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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 36922 Based on record review and interview during the recertification survey, the facility did not ensure each resident was treated with respect, dignity, and care in a manner and in an environment that promotes maintenance or enhancement of their quality of life for three (3) (Resident #s 19, 34, and 38) of 25 residents reviewed, and for residents on C Wing. Specifically, (a) Resident #19 was given plastic utensils for their meal; (b) Resident #34 returned from an early morning dialysis appointment and was placed in their room without access to the call bell. The resident requested to return to bed and was left sitting in their wheelchair for over an hour; (c) Resident #38 was not provided their adaptive built-up utensils for their meals; (d) staff on C Wing were entering residents rooms before properly knocking on the door. This is evidenced by: The Policy and Procedure titled, Resident Rights and Dignity, revised 10/2025, documented the facility's policy of ensuring and respecting all residents' rights. In addition, the facility would maintain strict adherence to state and federal guidelines regarding granting residents' rights, maintaining resident dignity, and ensuring a pleasant and home-like environment for residents and their families. (a) 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 and could be understood and understood others. During an observation on 3/17/2025 at 12:08 PM, the cart with lunch trays arrived on the B Wing at the front nurse's station desk. The lunch tray cart arrived at the resident's hall at 12:17 PM. Resident #19's lunch tray was obtained from the Certified Nurse Aide at 12:24 PM, and a new tray was obtained by the Certified Nurse Aide and delivered at 12:28 PM. (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

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River Ridge Living Center	100 Sandy Drive Amsterdam, NY 12010

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 3/17/2025 at 12:24 PM, a test tray was performed to measure the temperature and taste of Resident #19's lunch. The resident was provided with a regular fork, spoon, and plastic knife for utensils. During an interview on 3/17/2025 at 12:59 PM, Kitchen Supervisor #1 stated that they had been running short on utensils, and residents were issued plastic utensils. They stated they were unsure why utensils were short; staff may had accidentally thrown away the silverware. Kitchen Supervisor #1 stated that the facility ran out of spoons and residents were getting plastic spoons until they ran out, so no resident was issued spoons. They stated that they ordered more but were unsure when the spoons would arrive or how long they would last. (b) Resident #34: Resident #34 was admitted to the facility with diagnoses of end-stage renal disease requiring dialysis, Chronic obstructive pulmonary disease, and anxiety. The Minimum Data Set (an assessment tool) dated 12/25/2024 documented that the resident was cognitively intact. The resident was able to make themselves understood and to understand others. The Care Plan for Resident #34's Activities of Daily Living documented the following: The resident shows potential for decline in self-care and activities of daily living secondary to end-stage renal disease. Dressing, Grooming, Feeding, Bathing, Toileting, and Personal Hygiene were revised on 1/15/2025 with the goal that the resident would be clean, dry, and groomed daily. Care plan interventions were documented to check and assist as needed. During an observation on 3/12/2025 at 11:36 AM, Resident #34 was sitting in their wheelchair in their bedroom with oxygen being delivered by nasal cannula. The resident appeared to be in distress and could not move their wheelchair. The wheelchair's position was wedged between the end of the bed and a chair at the foot of the bed with the call bell attached to the top of the bed pillow. They had no ability to reach the call bell to call for help. During an interview on 3/12/2025 at 12:06 PM, Resident #34 stated they had an early morning seat for dialysis and were exhausted. They requested to go back to bed when they returned from dialysis, and the staff member placed them in the room, stating they would tell someone. After 30 minutes, they asked Licensed Practical Nurse #1 if they could get someone to get them back to bed, and the nurse replied they would get someone because they needed two people to assist. Resident #34 stated they were in pain and very tired when this surveyor entered the room at 11:57 AM, could not reach their call light, and had been asking for an hour to be put to bed. Resident #34 stated they could not reach their call bell for assistance, and had to sit and wait until someone came to help them. Resident #34 stated they felt upset and helpless. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/12/2025 at 12:23 PM, Licensed Practical Nurse #1 stated Resident #34 was dependent on two staff using the Hoyer lift to be transferred to their bed. They stated they were unaware that the resident had been left in the room without their call bell since coming back from dialysis but had called for assistance after this surveyor had made them aware that the resident wanted to go back to bed. They stated that Certified Nurse Aides should be checking the residents when they return from dialysis, and the person who left them in their room should have notified the assigned Certified Nurse Aide that the resident was back. Certified Nurse Aides should answer the resident's call light in a timely manner and assist the resident at the time of return. They could not assist the resident because they had been passing medication. Sometimes, residents need to wait, but Resident #34 should have had their call bell in reach. During an interview on 3/12/2025 at 1:15 PM, Registered Nurse Unit Manager #1 stated Resident # 34 should have had their call bell in reach before leaving their room. That is a dignity issue because they would need to holler out if they needed help. If a resident requests to go back to bed, they should not have to wait to go back to bed. There was enough staff to assist someone who was a 2-person assist with a Hoyer transfer back to bed without waiting an hour. The staff would need to be reeducated on placing call bells in reach so residents can get assistance when they need it. (c) Resident #38 Resident #38 was admitted to the facility with unspecified dementia (a decline in mental ability severe enough to interfere with daily life), essential (primary) hypertension (persistent high blood pressure), and type 2 diabetes mellitus (a chronic condition where the body does not use insulin effectively or does not produce enough insulin, leading to high blood sugar levels). The Minimum Data Set, dated dated dated [DATE] documented that the resident had moderate impairment in cognition, was able to make themselves understood, and was usually able to understand others. During an observation on 3/11/2025 at 1:02 PM, Resident #38 ate lunch in the common area. Resident #38 had their build-up spoon but did not have their adaptive built-up fork, and when asked if they had the adaptive fork, they stated that they did not and sometimes did not receive it. During an observation on 3/12/2025 at 9:32 AM, Resident #38 had one built-up spoon and one regular curved spoon. The resident's breakfast ticket documents that the resident is to have a built-up fork and a built-up spoon. A review of the resident's comprehensive care plan, Activities of Daily Living: Reduced Activities of Daily Living, dated 07/10/2023, documented adaptive devices/supportive equipment would be provided as per physical therapy /occupational therapy recommendation, built up fork, knife, and spoon with meals. A review of the resident's comprehensive care plan, titled Nutritional Status/Hydration, dated 7/10/2023, documented adaptive devices/supportive equipment would be provided as per physical therapy /occupational therapy recommendation built up fork, knife, and spoon w/ meals. A review of the resident's certified nurse aide's daily care card for eating on 3/13/2025 documented that the resident requires partial or moderate assistance to provide adaptive feeding devices: a built-up fork, built-up spoon, built-up knife, and scoop dish. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/12/2025 at 9:45 AM, Certified Nurse Aide #9 stated that according to the ticket, Resident #28 was supposed to have built-up utensils for eating assistance. They indicated that they did not have that item today. They further stated that the resident sometimes gets them and sometimes does not, depending on whether the kitchen has them. During an interview on 03/12/25 at 10:36 AM, Kitchen Supervisor #1 stated that they did not have any more adaptive forks or knives, and the resident received two spoons. They stated that recently, they noticed that residents are missing adaptive utensils. They indicated that they believed more had been ordered; however, they were unsure when they would arrive at the facility. They stated that they print the meal tickets for the residents and highlight the adaptive equipment on the ticket so that the resident receives the appropriate utensils. When assembling the trays, it is up to the individuals on the kitchen line to ensure everything is accounted for on the resident's tray. They stated that if something is missing on the resident's tray, staff will call down and get the item replaced on the resident's tray. They stated that it is difficult to replace the missing items when they do not have the item. During an interview on 03/12/2025 at 9:45 AM, Certified Nurse Aide #6 stated that Resident #28 was supposed to have built-up utensils for eating assistance. They stated that the resident sometimes gets them and sometimes does not. They contact the kitchen to get their utensils but sometimes get them depending on whether the kitchen has them. During an interview on 3/18/2025 at 10:05 AM, Registered Nurse #3 stated that staff should check meal trays and meal tickets for accuracy before bringing them to the residents. If any items were incorrect or missing, the kitchen needed to be called. Staff should have discovered the missing adaptive equipment on the resident's tray, called the kitchen, and held the tray until the missing equipment arrived. (d) C-Wing During an observation on the C-Wing on 3/11/2025 from 12:00 PM to 12:45 PM during lunch, staff passed meal trays to residents who were eating in their rooms and were observed not knocking on the resident's door before entering. Certified Nurse Aides #1, #2, #3 and Licensed Practical Nurse #1 were observed entering rooms in The Rehabilitation Unit. Rooms #45, #51, #58, #62, and #63 were entered without knocking and waiting for residents to respond. During an observation on 3/11/2025 at 1:15 PM, housekeeper #1 was cleaning resident rooms and entered the rooms without knocking. Housekeeper #1 entered a two-person resident's room [ROOM NUMBER] while cleaning without knocking before entering. The Housekeeper was observed going in and out of the room several times and in and out of the bathroom. Both residents were in their beds while the housekeeper was observed cleaning around them. During an observation on 3/12/2025 at 11:15 AM, housekeeper #1 entered a two-person resident, room [ROOM NUMBER], while cleaning without knocking before entering. Housekeeper #1 was observed stepping over Resident #34, who was seated in their wheelchair between the lower part of the bed and a chair. They continued going past the resident and going to the window with a cloth and a spray bottle to the window to clean the window. No conversation or explanation was given to the resident. No attempt to move the resident was observed. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation on 3/12/2025 from 12:15 PM to 12:30 PM, Certified Nurse Aides #3 and #4 were observed passing food trays to the following rooms on the rehabilitation unit. Rooms #46, #58, #62, and #63 were entered without knocking and waiting for residents to respond. During an interview on 3/11/2025 at 1:00 PM, Certified Nurse Aide #1 stated the unit was primarily rehabilitation and the residents were alert and oriented. Staff should be knocking on doors before entering if the door is closed or open. They stated that they are getting the trays out so they won't get cold and are always rushed, but staff should knock before entering. During an interview on 3/12/2025 at 12:07 PM, Housekeeper #1 stated they were new and still training but had been educated on knocking on the doors before entering and sometimes forgot. During an interview on 3/12/2025 at 12:15 PM, Housekeeping Supervisor #1 stated that they educate all staff on hire to knock on doors before entering the resident rooms. They stated that they would have to reeducate the staff again about the importance of this for the resident's rights and privacy. During an interview on 3/13/2025 at 11:07 AM, Registered Nurse #4 stated they had a lot of agency staff and had just done an in-service on knocking on residents' doors before entering the residents' rooms. They stated they could see more education would be needed again house-wide. 10 New York Code of Rules and Regulations 415.3 (c)(1)(i) 48413

