #48's bilateral heel floats while in bed for pressure reduction were not provided as per physician order and/or care plan. Findings include: The Policy and Procedure titled Pressure Injury Prevention and Management dated 3/2021 documented It is the policy of the facility to have appropriate interdisciplinary preventative care plan implemented when indicated. Purpose to prevent avoidable pressure injuries. Resident #48 had diagnoses of of cerebral vascular accident, hemiplegia, and hypertension. The Quarterly Minimum Data Set (an assessment tool) dated 7/26/2024, documented the resident's cognition was moderately impaired. The resident required set up assistance with eating and partial to moderate assistance for all other activities of daily living. The resident was assessed as being at risk for pressure ulcers, had an open lesion on the foot and had pressure relieving device/s to the bed and the wheelchair. The Care Plan titled Self-Care Deficit dated 3/29/24 and revised on 5/15/24 documented proper positioning, Heel Floats to both feet when in bed for pressure reduction and proper positioning. Physician orders dated 7/19/2024 documented Heel Floats to both feet when in bed, for pressure reduction and proper positioning . The 9/2024 Kardex directions documented Heel Floats to both feet when in bed, for pressure reduction and proper positioning; perform skin check when removed. There was no sign-off required for the CNAs. There was no documented evidence that heel floats were applied. There was no documented evidence in the September 2024 Medication Administration Record and/or Treatment Administration Record for the use of heel floats. There was no documented evidence that heel floats were applied. During observations on 09/24/24 at 6:51 AM, 10:10 AM, and 12:09 PM the resident was in bed, and their heels were positioned on the mattress. The black heel floats were not on the resident and were observed on the floor in the corner of the room. During observations on 9/25/24 at 8:58 AM, 12:19 PM and 3:38 PM, the resident was in bed with no heel floats on and their heels were positioned on the mattress. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/26/24 at 7:25 AM, Certified Nurse Aide #2 stated they knew how to take care of the resident as the nurse gave report. They stated they could look in the kiosk for directions. They stated they were unaware of any positioning devices for Resident #48. During an interview on 09/26/24 at 07:30 AM, Licensed Practical Nurse #3 stated the resident should have offloading booties and did not know why the resident did not have them on. If the resident refused the heel floats the Certified Nurse Aide should have notified the nurse and the nurse should write a progress note and notify the doctor. During an interview on 09/26/24 at 7:54 AM, Registered Nurse Manager #4 stated either the Certified Nurse Aide or the nurse should have applied the offloading device per the physician's order. If the resident refused the heel floats, the nurse should have notified the physician and written a note. During an interview 09/26/24 at 03:56 PM, Director of Nursing stated if a resident had an order and a care plan to off load their heels, they would expect the staff to apply the offloading device. If the resident refused it should have been documented and the medical provider should have been notified. 10NYCRR 415.12(c)(1)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 50766 Based on record review and interview conducted during the recertification and abbreviated surveys (NY00352594, NY00352648, NY00348708) from 9/24/24 to 9/28/24, the facility did not ensure there was sufficient nursing staff to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically, upon review of the staffing schedule from August 22, 2024 through September 25, 2024 the facility did not consistently provide adequate staffing on all units/shifts, to meet the needs of the resident/s. The findings are: During an interview on 09/25/24 at 11:20 AM, with the Administrator, the Facility Wide Assessment was reviewed and daily resident census information was requested. The Administrator stated they would provide clarification of minimum staffing requirements per shift, per title and per census. The following data was provided by Administrator: Certified Nurse Aides: 13-15 day shift, 10-13 evening shift, 6 night shift. Licensed Practical Nurses: 5-6 day shift, 4-5 evening shift, 3 night shift. Registered Nurses: 3-4 day shift, 1 evening shift, 1 night shift. A review of the facility staffing sheets from August 22, 2024 through September 25, 2024 and the minimum staffing provided by the Administrator based on Facility Wide Assessment and facility census, documented the facility was understaffed 35/35 days for Certified Nurse Aides and 24/35 days for Nurses. During Resident Council meeting on 9/25/24 at 2:06 PM, the [NAME] President stated there were not enough staff to provide resident cares. Sometimes residents could wait 3 hours to be changed, and there were only two Certified Nurse Aide on duty. During an interview on 09/27/24 at 03:53 PM Certified Nurse Aide #2 stated the facility is always understaffed and they routinely work double shifts and work extra shifts weekly. They stated they sometimes feel they have to accept overtime because there is not enough staff, and it is impossible to complete all tasks for all residents when staff is low. NY CRR 415.13(a)(1)(i-iii)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 50766 Based on record reviews and interviews conducted during the recertification and abbreviated surveys (NY00352594, NY00352648) from 9/24/24 to 9/28/24, the facility did not ensure that annual performance appraisals were performed for Certified Nurse Aides staff. Specifically, the facility was unable to provide evidence that 5 of 5 Certified Nurse Aides (Staff #14, Staff #15, Staff #16, Staff #17 and Staff #18), received an annual performance appraisal. The Facility Policy titled Staff Development Program (dated 11/8/23) documented: Nurses aides (Certified Nurse Assistants) are required to complete no less than 12 hours annually of in-service training that is sufficient to ensure the continuing competency of nurse aides and address any specific areas of weakness identified in performance evaluations and through the facility assessment. The findings are: During an observation and interview on 09/25/24 at 03:10 PM with Director of Nursing and Human Resources Director, the Director of Nursing was provided a random sample of five staff members to provide documentation of annual performance appraisals (Staff #14, #15, #16, #17 and #18). The Director of Nursing and Human Resources Director were unable to provide documentation reflecting an annual performance appraisal for 5/5 staff members randomly sampled. The Director of Nursing stated they were not able to provide proof of annual performance appraisals. The Director of Nursing stated they were responsible for ensuring staff received annual performance appraisals. 10 NYCRR 415.26

