STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335422	A. Building B. Wing	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Ridge Living Center	100 Sandy Drive Amsterdam, NY 12010

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 - Minimal harm or potential for 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 survey, the facility did not ensure the resident's right to be free from abuse and neglect for one (1) (Resident #14) of seven (7) residents reviewed for abuse and neglect. Specifically, for Resident #14, a Certified Nurse Aide provided care to the resident by themselves when the resident was care planned to be a two person assist with care. This resulted in the resident falling out of bed, sustaining ecchymosis (bruising) to their right facial area and a laceration above their right eye. Floor mats that were care planned to be on both sides of the bed parallel to the bed due to Resident #14 being at risk for falls were not in place during care when Resident #14 fell out of bed. This is evidenced by: Resident #14 was admitted to the facility with diagnoses of vascular dementia (dementia caused by a series of strokes. Restricted blood flow due to strokes reduced oxygen and glucose delivery to the brain, causing cell injury and neurological deficits in the affected region), epilepsy (a brain disease where nerve cells do not signal properly that cause seizures), 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 2/12/2025 documented the resident had severe impaired cognition, could be understood and sometimes understand others. Facility Policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program, updated October 2024, documented residents had the right to be free from abuse, neglect, misappropriation of resident property and exploitation. Facility Policy titled Care Plans, Comprehensive Person Centered, updated January 2024, documented a comprehensive, person-centered care plan that included measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs was developed and implemented for each resident. The comprehensive, person-centered care plan described the services to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The Comprehensive Care Plan for Activities of Daily Living: Impaired Physical Mobility effective 7/31/2018 documented Resident #14 required assistance with mobility/activities of daily living task performance related to impaired balance, weakness, and dementia. Resident #14 required two-person assist for bed mobility and transfers. (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: 335422	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/18/2025
NAME OF PROVIDER OR SUPPLIER River Ridge Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Sandy Drive Amsterdam, NY 12010	

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Comprehensive Care Plan for Falls effective 7/31/2028, documented as an intervention effective 9/10/2020 for Resident #14 to have floor mats when in bed. Resident #14's care card documented the resident was dependent for bed mobility and required a two-person assist for this task. The care card also documented the use of floor mats for Resident #14 when in bed. Facility Incident/Accident Report documented on 3/08/2025 at 5:30 AM, Resident #14 was on the floor. The Certified Nurse Aide stated when they performed care for this resident while the resident was in bed, they turned Resident #14 to the left side. The resident rolled out of bed and fell to the floor. Contributing factors documented there was a break in care plan. Resident #14 was a 2 person assist and only one Certified Nurse Aide provided care. Floor mats were not down parallel to Resident #14's bed. Progress note dated 3/08/2025, documented Resident #14 had a witnessed fall around 5:30 AM that day. The Certified Nurse Aide providing care stated they turned the resident to the left and the resident rolled out of bed and fell. Skin abrasion to right forehead and laceration to right upper side of eye was cleaned, pat dry, bacitracin was applied, steri-strip and ice pack applied. Range of motion was at baseline; neurological checks were in progress. No other injuries were noted at the time. Team Health was notified Progress note dated 3/11/2025 documented resident was being seen due to a fall that resulted in a head laceration and ecchymosis to the right eye. Bruising was turning yellow-green and head laceration was steri-stripped and open to air. Resident #14 was at their baseline neurological status. Provider note dated 3/11/2025, documented ecchymosis (bruise) to right facial area and laceration above right eye with steri-strip in place. Nursing to monitor for symptoms of infection. Cranial nerves 2-12 were grossly intact. Fall care plan was reviewed. Nursing was to monitor neurological status. Resident #14's neurological status and range of motion was at their baseline. Continue to monitor for developing complications and to monitor vital signs. During an observation on 3/11/2025 at 11:06 AM, Resident #14 was asleep in bed. Floor mats were parallel to the bed on both sides of the bed. Bruising was noted around their right side of the face and there was a steri strip above their right eye. During an interview on 3/13/2025 at 3:27 PM, Licensed Practical Nurse #3 stated on 3/08/2025 while a Certified Nurse Aide provided care to Resident #14, the Certified Nurse Aide rolled the resident too far and the resident rolled out of bed. Care should have been provided by two Certified Nurse Aides, but only one provided the care. Resident #14's care plan was not followed. The Certified Nurse Aide that provided the care to Resident #14 was from a staffing agency and was not permitted to return to the facility. During an interview on 3/14/2025 at 12:24 PM, Registered Nurse #3 stated the Certified Nurse Aide that provided care during this incident to Resident #14 did not follow Resident #14's care plan. Resident #14 was care planned to have two people assist with care, but the Certified Nurse Aide provided care by themselves. There were no floor mats down when this occurred and there should have been floor mats in place. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER River Ridge Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Sandy Drive Amsterdam, NY 12010	

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/17/2025 at 10:42 AM, Director of Nursing #1 stated Resident #14 was care planned to have two people assist with care but during this incident only one Certified Nurse Aide provided care. Resident #14 was rolled close to the edge of the bed, and they fell out of bed onto the floor. There were no floor mats down when this occurred, and the floor mats were care planned to be in place on the floor on both sides of the resident's bed parallel to the bed when Resident #14 was in bed. During an interview on 3/18/2025 at 9:59 AM, Administrator #1 stated this incident occurred on 3/08/2025 around 5:30 AM. Administrator #1 stated they found out about the incident on 3/10/2025. The Certified Nurse Aide involved in this incident was from an agency and they were not permitted to work in the facility anymore. 10 New York Code, Rules, and Regulations 415.4(b)(1)(i)