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 48413 Based on observation, record review, and interviews during a recertification survey, the facility did not ensure an interdisciplinary team assessed residents to determine their ability to safely self-administer medication when clinically appropriate for one (1) (Resident #16) of one (1) resident reviewed for medication administration. Specifically, Resident #16 was observed sitting in the solarium (a room that permits abundant daylight and views of the landscape while sheltering from adverse weather) of the B Wing administering their nebulized medication without being assessed as to whether they could safely self-administer their medication. This is evidenced by: The facility policy titled, Administering Medications, updated February 2024, documented that residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, had determined that they have the decision-making capacity to do so safely. Resident #16 was admitted to the facility with diagnoses of chronic systolic congestive heart failure (the heart does not pump blood well enough to give the body a normal supply), chronic atrial fibrillation (an irregular and often very rapid heart rhythm), and chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe). The Minimum Data Set (an assessment tool) dated 2/26/2025, documented that the resident was cognitively intact, could be understood and could understand others. During an observation on 3/11/2025 at 12:41 PM, Resident #16 was noted to have a nebulizer machine (a nebulizer is a machine that aerosolizes medication and delivers a fine, steady mist through a mouthpiece for inhalation) with DuoNeb, (a combination of Albuterol and Ipratropium bromide), for inhalation. During an interview on 3/11/2025 at 12:42 PM, Resident #16 stated that they took this medication about 4 times a day: nursing staff would hand them the medication, where they would open the medication, place it in the nebulizing cup, and self-administer it. Resident #16 stated that it had been done this way for a long time. They additionally stated that since they did not get to perform their morning medication administration that day (3/11/2025), they stated that they did not give the medication back to the nurse and were given their normal mid-day medication by the nurse, and now they have a spare in their room for later use. A record review of the resident's self-medication assessment conducted on 7/11/2024 documented that Resident #16 was questioned regarding their interest in the self-medication program. The assessment documented that the resident expressed no interest in the program, and therefore, no further evaluation was conducted. No other assessment was performed for Resident #16. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/14/2025 at 12:39 PM, Licensed Practical Nurse #3 stated for a resident to self-administer medication, they would have to have an assessment performed to allow self-administration, which Resident #16 did not have. They stated that they usually handed the Resident #16 their DuoNeb medication, and the resident opened it and placed it in the nebulizer cup for administration. They stated that the DuoNeb administration would be considered the same as self-administered medications. They stated that they should open the medication, place it in the nebulizer machine, and observe the resident administer it. During an interview on 3/18/2025 at 10:08 AM, Registered Nurse #3 stated if a resident wanted to self-administer medications, the physician would assess and provide the order for the resident to self-medicate. They stated that Resident #16 did not have an assessment or physician's order to self-administer their nebulized medication. During an interview on 3/18/2025 at 10:20 AM, Director of Nursing #1 stated that Resident #16 did not have an order for self-administration of medication. They stated that the resident would need to have an assessment conducted for them to self-administer medication without nursing staff present. 10 New York Codes, Rules, and Regulations 415.3 (e)(1)(vi)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36922 Based on observation, record review and interview conducted during a recertification and abbreviated survey (Case #NY00370532), the facility did not ensure each resident's right to make choices about aspects of their life that were significant for them for two (2) (Resident #'s 32 and 34) of 25 residents reviewed. Specifically, (a.) Resident #32 did not have a choice of time for application of their C-PAP (continuous positive airway pressure) machine. (b) Resident #34 did not have a choice of time for returning to bed after dialysis (treatment for kidney disease) appointments. This is evidenced by: 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 (an assessment tool) dated 1/31/2025, documented that the resident could be understood and understand others and was cognitively intact for daily living decisions. Review of Resident #32 comprehensive care plan for Respiratory Disorder dated 1/24/2025, had a stated goal of the following: resident would not experience complications of respiratory failure. During an observation on 3/17/2025 at 9:45 AM, Resident #32's room was noted to contain a C-PAP machine. There was no documented evidence that the comprehensive care plan addressed the resident's choice for when the C-PAP machine would be offered, or what would occur if/when refused by the resident. Review of the resident's Certified Nurse Aide Care Kardex dated 3/11/2025, revealed that the resident required substantial maximal and extensive assist from staff and 2-person care givers until out of bed. Review of Resident #32 Interdisciplinary Team Meeting on 1/30/2025, documented the family meeting was held, and the residents care concerns were addressed by the Register Nurse Manger. The social worker did not detail the concerns that the resident verbalized. No updating for adjustments to the facility and choices of care that the resident expressed to the facility about C-pap concerns. During an observation on 3/17/2025 at 9:45 AM, Resident #32 was resting in bed with oxygen on. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/18/2025 at 9:35 AM, Resident #32 who was alert and oriented to name and place, stated they used C-pap nightly during hours of sleep. The resident stated the schedule for placing the mask on them was done between 7:00 PM and 10:00 PM. The resident stated they refused because sometimes it was offered too early, and they were not settled in for the night. When it gets offered to early and they refuse, it was not offered again. They stated you cannot watch television or use your phone or move much once the mask is on. The resident stated they have asked for this to be addressed multiple times, but it has not been resolved. They stated no one had ever asked them why they kept refusing. Resident #32 stated it should be their choice and should be able to request when they want the C-pap mask to put on and not have to refuse because it is to early or because the staff is too busy. Review of the resident's Certified Nurse Aide Care Kardex dated 3/11/2025, revealed that the resident required substantial maximal and extensive assist from staff and 2-person care givers until out of bed. During an interview on 3/18/2025 at 10:45 AM, Registered Nurse #1 stated Resident #32 refused their C-pap machine because it was offered too early in the evening. They had just become aware of this. Resident #32 was in bed early in the evening because they were a 2 person assist but they preferred to watch television and did not want the mask to be put on just because they were in bed. They were reviewing the care plans for all the residents and taking into considerations their preference and choices for daily routines. Care planning and scheduling of treatments like application of C-pap should take into considerations of an alert residents desired routine. After review of the medical record Registered Nurse #1 could not find any documented care plan that could support Resident #32 choices for care and use of the C-pap at night. Resident #34: Resident #34 was admitted to the facility with diagnoses of end stage renal disease requiring dialysis (kidney failure is the inability of the kidneys to eliminate toxins from the body), chronic obstructive pulmonary disease (a lung disease that causes restrictions of airflow in the lungs and causes breathing problems), and anxiety (intensive, excessive, and persistent worry and fear about everyday situations).The Minimum Data Set, dated dated dated [DATE], documented the resident was cognitively intact, could be understood and understand others. The Care Plan for Activities of Daily Living documented the following: resident shows potential for decline in self-care and activities of daily living secondary to end stage renal disease, dressing, grooming, feeding, bathing, toileting and personal hygiene, revised 1/15/2025 with a goal that the resident would be clean, dry, and groomed daily. Care plan interventions documented to check and assist as needed. Resident #34 physician orders dated 1/14/2025 documented resident to receive hemodialysis at dialysis center on Monday, Wednesday, and Friday at 5:00 AM, for chronic kidney disease stage 5, End stage renal disease. During an observation on 3/12/2025 at 11:26 AM, resident was sitting in their wheelchair at the end of their bed in their designated room and had requested to go back to bed. (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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/12/2025 at 12:06 PM, Resident #34 stated they had an early morning seat for dialysis, and they were exhausted. By the time they return from dialysis they have been up 6 hours. They requested to go back to bed when they returned from dialysis, the staff member had placed them in the room stating they would tell someone. After 30 minutes they asked Licensed Practical Nurse #1 if they someone could get them back to bed. They stated they would get someone because they needed 2 people to assist them, but no one came. Resident #34 stated they were in pain and very tired when this surveyor entered the room at 11:57 AM, could not reach their call light, and had been asking for an hour to be put to bed. They could not reach their call bell to get assistance, so they had to just sit and wait until someone came to help them and felt upset and helpless. During an interview on 3/12/2025 at 12:45 PM, Certified Nurse Aide #3 stated they were the certified nurse aide assigned to Resident #34 for the day. They were not aware the resident had wanted to go back to bed because there was nothing on the residents care Kardex (resident care card for Certified Nurse Aide to follow) that documented that the resident preferred to go to bed on dialysis days. No one told them until now and they needed to get another person to help them because the resident was a a mechanical lift. During an interview on 3/12/2025 at 12:55 AM, Licensed Practical Nurse #1 stated Resident #34 was dependent on 2 staff to return to bed. They stated they were not aware the resident wanted to go back to bed when they first came back because they were busy passing medications. When the resident told them they waited because staff was getting other residents set up for lunch. They stated they have lunch and then start putting residents to bed. Staff works from 6:00 AM to 2:00 PM and there was a schedule that worked for getting residents up and back to bed. They were not aware the resident had been left without a call bell which would have made it difficult for the resident to make their wishes known. They further stated the certified nurse aide assigned to Resident #34 should have checked on the resident when they came back from dialysis. During a subsequent interview on 3/17/2025 at 11:46 AM, Resident #34 stated they were put off by staff who were always telling them they were too busy to put the resident back to bed and that lunch would be coming and then they could go back to bed after lunch. Resident #34 stated they wanted the exhaustion they felt when they returned from dialysis to be acknowledged and be allowed to rest in bed. During an interview on 3/17/2025 at 2:45 PM, Registered Nurse #1 stated Resident #34 should have the right to go back to bed when they wanted to. They were alert and it was their choice. Education to staff about residents rights would be reviewed and better care planning was needed to ensure the resident choice was respected. 10 New York Codes, Rules, and Regulations 415.5(b)(1-3)