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F 0811 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are assessed for appropriateness for a feeding assistant program, receive services as per their plan of care, and feeding assistants are trained and supervised.

50766

Based on observation, interview and record review conducted during the Recertification Survey and Abbreviated Surveys (NY 00352594, NY 00352648) from 9/24/24-9/28/24, the facility did not ensure two residents (Resident #52 and #22) were fed by staff members who completed a State-approved training course to assist residents in eating or drinking as required by regulations. Specifically, the facility was not able to provide documentation that Resident Assistants successfully completed a State approved training course for two Resident Assistants (Staff #6 and Staff #10) observed feeding Resident # 52 with a diagnosis of dysphagia/receiving a pureed diet and Resident #22 assessed to hold food in the mouth/cheeks or residual food in the mouth after meals and receiving a mechanically altered diet.

The findings are:

1. Resident #52 diagnoses included dementia, dysphagia, and significant weight change.

The 5/14/24 Physician Order documented regular diet, pureed texture, thin liquids consistency.

The 7/12/24 Quarterly Minimum Data Set documented Resident # 52 had severe cognitive impairment, received substantial/maximal assistance for eating and was on a mechanically altered diet (requiring change in texture of food/liquids).

The 7/31/24 revised Activities Daily Living Care Plan documented extensive assist of 1 staff for eating.

2. Resident #22 diagnoses included dementia, Type I Diabetes Mellitus, and schizoaffective disorder.

The 5/16/24 Physician Order documented low concentrated sweets diet, mechanical soft texture, thin liquids consistency.

The Nutrition Care Plan (revised 5/17/24) documented: the resident had a nutritional problem or potential nutritional problem related to the need for a dysphagia diet, dementia. Monitor/document/report any signs or symptoms of dysphagia: Pocketing, choking, coughing, drooling, holding food in mouth. Several attempts at swallowing. Provide a soft diet as ordered.

The Activities of Daily Living Care Plan with a revision date of 7/31/24 documented the resident required supervision for eating.

The 9/13/24 Annual Minimum Data Set documented Resident #22 had severe cognitive impairment, received supervision or touching assistance for eating, held food in the mouth/cheeks or residual food in the mouth after meals and received a mechanically altered diet/therapeutic diet altered (requiring change in texture of food/liquids).