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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 review and interviews during a recertification survey and abbreviated survey (Case #NY00370532), the facility did not ensure that all alleged violations involving abuse were reported immediately, or no later than 2 hours after the allegation was made for two (2) (Residents #14 and #32) of seven (7) residents reviewed for abuse. Specifically, (a.) an allegation of a Certified Nurse Aide not following care plan recommendations while they provided care for Resident #14 on 3/08/2025 which resulted in the resident falling out of bed sustaining ecchymosis (bruising) to the facial area and a head laceration above their eye was not reported to the New York State Department of Health until 03/10/2025. Specifically, (b.) for Resident #32 an allegation of abuse that had been reported to staff resulting in a mark on the resident's face was not been reported to New York State Department of Health by the facility. This is evidenced by: Facility policy titled, Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating, updated October 2024, documented all reports of resident abuse (including injuries of unknown origin), neglect, exploitation or theft/misappropriation of resident property are to be reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source was suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. Resident #14: Resident #14 was admitted to the facility with diagnoses of vascular dementia (dementia caused by a series of strokes. Restricted blood flow due to strokes reduced oxygen and glucose delivery to the brain, causing cell injury and neurological deficits in the affected region), epilepsy (a brain disease where nerve cells do not signal properly that cause seizures), 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 2/12/2025, documented the resident could usually make their self-understood, could sometimes understand others, and had moderate to severe cognitive impairment. Facility Incident/Accident Report documented on 3/08/2025 at 5:30 AM, Resident #14 was on the floor. The Certified Nurse Aide stated when they performed care for this resident while the resident was in bed, they turned Resident #14 to their left side. The resident rolled out of bed and fell to the floor. Contributing factors documented care plan was not followed. Resident #14 was a two- person assist and only one Certified Nurse Aide provided care. Floor mats were not down parallel to Resident #14's bed as they were care planned to be. (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	Progress note dated 3/08/2025, documented Resident #14 had a witnessed fall around 5:30 AM that day. The Certified Nurse Aide providing care stated they turned the resident to the left and the resident rolled out of bed and fell. Skin abrasion to right forehead and laceration to right upper side of eye was cleaned, pat dry, bacitracin was applied, steri-strip and ice pack applied. Range of motion was at baseline; neurological checks were in progress. No other injuries were noted at the time. Team Health was notified by email confirmation sent to the Administrator documented the webform submission for the Nursing Home Facility Incident Report was submitted on 3/10/2025 at 1:00 PM. During an interview on 3/17/2025 at 10:42 AM, Director of Nursing #1 stated they were made aware of this incident that occurred with Resident #14 on 3/08/2025 at 5:30 AM, on the morning of 3/10/2025 during the interdisciplinary team meeting. Director of Nursing #1 stated they told the Administrator what occurred, and they went to the reporting site to report the incident. They stated the incident should have been reported to the Department of Health within 2 hours of occurrence. It should have been reported on 3/08/2025 by 7:30 AM. The incident was reported on 3/10/2025 and was not reported when it should have been. During an interview on 3/18/2025 at 9:59 AM, Administrator #1 stated for incidents regarding abuse, they had 2 hours to report the incident to the Department of Health. Administrator #1 stated they found out about the incident that involved Resident #14 on 3/10/2025 around 10 AM during morning report. They stated they were not notified on 3/08/2025 that the incident had occurred. They further stated they did not know why they were not notified of the incident when it occurred. Administrator #1 stated they reported the incident on 3/10/2025 and was not reported within the two-hour time frame after it occurred. Resident #32 Resident #32 was admitted to the facility with diagnoses of heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), obstructive sleep apnea (a sleep disorder where breathing stops during sleep due to a blockage in the airway causing a decrease in oxygen delivery to the body) and osteomyelitis of the spine (bone infection from an open wound that is infected). The Minimum Data Set, dated [DATE], documented that the resident could be understood and understand others and cognitively intact for daily living decisions. An ACTS (Aspen Complaints Tracking System) complaint/incident report date 1/30/2025 documented that a complaint was submitted to the New York State Reporting division on 1/27/2025 that alleged Resident #32 had been abused during an overnight shift from 01/25 through 1/26/2025 at the facility. Intake number NY00370532. During review of the intakes by the complaints division it was determined there had been no facility generated report of the incident for the resident. Physician order dated 1/24/2025 documented: c-pap (portable machine with a mask at bedtime as ordered, settings at 2 Liters bleed (method of adding additional oxygen to C-pap (continuous positive airway pressure) machine to increase delivery of oxygen to the resident. During an interview on 3/14/2025 at 9:30 AM, Resident #32 stated an agency nurse had put their C-pap mask on and was rough with them. The nurse had been upset about something and when the nurse placed the C-pap mask on them the strap hit them in the face, and they pushed the mask down hard on their face and made the straps too tight. Resident #32 stated they reported this to Certified Nurse Aide #11 and later to Licensed Practical Nurse #1 because they had marks on their face. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER River Ridge Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Sandy Drive Amsterdam, NY 12010	

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/14/2025 at 12:38 PM, Administrator #1 stated they were made aware of the incident from overhearing staff talking about Resident #32 being slapped. This was reported to Director of Nursing #1, but Administrator #1 was not sure of the date. They stated they did not remember what had happened after that and no report had been made to the New York State Department of Health. During an interview on 3/14/2025 at 12:43 PM, Director of Nursing #1 stated Administrator #1 reported they had heard Resident #32 had been slapped by a staff member. Director of Nursing#1 stated they went to talk to the resident about the incident and Resident #32 stated the staff member had put their C-pap mask on too tight. They had not reported the incident because the resident did not say they were slapped, and had not investigated it any further. They thought it had been an agency nurse that had placed the mask on the resident, but nothing had been documented. They stated, they could not remember when it happened. If abuse occurred or was suspected, it should have been investigated and reported to the New York State Department of Health within 2 hours if there was an injury. They stated they had not reported it because Administrator #1 and Director of Nursing #1 thought Resident #32 had not been abused. They could not produce any documentation to collaborate their accounting of the event. During an interview on 3/18/2025 at 12:45 PM, Certified Nurse Aide #11 stated they had been told by Resident #32 that the Licensed Practical Nurse had hurt them when placing their C-pap on them. The Certified Nurse Aide #11 stated it happened when the resident was first admitted but was not sure of the date. They had reported it to Licensed Practical Nurse #1 because the resident had marks on their face. It was then reported to Administration. The Licensed Practical Nurse who had worked was an agency nurse and never came back to the facility. The resident's family was aware and complained about it to the Registered Nurse who was the unit manager but was no longer at the facility. The Certified Nurse Aide #11 stated they were not sure what happened or what the outcome of the incident was. 10 New York Codes, Rules, and Regulations 415.4(b)(2) Surveyor: [NAME], [NAME]