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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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 48413 Based on observation and interview conducted during a recertification survey, the facility did not provide a clean, comfortable and homelike environment for one (1) (Resident #17) of 25 residents reviewed. Specifically, Resident #17's personal clothing was not laundered and returned within a timely manner according to professional standards of practice. This is evidenced by: The facility's policy and procedure titled, Personal Property revised November 2024, documented Resident belongings are treated with respect by facility staff, regardless of perceived value. A representative of the admitting office advises the resident, prior to or upon admission, of the types and amount of personal clothing and possessions that the resident may keep in his or her room. The resident's personal belongings and clothing are inventoried and documented upon admission and updated as necessary. The facility promptly investigates any complaints of misappropriation or mistreatment of resident property. Resident #17 was admitted to the facility with diagnosis of end stage renal disease (kidneys no longer work as they should to meet the body's needs), atrial fibrillation (an irregular and often very rapid heart rhythm) and diabetes mellitus type 2 (the body cannot use insulin correctly and sugar builds up in the blood). The Minimum Data Set (an assessment tool) dated 3/15/2025, documented the resident was cognitively intact, could be understood, and understand others. During an interview on 3/11/2025 at 3:36 PM, Resident #17 stated when they were originally admitted they had 15 pairs of pants. They now only had 3 pairs of pants. They stated when their laundry was taken, it was not always returned. They also had a cell phone that was reported missing and had not been found. Resident #17 stated they did inform administration, name unknown, but the clothing nor cell phone had not been returned. Resident #17 also stated they were not aware of the grievance process and that they could file a grievance. Nursing Progress admission note dated 5/28/2020 at 3:49 PM, documented Resident was admitted to the facility. Prior to her recent hospitalization , resident was living by herself at her apartment. There was no mention of inventory of personal items. During an interview on 3/13/2025 at 1:01 PM, Director of Nursing #1 stated Facility linens go to an outside company. Some resident laundry was done by family members and some resident clothing was laundered by the facility and sent to the outside company. Currently there was a 2-bag system; clear was for resident clothing, blue was for linens that go out. All staff including agency staff had been educated on laundry process. Often staff place resident laundry in blue bag. Once in wrong bag it goes out, sometimes would get returns and sometimes not. Facility had recognized that this should not occur and was trying to move all laundry in house. When a resident reported missing clothing or personal items, staff would search for items and if they could not find the item, the item would be replaced. The resident should file a grievance which was handled by the Social Worker. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/14/2025 at 11:44 AM, Social Worker #1 stated when residents have something missing, a resident would generally notify floor staff who in turn would notify social worker. There were grievance forms on each desk and at the reception room that day. Social Worker #1 stated they outsource linens to an outside company and thought personal laundry items were mixed with linens. It was never brought to their attention that Resident #17 had missing items. Facility stated it would follow up and replace items that were not located. 10 New York Codes, Rules, and Regulations 415.5(h)(2) 48615

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 51317 Based on record review, and interviews conducted during the recertification survey, the facility did not ensure residents were aware of the grievance process. Specifically, (1.) grievance forms were not readily available to residents; (2.) residents did not have the option to file a grievance anonymously; and (3.) seven (7) of the 7 residents present at the Resident Council meeting reported they did not know the process by which to file a grievance. This is evidenced by: The facility Policy and Procedure titled, Grievance Policy, effective 12/2019, last revised 2/2025, documented each resident had the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. The facility would provide a mechanism for filing a grievance/complaint without fear of retaliation and/or barriers of service. To ensure residents were informed, the facility would conduct documented quarterly education on the grievance process during Resident Council meetings and as needed. This education would cover how to file a grievance, the role of the grievance official, and the steps involved in addressing and resolving concerns. During the Resident Council meeting held on 3/12/2025 at 11:00 AM, residents present did not know how to file a grievance and were unsure who the Grievance Officer was. Residents stated they would bring concerns to the Unit Manager. Residents felt that when they brought concerns to the Unit Manager, their concerns were not always addressed. During an interview on 3/14/2025 at 9:53 AM, Director of Social Work #1 stated they were the Grievance Officer for the facility. Grievance forms were kept in their office, at each nurse's station, and at the reception desk in the lobby. They stated residents were unable to file a grievance anonymously and did not have access to the grievance forms without asking for one, but it was something the facility needed to change. They had requested the maintenance department to attach plastic folders/holders on the walls in the lobby area so the grievance forms were accessible to the residents, but this was not done yet. They would also like to have a bin in the activities room for grievances as this was where the resident council meetings were held. Director of Social Work #1 stated the form used to record grievances was updated on 3/13/2025 and education was provided to staff regarding use of the new form and their policy regarding grievances. During an interview on 3/17/2025 at 10:42 AM, Director of Nursing #1 stated a resident could file a grievance by expressing a concern and they would bring the grievance form directly to the resident. The resident would complete the form, or a staff member would assist them with completing the form. The resident would also speak with a social worker or activities staff member to express a grievance. When a grievance form was completed, it was reviewed at morning report. Director of Nursing #1 did not know if there was a way for residents to file a grievance anonymously and stated they would need to ask the social worker. 10 New York Code Rules and Regulations 415.3(d)(1)(i)

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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. 51317 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. 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. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 36922 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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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 dated 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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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] 51317