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F 0811 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a brief interview on 9/24/24 at 12:23 PM the Director of Nursing stated the Speech Language Pathologist provided in-service for Resident Assistants upon hire. A thickened liquids competency was reviewed and after the in-service, resident assistants were able to feed residents. During observation/interview on 9/24/24 at 12:51 PM Resident Assistant #5 was observed handing out lunch trays on the second floor. They stated they frequently feed Residents and receive annual training from the facility Speech Pathologist. During an observation and brief interview on 9/24/24 at 12:54 PM, Resident Assistant #6 was observed feeding Resident #52. They stated they had worked for facility for about 4 weeks and they received an in-service on feeding the residents by Speech Pathologist on their first date of employment. During an interview on 9/26/24 at 10:30 AM the Speech Language Pathologist stated they were responsible for ensuring Resident Assistants received on their date of hire, an approximate one-hour training in-service/competency on feeding residents. They stated they had not completed and were not aware of a requirement for State approved training course. The Speech Language Pathologist stated the one hour competency documented the training provided: diet consistencies (regular, mechanical soft, ground, and pureed), fluid consistencies (regular thin, nectar, thick and honey) and positioning residents while feeding. They stated that upon completion of in-service/competency class, the facility considered Resident Assistants trained to feed residents. The Speech Language Pathologist stated Resident Assistants were informed to reach out to Unit Managers or them with any questions. The Speech Language Pathologist further explained that they believe feeding residents was allowed under the Certified Nurse Assistant or higher level of licensure scope of practice and not under the unlicensed Resident Assistant duties. They stated they had not discussed concerns about Resident Assistants feeding residents with Administration or Managers at the facility. During an observation on 9/26/24 at 12:33 PM, Resident Assistant #10 was observed feeding Resident #22 in the dining room on second floor of facility. During an interview on 9/26/24 at 2:18 Resident Assistant #10 stated they had been employed by the facility for about three weeks. They stated they had only received feeding assistance training at the facility on their date of hire and that the class was about 45 minutes and taught by the Speech and Language Pathologist. They stated the training covered resident swallowing problems, how to feed a resident, offering fluids, and food consistencies such as pureed and chopped. Resident Assistant #10 stated the Speech and Language Pathologist observed them feeding a resident on the 2nd floor about a week after their feeding assistance training date. They stated they were informed that feeding residents would be part of their duties when they interviewed with the Director of Human Resources. Resident Assistant #10 stated they had worked on different units in the building since their date of hire and feeding residents was frequently a part of shift duties. During an interview on 9/26/24 at 4:33 PM the Administrator stated Resident Assistants were provided with training from the Speech Language Pathologist and therefore they were allowed to feed the residents and that Nurses were responsible for supervising Resident Assistants. (continued on next page)

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F 0811 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a follow-up interview on 9/26/24 at 4:48 PM the Regional Director of Quality Assurance and Performance Improvement, the Administrator, and the Director of Nursing regarding Resident Assistants, the Regional Director of Quality Assurance and Performance Improvement stated that the Resident Assistants were allowed to feed residents after they took a one-hour competency in-service with the facility Speech Language Pathologist and demonstrated competency. The Regional Director of Quality Assurance and Performance Improvement stated they were not aware of any problem with Resident Assistants feeding residents with only a one-hour in-service/competency. The Regional Director of Quality Assurance and Performance Improvement stated that effective immediately, until they further investigate, they will allow only Certified Nurse Aidess and Licensed Nurses to feed residents. 10 NY CRR415.14

Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 50766 Based on record review and interview conducted during the recertification and abbreviated surveys (NY 00352594, NY 00352648) from 9/24/24 to 9/28/24, the facility did not ensure that Certified Nurse Aides were provided the required 12 hours of training to ensure safe delivery of care. Specifically, the facility was unable to provide evidence that 5 of 5 Certified Nurse Aide #14, #15, #16, #17 and #18), reviewed for Nurse Aide training, were provided 12 hours of mandatory training. The findings are: The Facility Policy titled Staff Development Program (dated 11/8/23) documented: Nurses Aides are required to complete no less than 12 hours annually of in-service training that is sufficient to ensure the continuing competency of Nurse Aides and address any specific areas of weakness identified in performance evaluations and through the facility assessment. During an observation and interview on 09/25/24 at 03:10 PM the Director of Nursing and Human Resources Director provided documentation of 7.0 hours of in-service training for Certified Nurse Aide #14, #15, #16 and #17. The Director of Nursing stated they were not able to provide a full 12 hours of in-service training for Certified Nurse Aide # 14, #15, #16, and #17 and they did not have any in-service hours for Certified Nurse Aide #18. The Director of Nursing stated they did not perform staff competencies in 2024 and were not able to provide documentation of staff competencies after 4/2023 for Certified Nurse Aide #14, #15, #16, #17 and #18. The Director of Nursing stated they were responsible for ensuring staff received the required 12 hours of annual in-service. During an interview on 09/26/24 at 11:22 AM the Regional Director of Quality Assurance and Performance Improvement stated proof of in-services provided by the Director of Nursing and Human Resources Director on 9/25/24 had clerical errors documented for the length of time of each in-service. They stated they were not aware who documented the times on the in-service attendance sheets, but they were wrong. The Regional Director of Quality Assurance and Performance Improvement stated they did not know why four different staff members on two different dates would log incorrect times for the in-service training. They stated Certified Nurse Aide #18, who was missing documentation may have in-service documentation in the Human Resources office waiting to be scanned electronically. No further documentation was provided. 10NYCRR 415.26