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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 observation, record review, and interview during a recertification and abbreviated survey (Case # NY00370532), the facility did not ensure that all allegations of abuse were thoroughly investigated for one (1) (Resident #32) of seven (7) residents reviewed for abuse. Specifically, Resident #32 reported an allegation of abuse and rough treatment when a nurse put on their C-Pap (continuous positive airway pressure machine) mask on them during an overnight shift between 1/25/2025 and 1/26/2025. The facility did not initiate an investigation until 3/18/2025 after the resident was reviewed during the survey process between 3/11/2025 through 3/18/2025. This is evidenced by: The facility's policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program - Reporting and Investigating, last updated October 2024, documented the residents have the right to be free from abuse, neglect, misappropriation of resident's property, and exploitation. All allegations of abuse are thoroughly investigated immediately. 1. All allegations are thoroughly investigated. The administrator initiates investigation. 2. Identify and investigate all possible incidents of abuse, neglect, mistreatment or misappropriation of the resident's property. 3. Investigate and report any allegations within timeframes required by federal requirements. 4. The administrator is responsible for keeping the residents and their representative informed of the progress of the investigation. 5. Protect residents from any further harm during investigations. 6. Interviews the resident and anyone who may have come in contact with the resident. 7. Documents the investigation completely and thoroughly. 8. Upon conclusion of the investigation, the investigator records the findings of the investigation on approved documentation forms and provides the completed documentation to the administrator. Resident #32 was admitted to the facility with diagnoses of heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), obstructive sleep apnea (a sleep disorder where breathing stops during sleep due to a blockage in the airway causing a decrease in oxygen delivery to the body), and osteomyelitis of the spine (bone infection from an open wound that is infected). The Minimum Data Set (an assessment tool) dated 1/31/2025, documented that the resident could be understood and understand others with intact cognition for decisions of daily living. An ACTS (Aspen Complaints Tracking System) complaint/incident report date 01/30/2025 documented that a complaint was submitted to the New York State Reporting division on 01/27/2025 that alleged Resident #32 had been abused during an overnight shift from 01/25 through 1/26/2025 at the facility. Intake number NY00370532. During review of the intakes by the complaints division it was determined there had been no facility generated report of the incident for the resident. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documented evidence that the facility reported the incident to the Department of Health, or an investigation was initiated. Physician order dated 1/24/2025 documented: C-pap (continuous positive airway pressure) at bedtime as ordered, settings at 2 liters bleed (method of adding additional oxygen to C-pap machine to increase delivery of oxygen to the resident. During an interview on 3/14/2025 at 9:30 AM, Resident #32 stated an agency nurse had put their C-pap mask on and was rough with them. The nurse had been upset about something and when the nurse placed the C-pap mask on them the strap hit them in the face, and they pushed the mask down hard on their face and made the straps too tight. Resident #32 stated they reported this to Certified Nurse Aide #11 and later to Licensed Practical Nurse #1 because they had marks on their face. During an interview on 3/14/2025 at 12:38 PM, Administrator #1 stated they were made aware of the incident from overhearing staff talking about Resident #32 being slapped. This was reported to Director of Nursing #1, but the Administrator #1 was not sure of the date. They stated they did not remember what happened after and no report was made to the New York State Department of Health. Also no investigation or documentation could be found to explain what had transpired. During an interview on 3/14/2025 at 12:43 PM, Director of Nursing #1 stated Administrator #1 reported they had heard Resident #32 had been slapped by a staff member. Director of Nursing#1 stated they went to talk to the resident about the incident and Resident #32 stated the staff member had put their C-pap mask on too tight. They stated they had not reported the incident because the resident did not say they were slapped and had not investigated it any further. They thought it had been an agency nurse that had placed the mask on the resident, but nothing had been documented, and could not remember when it happened. If abuse occurred or was suspected, there should have been an investigation immediately and the person accused should have been removed from resident care. After speaking to the resident no investigation or documentation was done and no report was made to the New York State Department of Health within 2 hours of the incident. They had not reported the incident because the Administrator #1 and the Director of Nursing #1 thought Resident #32 was not abused but should have investigated and documented the interview with the resident and taken statements from staff. During an interview on 3/18/2025 at 12:45 PM, Certified Nurse Aide #11 stated they had been told by Resident #32 that the Licensed Practical Nurse had hurt them when placing their C-pap on them. The Certified Nurse Aide #11 stated it happened when the resident was first admitted but was not sure of the date. They had reported it to Licensed Practical Nurse #1 because the resident had marks on their face. It was then reported to Administration. The Licensed Practical Nurse who had worked was an agency nurse and never came back to the facility. The resident's family was aware and complained about it to the Registered Nurse who was the unit manager but was no longer at the facility. Certified Nurse Aide #11 stated they were not sure what happened or the outcome of the incident. 10 New York Code of Rules and Regulations 415.4(b)(2)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews conducted during a recertification survey and abbreviated survey (Case # NY00328519), the facility did not ensure an environment that was free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents for two (2) (Resident #s 58 and 74) of five (5) residents reviewed. Specifically, (a.) for Resident #58 there was no adequate supervision to prevent an elopement; (b.) for Resident #74 a container of triamcinolone acetonide (a prescription cream) was stored on top on the nightstand in the resident's room permitting access to this cream by the resident or anyone that entered the room. This is evidenced by: The Facility's Policy and Procedure titled Accidents and Incidents - Investigating and Reporting revised 2024, documented this facility is in compliance with current rules and regulations governing accidents and/or incidents involving a medical device. The Facility's Policy and Procedure titled Wandering and Elopement revised 12/2024, documented it would ensure that the systems, tools and individuals were in place to make it possible to prevent unsafe wandering and or elopement and to ensure that actions were taken quickly and prudently should either occur. Mag locks and Door alarms must be operational 24 hours per day and must be routinely checked that they are Operational and should be checked after electrical storm and severe weather. The wander guard system in the lobby reception that is activated will not only alarm, but also have an orange strobe light activate on each unit. Once door is cleared and resident is safe, lobby reception would be notified that is safe to clear the alarm. When any door alarm is activated, the closest staff will respond. Secure resident to ensure their safety. If a resident who is identified at risk for elopement is observed near an exit, staff would redirect the resident to a more appropriate location and the nurse would be notified. In the event that it is determined that a resident is missing, the policy for missing resident will be followed. The whereabouts of the residents should be known at all times by staff. Wandering residents would have a wander guard intact at all times. Resident #58: Resident #58 was admitted to the facility with a diagnoses dementia (progressive or persistent loss of intellectual functioning), neuromuscular bladder dysfunction (dribbling urine, loss of feeling that the bladder is full, and being unable to control urine), and hypertension (when the pressure in blood vessels is too high). The Minimum Data Set (an assessment tool) dated 12/07/2024, documented resident was cognitively impaired, could be understood and understand others. The Comprehensive Care Plan effective 5/10/2023, last updated 2/13/2024 documented, Etiology: Dementia with associated features of memory impairment and/or poor judgement Change of environment. As Evidenced By: Wanders with limited regard for boundaries; leaves unit without telling staff. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Facility Investigative Report dated 11/20/2023, documented on 11/19/2023 Facility door alarm near C wing went off at approximately 9:20 PM. Licensed Practical Nurse #8 responded to alarm and noted that the door was closed, and they did not see anyone near the door or the hallway, so the alarm was turned off. Two nurses returning from their supper break saw Resident #58 walking in the parking lot. They approached resident and were able to direct them back into the building and onto A wing. Resident #58 was last seen at 9:15 PM by Certified Nurse Aide #12. There were no noticeable injuries to Resident #58. 30-minute safety checks were immediately instituted. It had been determined that staff did not follow the elopement policy. During an interview on 3/12/2025 at 9:16 AM, Licensed Practical Nurse #6 stated Resident #58's wander guard is on right wrist and the site is rotated periodically. The Unit side doors do not alarm when resident wearing a wander guard gets near it. Wander Guard only activates the double doors that lead to the front entrance. The Unit side doors will not open unless holding down the bar for 15 seconds, then the lock will release, and door will open. Prior to Resident #58's elopement on 11/19/2023, the side doors did not have the 15 second egress. Instead, doors opened when bar pushed. During an interview on 3/14/2025 at 12:02 PM, Licensed Practical Nurse #9 stated they heard the alarm while on the A wing and went to see what was going on, on the C wing. By the time they arrived the alarm was shut off. Licensed Practical Nurse #9 stated they asked Licensed Practical Nurse #8 about the alarm and Licensed Practical Nurse #8 stated it was nothing and they shut off the alarm. Licensed Practical Nurse #9 resumed what they were doing until resident came back in building with two other nurses. Licensed Practical Nurse #9 stated they should have conducted a head count prior to assuming the alarm was all clear. During an interview on 3/13/2025 at 1:01 PM, Director of Nursing #1 stated all staff respond when a door alarm is heard. Afterwards each unit conducts a head count, unless the opening of the alarm door was witnessed. All staff underwent elopement training following 11/19/2023 incident. Resident #74: Resident #74 was admitted to the facility with diagnoses of encephalopathy (a broad term for any brain disease that alters brain function or structure), non-ST elevation myocardial infarction ((a type of heart attack involving a partial blockage of a coronary artery leading to reduced blood flow to the heart), and candidiasis (a fungal infection typically on the skin or mucous membranes). The Minimum Data Set, dated [DATE] documented the resident had moderate cognitive impairment, could be understood, and understood others. Review of medical orders documented triamcinolone acetonide 0.1% topical cream (apply by topical route 2 times per day to bilateral lower extremities) was discontinued on 11/26/2024. During an observation and interview on 3/12/2025 at 10:09 AM, a container of a prescription cream, triamcinolone acetonide, was stored on top of Resident #74's nightstand next to their bed. The container had a prescription label with Resident #74's name on it. Resident #74 stated the cream was applied to their legs by the nurses and the nurses left the cream in their room. During an observation on 3/13/2025 at 12:32 PM, a container of a prescription cream, triamcinolone acetonide, was stored on top of Resident #74's nightstand next to their bed. The container had a prescription label with Resident #74's name on it. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/13/2025 at 12:42 PM, Certified Nurse Aide #8 stated they do not apply any cream to Resident #74's legs. During an interview on 3/13/2025 at 1:19 PM, Licensed Practical Nurse #3 stated Resident #74 did not self-administer any kinds of medication, nor had they been assessed to their knowledge to do so. They stated the triamcinolone acetonide cream was not being used anymore and the order for it had been discontinued. They stated the cream should not have been stored in Resident #74's room. It should have been kept in the medication cart when it was being used, and because it was no longer used it should have been removed from the medication cart. During an interview on 3/14/2025 at 11:41 AM, Registered Nurse #3 stated medication prescribed for Resident #74 should not be left in the resident's room. Resident #74 did not currently have triamcinolone acetonide cream prescribed for use. It was previously used for Resident #74, but the order for it to be used had been discontinued. When the cream was being used with the resident, it should have been stored on the medication cart. During an interview on 3/17/2025 at 10:42 AM, Director of Nursing #1 stated there were no residents in the building that were able to self- administer medications. Medications should be stored on the medication cart which should always be locked. Medications should not be stored in a resident's room. 10 New York Codes, Rules, and Regulations 415.12(h)(2)