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33538 36922 Based on observation, record review, and interviews conducted during a recertification survey, the facility did not develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframe's to meet a resident's medical, nursing, mental, and psychosocial needs that were identified in the comprehensive assessment for three (3) (Resident #s 24, 32, and 73) of 25 residents reviewed for Care Plans. Specifically, (a.) for Resident #24, the intervention for oxygen therapy as per physician order was not consistently followed; (b.) Resident #32 had reported an allegation of abuse, during the , that was not investigated or reported. No comprehensive care plan was added to the resident's person-centered care plan for at risk for victim of abuse and/or victim of abuse; and (c.) Resident #73 had kidney failure, was receiving dialysis and had no comprehensive care plan for dialysis. . This is evidenced by: 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 care plan described services furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Care plan interventions were chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and with relevant clinical decision making. 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 the resident could be understood and understand others and had moderately impaired cognition for daily living decisions. Care Plan with focus area of respiratory disorder effective 8/31/2023 documented Resident #24 was to have continuous oxygen via nasal cannula. An intervention effective 9/04/2023 documented Resident #24 was to receive oxygen therapy as per physician order. A review of medical order dated 5/15/2024 documented oxygen should be delivered via nasal cannula (a device that gives additional oxygen through the nose) at a rate of 2-3 liters continuously. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 3/11/2025 at 10:55 AM, Resident #24 was in their room seated in their wheelchair. There was an oxygen tank in the holder attached to their wheelchair that was turned off and there was an oxygen concentrator in their room that was turned off. Resident #24 was not wearing a nasal cannula and was not receiving supplemental oxygen. Resident #24 stated they were always supposed to receive supplemental oxygen. They stated the tubing from the concentrator did not reach to the bathroom and they did not know why 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 the nurse's station on their unit. Resident #24 was not wearing a nasal cannula and did not receive supplemental oxygen. 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 supposed to receive supplemental oxygen all the time. They stated Resident #24 would remove the oxygen when they went into the bathroom. Certified Nurse Aide #6 stated 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 Resident #24 received supplemental oxygen all the time. If an order for oxygen was continuous, oxygen should be on the resident all the time. Licensed Practical Nurse #3 stated Resident #24 spent a lot of 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 Resident #24 was on 2-3 liters of continuous oxygen and Resident #24 should receive supplemental oxygen all the time. During an interview on 3/17/2025 at 10:42 AM, Director of Nursing #1 stated if a resident had a physician order to receive continuous supplemental oxygen, the resident should receive supplemental oxygen all of the time. Resident #32 Resident #32 was admitted to the facility with diagnoses of osteomyelitis of the vertebra (spine), sacrum (triangular bone at the base of the spine), and sacrococcygeal (spine, sacrum and tailbone) region, (inflammation of the bone caused by infection), obstructive sleep apnea (decrease in oxygen during sleep causing oxygen to the brain to decrease) requiring the use of a, and a wound infection (open wound that is infected). The Minimum Data Set, dated dated dated [DATE], documented that the resident could be understood and understand others with intact cognition 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. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a completed record review for Resident #32 from 1/24/2025 through 3/18/2024 there was no documented evidence that the allegation of abuse had been addressed. There was no documented evidence of comprehensive person-centered care plan was found that addressed the resident as a victim at risk for abuse. There was no documented evidence that a follow up for the resident by social work had been completed or comprehensive care plan had been implemented by the social worker. During an interview on 03/14/2025 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 (continuous positive airway pressure) mask on too tight. They had not reported the incident because the resident did not say they were slapped, and Director of Nursing #1 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 Director of Nursing #1 could not remember when it happened. If abuse occurred or was suspected the social worker should have been involved and a comprehensive care plan for victim of abuse should have been initiated. During an interview on 3/18/2025 at 9:30 AM, Resident #32 stated they reported the nurse that had been rough with them when putting on their C-Pap machine. One of the straps hit me in the face and they pushed the mask down hard. The nurse appeared frustrated or angry because I had refused it earlier. After their C-pap machine had been removed in the morning on 1/26/2025, a red mark was observed across their nose and Certified Nurse Aide #11 asked about the mark. Resident #32 told care givers and their family about the incident that occurred and that it had left them uncomfortable. The resident stated it was an agency nurse and they did not know their name. They spoke with the Nurse Manager and made it clear they did not want that person to ever care for them again. The resident stated they always took care of themselves and had a lot of anxiety now that they had to depend on others. The resident felt the incident with the C-pap mask did not help them adjust knowing it could happen again because they were dependent for most everything. During an interview on 3/18/2025 at 12:38 PM, Registered Nurse #1 stated they could not find a comprehensive care plan for Resident #32 that addressed abuse. They stated the previous nurse manager had not implemented any abuse or at risk for abuse care plan. Registered Nurse #1 stated residents who feel vulnerable because they were dependent for all their care and could do little for themselves should have an at risk for abuse care plan to remind care givers to focus on teaching appropriate coping strategies. After a resident reports an allegation of rough handling the social worker should be involved and at the very least an at risk for abuse care plan should be implemented. Registered Nurse #1 stated they would need to review all care plans to ensure the residents needs were addressed. They stated they had not heard about the incident before today. Resident #73 Resident #73 was admitted to the facility with diagnoses of end stage renal disease (inability for the kidneys to remove toxins from the body and filter urine), requiring dialysis (the process of removing excess water, solutes, and toxins from the blood in people whose kidneys can no longer perform these functions naturally, dysphagia (difficulty swallowing food), requiring a surgically placed feeding tube for supplemental nourishment, and anemia (a condition where the blood does not have enough healthy red blood cells and hemoglobin (a protein in the blood). The Minimum Data Set, dated dated dated [DATE], documented that the resident could be understood and usually understands others with severely impaired cognition for decisions of daily living. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician order dated 2/20/2025 documented Resident #73 had an order for hemodialysis 3 times a week, on Monday, Wednesday, and Friday at 10:30 AM. Record Review on 3/18/2025 at 10:00 AM, revealed no documented evidence of comprehensive care plan for dialysis had been implemented with goals and intervention during Resident #73's admission. . During an interview on 3/18/2025 at 12:58 PM, Registered Nurse #1 stated they could not find a comprehensive care plan for dialysis for Resident #73. They stated one should have been implemented on admission. A well-structured care plan for dialysis was essential because the resident required special care to manage the kidney disease, fluid balance and other health concerns. Pre and post vital signs and weights should be the focus of the resident's dialysis book and that should be part of the care plan during the resident's admission. 10 New York Code of Rules and Regulations 415.11(c)(1) 51317

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36922 Based on record review, observations, and interviews conducted during a recertification survey, the facility did not ensure Comprehensive Care Plans were reviewed and revised by the interdisciplinary team after each assessment based on changing goals, preferences, and needs of the resident and in response to current interventions for two (2) (Resident #s 32 and 68) of 25 residents reviewed. Specifically, (a.) for Resident #32, the Comprehensive Care Plan for Respiratory Therapy was not reviewed and revised to include changes in the resident's refusal of their C-pap (continuous positive airway pressure machine) for severe sleep apnea. Specifically, (b.) Resident #68's Comprehensive Care Plan for musculoskeletal disorder (a condition that affect the muscles, bones, and joints) was not revised after the resident refused use of a wedge in between their thighs for positioning. This is evidenced by: The facility policy titled, Care Plans, Comprehensive Person-Centered, updated, 1/2024, 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 care plan would describe services furnished to attain or maintain the resident's highest practicable physical, mental, psychosocial well-being and describe services that would otherwise be provided but are not provided due to the resident exercising their rights, which included the right to refuse treatment. Assessments of residents were ongoing and care plans were revised as information about the residents and their condition changed. The interdisciplinary team must review and update the care plan for reasons that included when the desired outcome was not met and at least quarterly, in conjunction with the required Minimum Data Set assessment. The resident had the right to refuse to participate in the development of their care plan, medical or nursing treatments. Such refusals would be documented in the resident's clinical record in accordance with established policies. A review of the facility policy titled, Oxygen Administration, dated 1/2019, documented the facility was to provide oxygen by oxygen mask/cannula to residents with deficiencies or abnormalities of pulmonary function, to prevent or reverse hypoxia, and improve tissue oxygenation. The procedure documented that the tubing was to be attached, labeled, dated, as well as to follow the orders for oxygen in the electronic record system to guide staff. 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), 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 cognitively intact for daily decision making. Physician order dated 1/24/2025 documented: c-pap 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. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 3/14/2025 at 9:35 AM, Resident #32 was resting in bed. The residents C-pap mask was sitting on the resident's end table. It was not cleaned or labeled. During an observation on 3/17/2025 at 11:15 AM, Resident #32 was receiving oxygen at 2.0 liters via a nasal cannula that was connected to an oxygen concentrator (a device that provides a continuous supply of oxygen). A review of Resident #32's medical orders documented that the resident was to receive their C-pap at hours of sleep (HS) as ordered setting: 2 liters bleed. A review of Resident #32's Treatment Administration Record dated March 2025, documented to monitor mask for proper fit and condition when applied. Adjust as needed 7:00 PM to 10:00 PM. Start date 1/24/2025. A review of Resident #32's Treatment Administration Record dated March 2025; documented C-pap at hour of sleep as ordered with setting 2 Liters bleed. Apply at 8:00 PM. Start Date: 1/24/2025. Fill humidification chamber to fill line with sterile water prior to use. A review of Resident #32's Treatment Administration Record dated March 2025, documented the resident refused application of the C-pap mask on 3/05/2025, 3/07/2025, 3/14/2025, 3/15/2025, 3/16/2025 and 3/18/2025. A review of Resident #32's Comprehensive Care Plan created on 1/24/2025, documented the resident had experienced signs and symptoms of respiratory disorder as evidenced by sleep apnea requiring C-pap and asthma. Goal was to prevent the resident from experiencing complications of respiratory failure or dysrhythmia. Interventions stated apply C-pap at bedtime, monitor oxygen saturation and observe C-pap mask for leaks. Care Plan was last updated on 1/27/2025. There was no documented evidence on the Comprehensive Care Plan that resident refused C-Pap at night. During an interview on 3/17/2025 at 12:31 PM, Licensed Practical Nurse #1 stated Resident #32 used their C-pap machine at night and did not know why the resident had oxygen on. No one had reported any concerns about the resident to them. The resident could use oxygen if they had a low oxygen saturation level. Resident #32's oxygen saturation level was not regularly monitored during the day unless they complained of shortness of breath. During an interview on 3/18/2025 at 9:30 AM, Resident #32 stated their C-pap mask was broken, and the nurse had ordered a new mask for them. It had been broken for a while and they were not sure when it had happened. They stated sometimes the nurse would put the oxygen on them if they did not feel well. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/18/2025 at 10:50 AM, Registered Nurse #1 stated that they were not aware the face mask for the residents C-pap machine was broken. They would check on this and find out what happened. When Registered Nurse #1 reviewed the record there was no documentation to identify what happened. They stated they were told the mask was broken and a new one had been ordered. The physician had not been notified, and the resident did not have an order for oxygen or monitoring for the oxygen saturation. They stated it would need to be updated in the care plan and it should have been updated when the C-pap mask broke. They stated Resident #32 was refusing the C-pap at night and no documentation of the physician notification was found. They stated the care plan needed to be reviewed and updated after physician notification was completed to ensure the resident received the care ordered and to prevent any respiratory distress. During an interview on 3/18/2025 at 11:15 AM, Director of Nursing #1 stated that nursing staff should be closely monitoring the resident's respiratory status. They stated staff should be following the orders provided by the physician, and if there were any exceptions, staff should be contacting the physician for clarification. They stated that care plans need to be revised whenever there was a change in the resident's status or if a resident refused the treatment ordered by the physician. Resident #68 Resident #68 was admitted to the facility with diagnoses of quadriplegia (a condition characterized by the partial or complete loss of motor and sensory function in all four limbs), traumatic brain injury (brain dysfunction caused by an outside force, usually a violent blow to the head), and dementia (a group of thinking and social symptoms that interferes with daily living). The Minimum Data Set, dated dated dated [DATE], documented the resident was severely cognitively impaired, was rarely/never understood and could rarely/never understand others. The Comprehensive Care Plan for Musculoskeletal Disorder' effective 6/28/2023, documented an intervention effective 4/01/2024, Resident #68 was to have a wedge in between their thighs for positioning. Care Card for Resident #68 documented for turning and positioning, a pillow was to be placed between Resident #68's knees. During an observation on 3/12/2025 at 9:45 AM, Resident #68 was in their bed. There was no wedge between their thighs for positioning. During an interview on 3/12/2025 at 9:57 AM, Certified Nurse Aide #6 stated there was a cushion to put between Resident #68's knees, but the resident tended to rip it out. According to Resident #68's care plan, there should have been a wedge between their thighs but currently there was nothing between their thighs. During an observation on 3/13/2025 at 12:37 PM, Resident #68 was in the hallway outside of their room in their wheelchair. There was no wedge between their thighs for positioning. During an interview on 3/13/2024 at 3:23 PM, Licensed Practical Nurse #3 stated a pillow was to be placed in between Resident #68's knees because they were contracted, but the resident would grab it with their left arm and remove it. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/13/2025 at 2:43 PM, Director of Rehabilitation #1 stated they had trialed a pillow between the legs of Resident #68, but this intervention did not continue because it did not go well, and the resident would remove it. They stated they trialed a few different things to put between Resident #68's legs, but they did not work as Resident #68 removed them or the trialed items would become dislodged due to their movements. Director of Rehabilitation #1 stated the care plan should have been updated if it was determined the intervention was no longer appropriate. During an interview on 3/14/2025 at 11:28 AM, Registered Nurse #3 stated when they went into Resident #68's room, there was a pillow between their knees. When the Surveyor informed Registered Nurse #3 that Resident #68 had been observed without a pillow/cushion between their thighs, Registered Nurse #3 stated they had seen them at times without the pillow between their thighs as Resident #68 would remove the pillow. Registered Nurse #3 stated there was no mention of Resident #68's refusal or removal of the pillow in between their legs in the care plan. During an interview on 3/17/2025 at 10:42 AM, Director of Nursing stated Resident #68 should have had a noncompliance care plan in place if they refused use of a wedge between their legs. This was added to their comprehensive person-centered care plan on 3/14/2025. 10 New York Code of Rules and Regulations 483.21 (b)(2)(iii) 48615 51317

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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 48615

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.

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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 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 dated 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)

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 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) 51317