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY Based on observations, record review, and interviews conducted during the recertification survey, the facility did not ensure that each resident received the necessary respiratory care and services that were consistent with professional standards of practice for four (4) (Residents #'s 24, 32, 34, and 61) of 5 residents reviewed for oxygen administration. Specifically, supplemental oxygen was not provided as ordered by the physician.

This is evidenced by:

A review of the facility policy titled Oxygen Therapy, dated January 2024, documented that the facility was to provide respiratory therapy assessment and treatment to residents with deficiencies or abnormalities of pulmonary function for whom a provider's order had been written.

Resident #24:

Resident #24 was admitted to the facility with diagnoses of chronic obstructive pulmonary disease (an ongoing lung condition caused by damage to the lungs resulting in swelling and irritation inside the airways that limit airflow into and out of the lungs), emphysema (a chronic lung disease that permanently damages the lungs' air sacs, making it difficult to breath) and acute respiratory failure with hypoxia (occurs when the lungs struggle to deliver enough oxygen to the blood, leading to low oxygen levels). The Minimum Data Set (an assessment tool) dated 1/02/2025 documented that the resident could be understood and understand others and had moderately impaired cognition for daily living decisions.

A review of medical orders dated 5/15/2024 documented that oxygen should be delivered via nasal cannula (a device that gives additional oxygen through the nose) at a rate of 2-3 liters continuously.

A review of the resident-centered care plan with a focus on respiratory disorder, effective 08/31/2023, Resident #24 was to receive continuous oxygen via nasal cannula. The care plan intervention for Resident #24 was documented as receiving oxygen therapy per the physician's order.

During an observation and interview on /11/2025 at 10:55 AM, Resident #24 was in their room, seated in their wheelchair. An oxygen tank in the holder attached to their wheelchair was turned off, and an oxygen concentrator in their room was turned off. Resident #24 was not wearing a nasal cannula and was not receiving supplemental oxygen. Resident #24 stated that they were always supposed to receive supplemental oxygen. They stated that the tubing from the concentrator did not reach the bathroom, and they did not know why the staff did not have them use oxygen in a holder attached to the back of their wheelchair that could accompany them into the bathroom.

During an observation on 3/11/2025 at 1:06 PM, Resident #24 was in their wheelchair eating lunch near their unit's nurse station. Resident #24 was not receiving supplemental oxygen.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/13/2025 at 12:58 PM, Certified Nurse Aide #6 stated Resident #24 used the tank on the back of their wheelchair to provide supplemental oxygen during the day and the concentrator to supply supplemental oxygen when they were in their bed. They were unsure if Resident #24 was always supposed to have supplemental oxygen. They further stated Resident #24 would remove the oxygen when entering the bathroom. Certified Nurse Aide #6 stated that if the oxygen was ordered for Resident #24 to use continuously, it should be used when they were in the bathroom. During an interview on 3/13/25 at 3:24 PM, Licensed Practical Nurse #3 stated that Resident #24 always received supplemental oxygen. If an oxygen order was continuous, oxygen should always be on the resident. Licensed Practical Nurse #3 stated that Resident #24 spent much time in their room, so they mostly used the concentrator to supply supplemental oxygen. During an Interview on 3/14/2025 at 11:37 AM, Registered Nurse #3 stated that Resident #24 was on 2-3 liters of continuous oxygen and should always receive supplemental oxygen. Resident #34: Resident #34 was admitted to the facility with diagnoses of chronic obstructive pulmonary disease (an ongoing lung condition caused by damage to the lungs resulting in swelling and irritation inside the airways that limit airflow into and out of the lungs), essential hypertension (a condition characterized by persistently high blood pressure without an identifiable underlying cause), and chronic respiratory failure with hypoxia (occurs when the lungs struggle to deliver enough oxygen to the blood, leading to low oxygen levels). The Minimum Data Set, dated [DATE] documented that the resident could be understood and understand others and had moderately impaired cognition for daily living decisions. A review of medical orders dated 1/13/2025 documented that oxygen should be continuously delivered via nasal cannula at a rate of 4 liters. A review of the resident-centered care plan with a focus on respiratory disorder, effective 10/04/2024, documented that Resident #34 was to receive continuous oxygen via nasal cannula. The care plan intervention for Resident #34 was noted as receiving oxygen therapy as per the physician's order. During an observation on 3/12/2025 at 11:35 AM, Resident #34 was in their room sitting in their wheelchair. Resident #34 was wearing an oxygen cannula, and the oxygen concentrator was set at 3.5 liters instead of the ordered 4 liters. During an observation on 3/13/2025 at 12:36 PM, Resident #34 was sitting in their wheelchair in their designated bedroom with oxygen being delivered via nasal cannula. The oxygen setting on the portable concentrator was observed to be at 3.5 liters instead of the ordered 4 liters. During an interview on 3/12/2025 at 12:06 PM, Resident #34 stated they had an early morning seat for dialysis and would switch to a portable tank to go to dialysis. When they returned, the nurse would put them back on the concentrator. Resident #34 stated they were always on 4 liters of oxygen. They stated the nurses monitored the concentrator settings. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/12/2025 at 1:15 PM, Registered Nurse #1 stated they reviewed Resident #34's orders, and the physician's order was 4 liters via nasal cannula. They stated nurses should carefully check that the oxygen levels were correct when passing medications and providing care. If Nurses were not doing that, they would need to be reeducated. During an interview on 3/13/2025 at 2:01 PM, Licensed Practical Nurse #1 stated that Resident #34 sometimes adjusts the oxygen concentrator themselves. It had not been checked the night before, and maybe it got adjusted at a lower rate somehow. They stated they might have looked at it incorrectly and would change it to ensure the oxygen delivery was correct. Resident #61: Resident #61 was admitted to the facility with diagnoses of chronic respiratory failure with hypoxia (a condition where you do not have enough oxygen in the tissues), chronic obstructive pulmonary disease, and chronic systolic (congestive) heart failure (a chronic condition in which the heart does not pump blood as well as it should). The Minimum Data Set, dated [DATE], documented that the resident had intact cognition and could be understood and understood by others. A review of medical orders dated 9/24/2024 documented that oxygen should be delivered via nasal cannula (a device that gives additional oxygen through the nose) at a rate of 3-4 liters continuously to maintain pulse oximetry of greater than 90%. A review of Resident #61's care plan dated 2/01/2025, with a focus on respiratory disorder documented an intervention for Resident #61, was to receive oxygen therapy as per the physician's order. During an observation and interview on 3/11/2025 at 10:20 AM, Resident #61 was out of their room, in the common area, seated in their wheelchair, and the resident was not on their prescribed oxygen. There was no oxygen tank in the holder attached to their wheelchair and an oxygen tubing was seen coming out of the holder. Resident #61 stated that they were supposed to always be on oxygen due to their respiratory issues. When asked why they were not on the oxygen, they indicated they did not have an oxygen bottle in their wheelchair. When asked where the bottle was located, they stated that they did not know. During an interview on 3/17/2025 at 12:12 PM, Licensed Practical Nurse #4 stated that Resident #61 had an order of 3-4 liters of oxygen to be administered via nasal cannula continuously. They stated that the resident should always be on oxygen, even out of their room. They stated that Resident #61 sometimes took the oxygen off and was continuously reminded that they should place the oxygen cannula back on. Licensed Practical Nurse #4 stated they were unsure why the resident did not have an oxygen tank in their holder on the wheelchair and that they should have had one so Resident #61 could be wearing their oxygen continuously as prescribed by the physician. During an interview on 3/18/2025 at 10:40 AM, Registered Nurse #3 stated that Resident #61 was on 3-4 liters of continuous oxygen and should always receive supplemental oxygen. They stated that they were unsure why the resident was not on oxygen and that the staff should have obtained an oxygen bottle so they could be on oxygen. 10 New York Code of Rules and Regulations 415.12(k)(6)