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33538 Based on record review and staff interviews conducted during the recertification survey, the facility did not ensure that it maintained acceptable parameters of nutritional status, provided nutrition care and services to each resident consistent with the resident's comprehensive assessment, recognized, evaluated, and addressed the needs of every resident for two (2) (Resident #s 51, and 64) of five (5) residents reviewed for nutrition/hydration status maintenance. Specifically, (a.) Resident #51's weight was not monitored as indicated in their comprehensive person-centered plan of care despite being at risk for weight changes, and a quarterly dietary assessment was not completed to address the nutritional status of this resident. (b.) for Resident #64, nutritional care plan was not implemented, quarterly dietary nutrition status assessment was not completed, and weight were not done as scheduled despite Resident #61 being at risk for weight changes. This is evidenced by: Facility policy titled Nutritional assessment, updated September 2024, documented as part of the comprehensive assessment, a nutritional assessment, including current nutritional status and risk factors for impaired nutrition, shall be conducted for each resident. The dietitian, in conjunction with the nursing staff and healthcare practitioners, would conduct a nutritional assessment for each resident upon admission and as indicated by a change in condition that placed the resident at risk for impaired nutrition. Resident #51: Resident #51 was admitted to the facility with diagnoses of Parkinson's Disease (a disorder of the central nervous system that affects movement, often including tremors), lymphoma (cancer of the lymphatic system), and severe protein-calorie malnutrition (a condition in which a person does not consume enough protein and calories to meet their body's needs. The Minimum Data Set (an assessment tool) dated 2/19/2025 documented the resident was cognitively intact, could understand others, and could make themselves understood. A review of Section K (Swallowing/Nutrition Status) of the Minimum Data Set, dated dated dated ,d+[DATE] documented Resident #51 had a weight loss of 5% or more in the last month or 10% or more in the last 6 months and was not on a physician-prescribed weight-loss regimen. Comprehensive Person-Centered Care Plan for Nutritional Status/Hydration effective 1/28/2020 documented Resident #51 was at risk for skin breakdown, weight changes, dehydration, irregular bowel function, and poor dentition. It included monitoring of nutritional status via intakes, hydration, weights, labs, skin, bowel movements and plan of care and weigh monthly as interventions. Review of Weight Log in Resident # 51's electronic health record documented on 1/07/2025, the resident weighed 193.6 pounds. On 3/06/2025, the resident weighed 178 pounds which was a -8.06 % loss. There was no documented evidence of weight for the month of February 2025. (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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Electronic Health Record for Resident #51 documented a quarterly dietary review assessment was initiated on 2/14/2025. This assessment was blank. The electronic Health Record documented this quarterly dietary review assessment was overdue on 2/21/2025. During an interview on 3/11/2025 at 1:38 PM, Resident #51 stated they have lost weight, and they were not trying to lose weight. They stated they have lost weight as they did not like the food. During an interview on 3/13/2025, Licensed Practical Nurse #3 stated Resident #51 had lost weight and was a picky eater. They stated the resident would not drink supplement and sometimes they only ate a jelly sandwich. They further stated they offered Resident #51 substitutes when they did not eat or offered to get the resident more food, but most of the time the resident wanted a jelly sandwich. During an interview on 3/14/2025 at 11:45 AM, Registered Nurse #3 stated there was supposed to be a meeting with the interdisciplinary team on 3/12/2025 regarding Resident #51's nutritional status, but it was canceled due to survey occurring at the facility. Registered Nurse #3 stated there was no documentation of the weight of Resident #51 in the medical record for the month of February 2025. During an interview on 3/14/2025 at 10:12 AM, Registered Dietitian #1 stated nutrition assessments were done on residents upon admission to the facility, quarterly, annually and if there was a significant change for the resident. They stated how often a resident was weighed was indicated on their care plan. According to Resident # 51's care plan, they should be weighed monthly. Registered Dietitian #1 stated Resident #51 was weighed on 1/07/2025 and 3/06/2025. They stated Resident #51 was not weighed monthly. Registered Dietitian #1 stated Resident #51 had an annual dietary assessment completed on 9/02/2024. Their quarterly assessment was due on 2/21/2025 but it was not completed. Registered Dietitian #1 stated Resident #51 should have had a quarterly dietary assessment completed in December of 2024. During an interview on 03/17/2025 at 10:42 AM, Director of Nursing #1 stated dietary assessments were completed for residents upon admission to the facility, quarterly and more often if needed based on medical concerns. They stated dietary assessments should always be completed quarterly because it was a required piece of the Minimum Data Set and it was reviewed by the interdisciplinary team. Director of Nursing #1 stated a quarterly dietary assessment was scheduled for Resident #51 on 2/14/2025 and it was not completed. They stated at that time, the facility transitioned to using a new Registered Dietitian. The previous Registered Dietitian was asked repeatedly to complete dietary assessments and they did not. Resident #64: Resident #64 was admitted to the facility with diagnoses of chronic congestive heart failure (a long-term condition where the heart cannot pump enough blood to meet the body's needs leading to fluid buildup and various symptoms), acute respiratory failure (a condition where there is not enough oxygen or too much carbon dioxide in your body) and chronic kidney disease (longstanding disease of the kidneys leading to renal failure). The Minimum Data Set, dated dated dated [DATE] documented the resident had moderate cognitive impairment, could understood and understand others. Review of Resident #64's medical records regarding weight documented the following weights for the resident: (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/07/2025 145.2 pounds 01/22/2025 137.8 pounds There were no documented evidence of weights for Resident #62 after 1/22/2025. Binder on Resident #64's unit labeled as the weight binder documented on the weight schedule on the front of the binder weights were obtained monthly according to room schedule. Monthly weights were due by the 11th day of the month. Resident #64 was scheduled to be weighed on day 8 of each month. Nutrition assessment dated [DATE] documented this resident was at risk for dehydration, skin breakdown, weight changes, irregular bowel function decreased mobility and altered dentition. Review of Resident #61' s medical records was completed. There was no comprehensive care plan regarding nutrition for Resident #64. There were no documented evidence of medical provider notes regarding weight or nutrition status for Resident #64. During an interview on 3/18/2025 at 12:09 PM, Registered Nurse #2 stated all residents should have a nutrition care plan. Resident #64 had a care plan for hydration but they did not have one for nutrition. The nutrition care plan was usually completed by the registered dietitian. Registered Nurse #2 stated they were going to put a nutrition care plan into place now for Resident #64. They stated the most recent nutrition assessment was from one year ago. There should be a nutrition assessment done quarterly and Resident #64 did not have a nutrition assessment done quarterly. Registered Nurse #2 stated when a weight loss was identified, the physician, registered dietitian, family of the resident should be notified and a progress note regarding the weight loss should be written. 10 New York Code Rules and Regulations 415.12(c)(2) 51317

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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** 36922 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. (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 3/13/2025 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 dated 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 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) (continued on next page)

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	48413 51317

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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.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 33538

Based on observation, record review, and interviews during a recertification survey, the facility did not ensure the provision of sufficient nursing staff to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident throughout the facility. Specifically, (1) an analysis of the actual staffing schedule showed that on multiple occasions from 1/01/2025 to 3/17/2025, the facility was below the minimum levels required; (2) staff reported a lack of sufficient staffing; and (3) residents reported during interviews that the facility was short-staffed at times, and this resulted in call bells not being answered timely and long wait times for care to be provided

This is evidenced by:

Upon entrance to the facility on [DATE] there were 109 residents residing on 3 units. Upon observation and review of the Facility Staffing Sheet there were 3 Registered Nurses, 6 Licensed Practical Nurses, and 8 Certified Nurse Aides on duty.

The Facility Assessment, last reviewed on 1/10/2025, documented the facility's bed capacity was 120, with a daily average of 115. The section titled Direct Care Staffing, weekdays and weekends, documented the following:

- Day shift required 3 Registered Nurses, 7 Licensed Practical Nurses, and 12 Certified Nurse Aides

- Evening shift required 1 Registered Nurse, 6 Licensed Practical Nurses, and 12 Certified Nurse Aides

- Night shift required 1 Registered Nurses, 3 Licensed Practical Nurses, and 6 Certified Nurse Aides

A review of staffing sheets provided by the facility from 1/01/2025 through 3/17/2025 documented they did not meet their assessed minimum staffing most day and evening shifts, for the following:

- On 1/01/2025, the day shift had 1 Registered Nurse, 6 Licensed Practical Nurses, and 10 Certified Nurse Aides. The evening shift had 1 Registered Nurse, 6 Licensed Practical Nurses, and 11 Certified Nurse Aides.

- On 1/02/2025, the day shift had 3 Registered Nurse, 6 Licensed Practical Nurses, and 12 Certified Nurse Aides.

- On 1/03/2025, the day shift had 3 Registered Nurse, 6 Licensed Practical Nurses, and 9 Certified Nurse Aides. The evening shift had 1 Registered Nurse, 4 Licensed Practical Nurses, and 12 Certified Nurse Aides.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 1/04/2025, the day shift had 1 Registered Nurse, 5 Licensed Practical Nurses, and 9 Certified Nurse Aides. The evening shift had 1 Registered Nurse, 6 Licensed Practical Nurses, and 9 Certified Nurse Aides. - On 2/14/2025, the day shift had 2 Registered Nurse, 7 Licensed Practical Nurses, and 10 Certified Nurse Aides. The evening shift had 1 Registered Nurse, 4 Licensed Practical Nurses, and 12 Certified Nurse Aides. - On 2/15/2025, the day shift had 1 Registered Nurse, 6 Licensed Practical Nurses, and 12 Certified Nurse Aides. The evening shift had 1 Registered Nurse, 4 Licensed Practical Nurses, and 11 Certified Nurse Aides. - On 2/16/2025, the day shift had 2 Registered Nurse, 4 Licensed Practical Nurses, and 7 Certified Nurse Aides. The evening shift had 1 Registered Nurse, 4 Licensed Practical Nurses, and 9 Certified Nurse Aides. - On 3/12/2025, the day shift had 3 Registered Nurse, 6 Licensed Practical Nurses, and 12 Certified Nurse Aides. The evening shift had 1 Registered Nurse, 6 Licensed Practical Nurses, and 11 Certified Nurse Aides. - On 3/13/2025, the day shift had 3 Registered Nurse, 5 Licensed Practical Nurses, and 12 Certified Nurse Aides. The evening shift had 1 Registered Nurse, 6 Licensed Practical Nurses, and 11 Certified Nurse Aides. - On 3/16/2025, the day shift had 3 Registered Nurse, 6 Licensed Practical Nurses, and 8 Certified Nurse Aides. The evening shift had 1 Registered Nurse, 6 Licensed Practical Nurses, and 11 Certified Nurse Aides. During an interview on 3/11/25 at 12:18 PM, Resident #17 stated the staff had too much to do and put them on the back burner. During an interview on 3/11/25 12:35 PM, Resident #41's family member stated they had brought staffing concerns to the facility Administrator. During a surveyor lead group resident meeting on 3/12/2025 at 11:00 AM the 7 residents in attendance all reported insufficient staffing to meet their needs. Often having to wait an hour after staff turn off their call light and tell them they would be back to provide requested care. During an interview on 3/17/2025 at 12:35 PM, Certified Nurse Aide #7 stated they were often short staffed, and residents would have to wait for care. They were able to provide all needed care but no time for anything extra. During an interview on 3/18/25 12:09 PM, Registered Nurse #2 stated they often must help out by giving medications, toileting residents, and doing dressing changes when the staffing is low and then stay late to get their job done. (continued on next page)

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

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/18/25 at 12:20 PM, Facility Administrator #1 stated they were aware of not having enough nurses and Aides. They offer sign on bonuses and paid Certified Nurse Aide training. They advertise all over and use multiple agencies to fill vacancies. They stated they do the best they could but that was not always enough. During an interview on 3/18/25 12:41 PM, Director of Nursing #1 stated they were aware of consistent weekend staffing issues. They use 3 agencies and offer bonuses to cover the shifts. They stated they were not aware of any care not being provided; however insufficient staffing resulted in residents waiting for care that they should not have to wait for. 10 New York Code Rules and Regulations 415.13(a)(1)(i-iii) 51317

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 33538 Based on record review and interview during the recertification survey, the facility did not ensure development of policies and procedures for the monthly drug regimen review that included, but was not limited to, time frames for the different steps in the process. Specifically, the facility policy titled, Long Term Care Solutions, Drug Regimen Review did not identify time frames for when the Pharmacist would notify the facility and Physician of irregularities, how long the Physician had to respond to the report or how long the nursing staff have to address identified issues requiring nursing intervention. This is evidenced by: An undated policy titled, Long Term Care Solutions, Drug Regimen Review documented, Upon completion of a drug regimen review by the consultant pharmacist the following steps are taken: If an irregularity is identified, the consultant pharmacist documents the relevant drug and summary of recommendation in the resident's medical record. A separate drug regimen review document is completed by the consultant pharmacist whenever an irregularity is identified. The attending physician, director of nursing, and medical director are notified of all irregularities. Notification of irregularities to the facility is dependent on severity. Response to Irregularities: Drug regimen reviews that require physician intervention would be responded to by the physician/designee in a timely manner. For those recommendations that do not require a physician intervention, such as one to monitor vital signs or weights, the director of nursing or designated licensed nurse addresses and documents actions taken. The policy did not address the time frames for steps in the Medication Regimen Review process. During an interview on 3/17/2025 at 11:15 AM, Director of Nursing #1 stated the policy was provided by the Pharmacy and they were not aware it did not have all of the necessary information. 10 New York Code Rules and Regulations 415.18(c)(2) 51317

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48615 Based on observation, record review, and interviews conducted during a recertification survey, the facility did not ensure that its medication error rate did not exceed 5% for two (2) (Resident #s 41 and 80) of 13 residents observed during a medication pass for a total of 27 observations. This resulted in a medication error rate of 7.41%. This is evidenced by: The Facility's Policy and Procedure titled Administering Medications revised February 2024, documented . only persons licensed or permitted by this state to prepare, administer and document the administration of medications may do so. As required or indicated for a medication, the individual administering the medication records in the resident's medical record: (a) the date and time the medication was administered. (b) the dosage. (c) the route of administration. (d) the injection site (if applicable); (e) any complaints or symptoms for which the drug was administered. (f) any results achieved and when those results were observed; and (g) the signature and title of the person administering the drug. Residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely. Each nurses' station has a current Physician's Desk Reference (PDR) and/or other medication reference, as well as a copy of the surveyor guidance for F755-761 (Pharmacy Services) available. Manufacturer's instructions or user's manuals related to any medication administration devices are kept with the devices or at the nurses' station. Resident #41: Resident #41 was admitted to the facility with diagnoses of Alzheimer Disease (a progressive brain disorder that primarily causes memory loss and thinking difficulties), osteoarthritis (when the cartilage that cushions the ends of bones in your joints gradually deteriorates), and constipation. The Minimum Data Set (an assessment tool) dated 1/29/2025, documented resident had moderate cognitive impairment, could be understood, and understand others. During an observation on 3/12/2025 at 11:45 AM, A Wing CART 1, Licensed Practical Nurse #5 mixed 1 teaspoon of Metamucil powder in 4 ounces of water. They brought the medication to Resident #41's room and gave the medication to Resident #41's wife to administer to the resident. Licensed Practical Nurse #5 left the room and closed the door without observing resident consuming prescribed medication. They then signed that the medication had been administered in the medication administration record. During an interview on 3/12/2025 at 11:47 AM, Licensed Practical Nurse #5 stated Resident #41's wife was very demanding and difficult. They always gave them the medication to administer to avoid any conflict. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/12/2025 at 12:10 PM, Licensed Practical Nurse #6 along with Registered Nurse #2 and Registered Nurse #3 stated family members were not allowed to administer medications. There were no exceptions at this time. Director of Nursing #1 stated at no time should family members administer medications without a resident assessment, family member assessment, and physician order. If there were any exception, the resident would have a care plan in place and orders would be in the medication administration record. Resident #80: Resident #80 was admitted to the facility with diagnoses of diabetes mellitus type 1 (chronic condition that affects the insulin making cells of the pancreas),chronic kidney disease (loss of function in the kidneys), and hypertension (when the pressure in blood vessels is too high). The Minimum Data Set, dated dated dated [DATE], documented resident was cognitively intact, could be understood, and understand others. During an observation on 3/12/2025 at 11:21 AM, A wing CART 2, Licensed Practical Nurse #7 drew 10 units of Humalog using an insulin Kwik Pen that was prescribed for Resident #80. They did not prime the pen with 2 units of insulin prior to drawing the prescribed amount as recommended by manufacturer. During an interview on 3/12/2025 at 11:21 AM, Licensed Practical Nurse #7 stated they were unaware that they should prime pen with each use. Instead, they had the understanding that priming pen was only required for initial use only. During an interview on 3/13/2025 at 01:01 PM, Director of Nursing #1 stated each nurse received training upon hire for medication administration including the administration of insulin. New hire nurses were assigned to a preceptor who observed, mentor, and signed off on medication administration competency prior to administering medication independently. 10 New York Codes, Rules, and Regulations 415.12 (m)(1)]

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48615 Based on observation, record review, and interviews conducted during the recertification survey, the facility did not ensure drugs and biologicals were labeled and stored in accordance with professional standards of practice for three (3) (A, B, and C Wings) of three (3) medication carts, and 1 (C Wing) of 2 medication rooms reviewed. Specifically, (a.) 1 Novolog Kwik insulin pen was in a bag labeled Degludec insulin; (b.) 8 insulin kwik pens and 3 vials of insulin had no open and or expiration dates; (C.) 2 bottles of Megace liquid were discontinued; (d.) 3 inhalers had no open and or expiration dates; (e.); 3 bottles of eye drops had no open and or expiration dates; (f.) 1 bottle of eye drops opened [DATE], expired as of [DATE]; (g.) 1 opened bottle of Jevity Tube feed with 200 milliliters remaining was found in the medication room refrigerator; (h.) 1 black extra-large ice pack belonging to a discharged resident was found in the medication room refrigerator. 1 crate overflowing with discontinued medications were found in the medication room. This is evidenced by: The facility's Policy and Procedure titled Administering Medications updated ,d+[DATE], documented the facility stores all drugs and biologicals in a safe, secure, and orderly manner. #12. The expiration/beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container. #17. Insulin pens are clearly labeled with the resident's name or other identifying information. Prior to administering insulin with an insulin pen, the nurse verifies that the correct pen is used for that resident. The facility's Policy and Procedure titled Storage of Medication revised ,d+[DATE], documented #4. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed. During an observation on [DATE] at 10:49 AM, A Wing, Medication Cart 1 contained 1 Degludec insulin pen inside of a bag labeled Novolog Kwik pen with no open and or expiration dates; 1 Novolog, 1 Basaglar, 3 Humalog, and 1 Tresiba insulin pens, along with 2 Lantus vials had no open or expiration dates. 2 bottles of Megace liquid, discontinued as of [DATE]. During an observation on [DATE] at 3:02 PM, C Wing Medication Cart contained 1 lispro insulin pen, 1 Humalog insulin pen and 1 Humalog insulin vial with no open and or expiration dates. 1 bottle of Latanoprost 0.05% eye drops opened [DATE], expired as of [DATE]. 1 bottle Artificial tears, and 1 Budesonide inhaler had no open and or expiration dates. During an observation on [DATE] at 11:52 AM, B Wing Medication Cart contained 1 bottle of Lumigan 0.01% eye drops, 1 bottle of artificial tears eye drops, 1 Budesonide inhaler, and 1 Albuterol inhaler with no open and or expiration dates. During an observation on [DATE] at 12:20 PM, C Wing Medication Room Refrigerator contained 1 opened bottle of Jevity Tube feed with 200 milliliters remaining; 1 black extra-large ice pack belonging to a discharged resident and 1 crate overflowing with non-narcotic discontinued medications. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Licensed Practical Nurse #1 stated the nursing supervisor collected discontinued medications weekly but was not sure when they last collected discontinued medications. During an interview on [DATE] at 1:01 PM, Director of Nursing #1 stated it was the responsibility of each nurse assigned to a medication cart to ensure the cart was clean and orderly. All nursing staff must check the expiration date of any medication before administering. All multi-dose insulin medications should be labeled with both open and expiration dates. During new hire orientation all nurses are made aware of medications with shortened expiration dates after opening that includes insulins, inhalers and eye drops. Director of Nursing #1 stated discarded medications were to be packed up daily and brought to the supervisor. Any unused tube feed should be discarded. 10 New York Codes, Rules, and Regulations 415.18(d)