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews during a recertification and abbreviated survey (Case #'s NY00349575 and NY00370532), the facility did not ensure that food and drink were palatable and attractive for two (2) (Residents #19 and 32) of 11 residents reviewed for palatable and appealing food and drink. Specifically, (a.) residents complained that the food was cold, unattractive, and generally unpalatable during the resident council meeting; (b.) Resident #19's lunch tickets did not match what the resident received during their lunch service on 3/17/2025; (c.) Resident #32 complained of cold, unattractive, and not palatable food, and during lunch service on 3/13/2025, the resident's food tray did not match their ticket This is evidenced by: A facility policy titled Food and Nutrition Services, dated 1/2024, documented that the facility would provide each resident with a nourishing, palatable, well-balanced diet that meets their daily nutritional and special dietary needs, considering each resident's preferences. Resident # 19: Resident # 19 was admitted to the facility with diagnoses of heart failure (a condition in which the heart cannot pump enough blood to meet the body's needs), chronic kidney disease, stage 3 (kidneys have mild to moderate damage, meaning they are less effective at filtering waste and fluid from your blood), and chronic obstructive pulmonary disease (a group of lung diseases that cause progressive and irreversible airflow obstruction, leading to breathing difficulties). The Minimum Data Set (an assessment tool) dated 3/28/2025 documented that the resident had intact cognitive ability, could be understood and understood others. During the resident council meeting on 3/12/2025 at 11:00 AM, Resident #19 stated that the food was always cold and not appealing or appetizing. Resident #19 stated that the trays for meals never arrive on the unit at a consistent time. They stated that they did not bother for staff to reheat their food, as it would take a long time to get it back. They stated that items are always wrong and missing when the trays arrive for meals. During an observation on 3/17/2025 at 12:24 PM, Resident #19 was to receive a whole egg salad sandwich, half cup of tossed salad, 6 ounces of chef's choice soup, half cup of mixed fruit, two packets of mustard and mayo each, two containers of 1% milk, a packet of thousand island dressing, and 4 ounces of iced tea. In comparing the lunch ticket and meal tray, the resident received corned beef and cabbage with potatoes, carrots, applesauce, milk, and chocolate ice cream. The resident did not receive any items that were documented on their lunch ticket, except for one container of 1% milk. During a test tray on 3/17/2025, the temperature and taste of Resident #19's lunch were assessed. The corned beef and cabbage were at 114.1 degrees Fahrenheit and tasted as expected. The beef was easily chewed and broken down. The carrots were at 108.5 degrees Fahrenheit and tasted as expected. The potatoes were at 119.7 degrees Fahrenheit and tasted as expected. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Kitchen Supervisor #1 was interviewed on 3/17/2025 at 12:59 PM after they brought the replacement tray to Resident #19. Resident #19's replacement tray did not match the resident's lunch ticket. Kitchen Supervisor #1 stated that they had been short-staffed and did not have the time to portion out the items. They stated that the facility ran out of hard-boiled eggs to make the egg salad sandwiches last Thursday. They stated that they had given the resident the regular meal for lunch, even though their lunch ticket documented that they had requested a substitute. They stated that they did not mention the lack of requested items to the resident and did not ask if they would like a different substitute since the facility did not have the requested item. Resident # 32: Resident #32 was admitted to the facility with diagnoses of heart failure (a chronic condition in which the heart does not pump blood as well as it should), diabetes mellitus, and osteomyelitis of the spine (bone infection from an open wound that is infected). The Minimum Data Set (an assessment tool) dated 1/31/2025, documented that the resident could be understood and understand others with intact cognition for decisions of daily living. A review of Resident #32's diet documented that the resident was initially ordered a regular diet with thinned liquids upon admission on [DATE]. Review of Resident #32's Comprehensive Nutritional Care Plan, implemented on 1/24/2025, documented a potential alteration in nutritional status related to obesity, infection, gastroesophageal reflux disease, and iron deficiency. Goals stated as follows: A. The resident will consume greater than 75 percent of each meal. B. The resident will state their food preferences and tolerances. Interventions: A. Diet as ordered by the medical doctor. B. Provide an appropriate, consistent diet. C. Provide nutritional supplements and nourishments as tolerated by the resident. Last updated on 1/27/2025. Dietary meal ticket dated 3/13/2025 for Resident #32 documented 4 oz beef ravioli, 4 ounces zucchini, one piece apple coffee cake, 2 percent milk, 8 ounces coffee, one package sugar, one package pepper, and one creamer, During an observation on 3/13/2025 at 12:15 PM, Resident #32's food tray was delivered. It consisted of noodles with a butter sauce, green beans, milk, and coffee cake. The resident was observed to eat about 25 percent of the meal. The green beans were mushy, and the sauce on the noodles was not marinara as stated on the ticket. The noodles were overcooked and mushy, and the butter was congealed, appearing semi-solid and unappetizing. During an interview on 3/13/2025 at 12:45 PM, Resident #32 stated that the food was not what they had ordered. They further stated that the meal was cold, the milk was warm, and they had not received coffee. Resident #32 stated that the food was always cold and mostly inedible so that the family would bring them food. They had complained, but nothing had changed. During an interview on 3/13/2025 at 12:57 PM, Certified Nurse Aide #1 stated that one of the biggest complaints they received from the resident was cold food. They stated the food on the tray did not always match what was on the ticket. They stated they sometimes would get the resident a sandwich if the resident asked. If the kitchen run out of a particular food on the menu, they substituted something else. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/17/2025, at 12:42 PM, Registered Dietician #1 stated residents should be informed of food substitutions before trays arrive, allowing them to participate in the substitution. Registered Dietician #1 stated they would review the resident because they had a wound and look to add nutritional drinks and protein. They further stated they were not familiar with the resident and would meet with them later to review their concerns and preferences. Registered Dietician #1 was unsure about staff training but stated that the person who brought the tray to the resident should have checked to ensure the food ticket matched what was on the tray and asked the resident if it was acceptable. During an interview on 3/18/2025, at 11:07 AM, Administrator #1 stated that they had been undergoing changes with staff in the facility. Food complaints were common, and they were working on the menu. They stated staff should verify that meal tickets match the food on the trays. If a resident did not like the food or said it was cold, a new tray should be ordered. 10 New York Code of Rules and Regulations 415.14(d)(1)(2)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review during a recertification and abbreviated survey (Case #NY00349575), the facility did not ensure it established and maintained an infection prevention and control program (IPCP) designed to help prevent the development and transmission of communicable diseases and did not maintain infection control prevention during dressing changes for two (2) (Resident #s 32 and 47) of four (4) residents reviewed for pressure sores. Specifically: (a.) for Resident #32, Licensed Practical Nurse #1 did not set up and maintain a clean field and proper infection control that included proper hand hygiene was performed, during a dressing change to prevent contamination of a resident's wound; (b.) for Resident #47, Licensed Practical Nurse #5 did not change gloves and hand sanitize during the dressing change; (c.) Staff did not maintain isolation precautions by closing doors to isolation rooms with residents who were positive for Covid 19 and on droplet precautions; (d.) the facility did not complete a water system environmental assessment for Legionella within the past year. This is evidenced by: The facility's policy titled Wound Care, last revised 3/2024, documented the following: 1. Use disposable cloth (paper towel was adequate) to establish clean field on resident's overbed table. Place all items to be used during procedure on the clean field. Arrange the supplies so they can be easily reached. 2. Wash and dry your hands thoroughly. 3. Position resident. Place disposable cloth next to resident (under the wound) to serve as a barrier to protect the bed linen and other body sites. 4. Put on exam glove. Loosen tape and remove dressing. 5. Pull glove over dressing and discard into appropriate receptacle. Wash and dry your hands thoroughly, put on gloves. 6. Put on gloves. Change gloves and hand sanitize between cleansing of the wound. 7. Use no-touch technique. Use sterile tongue blades and applicators to remove ointments and creams from their containers. 8. Pour liquid solutions directly on gauze sponges on their papers. 9. Wear exam gloves for holding gauze to catch irrigation solutions that are poured directly over the wound. 10. Wear sterile gloves when physically touching the wound or holding a moist surface over the wound. 12. Dress wound. Pick up sponge with paper and apply directly to area. [NAME] tape with initials, time, and date and apply to dressing. Be certain all clean items are on clean field. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	13. Remove the disposable cloth next to the resident and discard into the designated container. 14. Discard disposable items into the designated container. Discard all soiled laundry, linen, towels, handwash into the soiled laundry container. Remove disposable gloves and discard into designated container. Wash and dry your hands thoroughly. (a.) Resident #32: Resident #32 was admitted to the facility with diagnoses of heart failure (a chronic condition in which the heart does not pump blood as well as it should), obstructive sleep apnea (a sleep disorder where breathing stops during sleep due to a blockage in the airway causing a decrease in oxygen delivery to the body), and osteomyelitis of the spine (bone infection from an open wound that is infected). The Minimum Data Set (an assessment tool) dated 1/31/2025, documented that the resident could be understood and understand others and was cognitively intact for decisions of daily living. A Physician Order dated 1/31/2025 documented the following: Cleanse sacral wound with Dakin ' s solution 0.125 percent, apply calcium alginate packing to base of wound, secure with silicone border suprabasorb twice daily and prn (as needed). Review of Resident #32 Comprehensive Care Plan for pressure ulcer and wound care dated 1/24/2025, documented the goal was resident would not experience complications of infections, or concerns. The Electronic Treatment Administration Record for March 2025 documented the following: Dakin ' s Solution 0.125 percent, cleanse sacral wound with Dakin ' s solution per treatment, order 2 times a day for osteomyelitis of vertebra, sacral and sacrococcygeal region. Start date 1/31/2025. During an observation on 3/13/2025 at 11:30 AM, Licensed Practical Nurse #1 with the assistance of Certified Nurse Aide #6 performed wound care for Resident #32 on their stage 4 coccyx wound. Licensed Practical Nurse #1 brought dressing supplies into the room and placed them on the resident ' s bedside table. They washed their hands with soap and water for 10 seconds, dried them, put gloves on and removed the old dressing, changing their gloves they proceeded to clean the resident from a recent bowel movement. After cleaning the residents peri area, Licensed Practical Nurse #1 placed soiled washcloths in a bag on the bed. They changed their soiled gloves and began cleaning the wound on the coccyx with gauze using wound supplies that had been placed on the bedside table. Licensed Practical Nurse #1 did not sanitize their hands between glove changes after having removed the old dressing, cleaning the feces from the resident ' s anus, and placing the old, soiled dressing into the garbage. Licensed Practical Nurse #1 contaminated the wound when cleansing the wound going from outer area into the wound. They changed their gloves and placed the calcium alginate (a dressing for wound healing) in the wound and applied a dry clean silicone border dressing to Resident #32 ' s coccyx without hand sanitizing before each step. During an interview on 3/17/2025 at 11:10 AM, Licensed Practical Nurse/Infection control preventionist #1 stated the first step in preparing for a dressing change was to prepare a clean field. Staff had recently been educated on wound care. Hands should have been sanitized between glove changes for each step especially if the resident had visibly soiled areas around the wound. Dressing material should have been opened and placed on the clean field and gloves should have been changed because the outside of the package was considered dirty. Licensed Practical Nurse #1 would have to be reeducated about clean technique during a dressing change. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335422	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Ridge Living Center	100 Sandy Drive Amsterdam, NY 12010