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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. 36922 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 1/24/2025. 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) 48413

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide special eating equipment and utensils for residents who need them and appropriate assistance. 48413 Based on observation, record review, and interviews during the recertification survey, the facility did not ensure that special eating equipment and utensils were provided for one (1) (Resident #38) of seven (7) residents reviewed for dining. Specifically, for Resident #38, adaptive eating equipment was not provided to maintain or improve the resident's ability to eat independently. This is evidenced by: Resident #38 was admitted to the facility with unspecified dementia (a decline in mental ability severe enough to interfere with daily life), essential (primary) hypertension (persistent high blood pressure), and type 2 diabetes mellitus (a chronic condition where the body does not use insulin effectively or does not produce enough insulin, leading to high blood sugar levels). The Minimum Data Set (an assessment tool) dated 2/15/2025 documented the resident had moderate impairment in cognition, was able to make themselves understood, and was usually able to understand others. During an observation on 3/11/2025 at 1:02 PM, Resident #38 was eating lunch in the common area. Resident #38 had their build-up spoon but did not have their adaptive built-up fork, and when asked if they had the adaptive fork, they stated that they did not and sometimes did not receive it. During an observation on 3/12/2025 at 9:32 AM, Resident #38 had one built-up spoon and one regular curved spoon. The resident's breakfast ticket documented that the resident was to have a built-up fork and a built-up spoon. A review of the resident's comprehensive care plan titled, Activities of Daily Living: Reduced Activities of Daily Living and dated 7/10/2023, documented adaptive devices/supportive equipment would be provided as per physical therapy /occupational therapy recommendation, built up fork, knife, and spoon with meals. A review of the resident's comprehensive care plan titled, Nutritional Status/Hydration and dated 7/10/2023, documented adaptive devices/supportive equipment would be provided as per physical therapy /occupational therapy recommendation built up fork, knife, and spoon with meals. A review of the resident's Certified Nurse Aide's daily care card for eating on 3/13/2025 documented that the resident required partial or moderate assistance to provide adaptive feeding devices: a built-up fork, built-up spoon, built-up knife, and scoop dish. During an interview on 3/12/2025 at 9:45 AM, Certified Nurse Aide #9 stated that according to the ticket, Resident #38 was to have built-up utensils for eating assistance. They further stated that Resident #38 did not have that item today; that it was dependent on whether or not the kitchen had adaptive utensils available. They stated the resident sometimes did not receive them. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/18/2025 at 10:05 AM, Registered Nurse #3 stated staff were to check meal trays and meal tickets for accuracy before bringing the trays to the residents. They stated staff were to call the kitchen if any items were incorrect or missing. They stated staff should have discovered the missing adaptive equipment on the resident's tray, called the kitchen, and held the tray until the missing equipment arrived. During an interview on 3/12/2025 at 10:36 AM, Kitchen Supervisor #1 stated that Resident #38 had one built-up spoon and one regular curved spoon because the kitchen did not have any more adaptive forks or knives. They stated that recently, they noticed residents were missing adaptive utensils; they believed more had been ordered but were unsure when the items would arrive. They stated that it was difficult to replace the missing items when the kitchen did not have them. 10 New York Code of Rules and Regulations 415.14(g)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 21414 Based on observation, record review, and interview during the recertification survey, the facility did not ensure food was stored, prepared, distributed, or served food in accordance with professional standards for food service safety in the main kitchen and two (2) of three (3) kitchenettes. Specifically, equipment, floors, and walls were not clean and/or were in good repair, and the facility did not have the correct equipment to test the chemical sanitizing solution. This is evidenced by: During observations of the main kitchen on 3/11/2025 at 10:18 AM, the following was noted: 1. Test papers to check the sanitizing solution did not have a graduation of 150 parts per million of quaternary ammonium compound graduation and another above 400 parts per million of quaternary ammonium compound. The efficacy range as stated on the sanitizer concentrate label was between 150 and 400 parts per million of quaternary ammonium compound. 2. The following items were soiled with food particles: Bulk food containers. Shelving. Sheet pan rack. Stoves. Floor under cooking line equipment. Shelving under serving line.Underside of dining room tables. During observations of the A-Wing kitchenette on 3/11/2025 at 11:16 AM, the following was noted: The microwave oven, refrigerator, floor in corners, and bathroom floor were soiled with food particles and/or dirt. Plastic panels in the freezer section of refrigerator were covered with white duct tape. The walls were scraped, and one hole was found above microwave oven. During observations of the B-Wing kitchenette on 3/11/2025 at 11:21 AM, the following was noted: The walls, floor in corners, and bathroom floor were soiled with food beverage splashes and/or dirt. Plastic panels in the freezer section of refrigerator were covered with white duct tape. The walls were scraped and had 4 holes. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/11/2025 at 2:50 PM, Administrator #1 stated that they would speak with the dietary, housekeeping, and maintenance staff about cleaning and about the noted maintenance items. 10 New York Codes, Rules, and Regulations 415.14(h)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. 21414 Based on observation, record review, and interview during the recertification survey, the facility did not ensure food brought for residents by family or visitors was stored safely and in a way that is either separate or easily distinguishable from facility food on one (1) (A-Wing Unit) of three (3) resident units. Specifically, resident food stored in the resident unit kitchenette refrigerators was not properly labeled. This is evidenced by: The document titled, Food Brought by Family/Visitors and dated 11/2024, documented that food brought to residents are to be labeled with the resident name, date, and use-by date. During observations on the A-Wing Kitchenette on 3/11/2025 at 11:16 AM, two restaurant entrees were not labeled and dated. During an interview on 3/11/2025 at 2:51 PM, Administrator #1 stated that the staff should label food brought to residents with the resident name, date received, and the date to discard the food. They further stated that staff would be re-educated on labeling food brought to residents. 10 New York Codes, Rules, and Regulations 415.14(h)

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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** 36922 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. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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 dated 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. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10 New York Codes, Rules, and Regulations 415.19(a), 483.65 48615

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 21414 Based on observation, record review, and interviews during the recertification survey, the facility did not maintain a pest-free environment and an effective pest control program on one (1) of six (6) resident units. Specifically, small fly infestation was found. This is evidenced by: During observations on 3/11/2025 from 10:15 AM through 12:35 PM, Little black flies were found in the corridors by Room #s 54, 57, 62, and 73. Little black flies were found flying around a resident with a feeding tube on the C-Wing. During observations on 3/12/2025 at 9:45 AM, little black flies were found flying around staff serving meal trays. During an interview on 3/11/2025 at 11:30 AM, Family Member #10 stated that the fly infestation was so bad they covered the television in the resident room and that it helped when the trash was removed from the room. During an interview on 3/12/2025 at 12:15 PM, Certified Nurse Aide #3 stated there have been black flying bugs since they were hired, and that though the facility had a pest control vendor, the problem was worse on some days more than other days. During an interview on 3/13/2025 at 1:59 PM, Administrator #1 stated that they were aware of the fly problem on the C-Wing, a pest control vendor had treated for this issue last week and staff would need to take the after-meal trays off the units much earlier than is done presently. 10 New York Codes, Rules and Regulations 415.29(j)(5)