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/18/2025 at 11:47 AM, Licensed Practical Nurse #1 stated they had not realized they had contaminated their gloves several times during the dressing change for Resident #32. They acknowledged they had not followed proper wound care procedure while putting on and removing and gloves. Hands should have been sanitized between steps, gloves changed, and they should have prepared a clean field before beginning the wound care. During an interview on 3/17/2025 at 2:17 PM, Director of Nursing #1 stated the Licensed Practical Nurses had been trained on wound care. The Licensed Practical Nurse/ Infection Control Preventionist #1 was certified to monitor the infections in the facility and to monitor and do audits and evaluate staff performance on wound care. There was a shortage of Registered Nurses, and properly trained Licensed Practical Nurses should have been able to perform this task. A clean field was the first thing that should be done before beginning wound care. Items and supplies should not have been used once they were placed in the nurse ' s pocket. Sanitizing of the hands should have been done before putting clean gloves on before each step in the procedure. (b) Resident #47: Resident #47 was admitted to the facility with diagnoses of paraplegia, unspecified (paralysis that affects the legs, making it impossible to stand or walk), diabetes mellitus (The body ' s ability to produce or respond to the hormone insulin was impaired), and cellulitis (local skin infection) of lower extremities. The Minimum Data Set, dated [DATE], documented Resident #47 could understand and be understood by others with intact cognition for decisions of daily living. Physician Order dated 4/12/2024, renewed monthly to current, documented wound care to left trochanter: Cleanse with 0.125% Dakin ' s solution. Apply hydrocortisone to peri wound; collagen and alginate packing to base of the wound; apply superabsorbent silicone and cover with foam dressing. During an observation on 3/18/2025 at 9:44 AM, Licensed Practical Nurse #5 performed a dressing change of left trochanter for Resident #47. Licensed Practical Nurse #5 removed the old dressing which was noted to have a moderate amount thick yellow drainage on the gauze. After removing old dressing, Licensed Practical Nurse #5 removed the old gloves and applied sterile gloves. They cleansed the wound using multiple 4 x 4 gauze. Licensed Practical Nurse #5 wiped inside of the dirty wound with right hand then exchanged gauze from left clean hand into soiled right hand, contaminating left hand. They repeated the steps 4 times, dirty hand touching clean hand, then applied packing gauze inside of the wound. After they applied packing to the wound, they removed the packing, stating it was wrong size. They cut a new piece of packing and re-applied. Sterile gloves were not changed at any time after touching drainage and contents from inside of the wound. The wound was covered with a dry dressing. Licensed Practical Nurse #5 stated the wound was assessed and measured by the Wound Care Team. During an interview on 3/18/2025 at 10:08 AM, Registered Nurse #4 stated nursing staff completed an infection control training including dressing changes the previous day, 3/17/2025. Licensed Practical Nurse #5 was in attendance. In addition, Infection Control and Prevention was covered during new hire orientation. (c.) Finding: Doors to rooms designated for isolation for Covid Positive Residents were not closed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335422	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/18/2025
NAME OF PROVIDER OR SUPPLIER River Ridge Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Sandy Drive Amsterdam, NY 12010	

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Signage on room # ' s 54 ,63, and 66 carried the following notification: Droplet Precautions with Personal Protective Equipment Usage and hand washing instructions, Quarantine Room precautions and instructions prior to entering room, and contact precautions and instruction for all staff before entering and before exiting. During observation on 3/11/2025 from 9:45 AM and 12:35 PM, Covid rooms on the rehabilitation unit were observed to be left open by staff who went into the room to deliver care. Room #s 54, 63 and 66 were left open after staff exited rooms. During observation on 3/12/2025 from 9:45 AM and 12:35 PM, Covid rooms on the rehabilitation unit were observed to be left open by staff who went into the room to deliver care. Room # ' s 54, 63 and 66 were left open after staff exited rooms. During an interview on 3/12/2025 at 12:35 PM, Certified Nursing Aide #1 stated the staff keeps forgetting to close the door after they take off their personal protective equipment but that the doors should have been closed because the residents had tested positive for Covid 19 and were on isolation. During an interview on 3/12/2025 at 1:07 PM, Registered Nurse Educator #5 stated the doors to the isolation rooms should be closed. Droplet precautions meant an infection was airborne and could be spread in the air. They did not know why the staff had not maintained infection control but would start to reeducate staff about the importance of closing the doors of the rooms with signage that designated the resident was on precautions. (d) Legionella Finding #1: Water Management and Sampling Plan There was no documented evidence that the facility developed a Water Management and Sampling Plan. During an interview on 3/13/2025 at 10:21 AM, Consultant #1 stated that they would search the facility files for a Water Management and Sampling Plan and would develop one if it could not be found. Finding #2: Water System Environmental Assessment There was no documented evidence that the facility completed a water system environmental assessment for Legionella within the past year. During an interview on 3/12/2025 at 12:29 PM, Administrator #1 stated that the last facility risk assessment for legionella was completed on 1/11/2024, and another assessment would be completed. 10 New York Codes, Rules, and Regulations 415.19(a), 483.65