STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335449	A. Building B. Wing	03/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Achieve Rehab and Nursing Facility	170 Lake Street Liberty, NY 12754

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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review during an Abbreviated Survey (456441), it was determined that the facility assessment failed to adequately identify and indicate how they maintain the resources necessary to care for its residents. Specifically, the facility assessment failed to adequately identify how the facility addresses contingency planning regarding necessary resources and failed to identify a facility plan to maximize recruitment and retention of direct care staff.The facility's assessment dated [DATE], reviewed by Quality Assurance and Performance Improvement Committee on 09/04/2025 is the most recent assessment conducted by the facility, it is the facility assessment that was reviewed as part of the Abbreviated Survey noted above, and which for these findings will be known as the facility assessment.The facility assessment indicates that the facility is a 140 bed Skilled Nursing Facility (SNF) with four (4) nursing units: one rehabilitation unit, one stepdown medically complex unit, and two long term care units housing residents with Dementia and other chronic illnesses. There is no breakdown showing the bed capacity per unit.The facility's assessment under subheading Staffing Plan states the following: Based on resident census and acuity, staffing is assigned to ensure there are sufficient staff to meet the needs of the residents at any given time. Staffing is reviewed prior to each shift to account for admissions, trips to medical appointments and acuity. It is the intent to assign the same staff to nursing units in order to maintain continuity of care. In the event there are multiple admissions, additional RNs are scheduled to ensure timely assessment and customer service.The facility assessment does not adequately identify contingency planning for events that do not require the activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident care.The facility's assessment also does not identify how the facility develops and or maintains a plan to maximize recruitment and retention of direct care staff.10NYCRR S415.26

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and interviews during an abbreviated survey (456441), the facility did not maintain medical records on each resident that are complete and accurately documented in accordance with accepted professional standards and practices for 1 out of 3 residents (Resident #2) reviewed for documentation. Specifically, on 13 different dates in December 2024 Resident #2 was due to receive medications at 9:00am and the medication administration audit report indicates that the 9:00am medications were not administered at the scheduled time.The facility medication and administration policy last revised 10/24 documented that the facility staff will provide safe and accurate medication administration to the residents. Medications are administered by licensed nurses, with and in accordance with physician order. Documentation of medication administration is completed at the time of dosage administration. Under the section titled general information: The right medication, is given to the right resident, at the right time, by the right route, in the right dose. Each shift the medication nurse is responsible to administer the medications prescribed for that shift and: the 11-7 medication nurse is responsible to administer all 7am medications and finger sticks, the 7-3 medication nurse is responsible to administer all 3pm medications and finger sticks, and the 3-11 medication nurse is responsible to administer all 11pm medications and finger sticks. The medication administration policy has a numbered section with a sub heading titled Medication Pass where it documented 1. Each shift a nurse is assigned to administer medications for that shift and is responsible for the medication cart and is not to be distracted or disturbed by staff unless absolutely necessary during the medication pass. It further documented under step 10. Documentation of administration of medication is completed on the computer immediately after administration with the nurse's initials, in the corresponding date and time for the medication. 19. At the end of each shift, the medication nurse is responsible to review each MAR, 24-hour report, and the nurses notes, to ensure that documentation of administration of medications for that shift is accurate and complete. 20. Medication errors are to be reported immediately and to the physician responsible for the resident, investigated, tracked and reported a QA, by the DONResident #2 was admitted with Essential hypertension, Adjustment disorder with mixed anxiety and depressed mood, and major depressive disorder, recurrent unspecified.The 12/01/2025 Quarterly Minimum Data Set (resident assessment tool) documented Resident #2 was cognitively intact, they were dependent for most activities of daily living and used a wheelchair for ambulation.Review of the standing medication orders active from May 2024 through December 2024 for Resident #2 found the following:Acidophilus Probiotic Oral Tablet (Lactobacillus) Give 1 capsule by mouth two times a day for probiotic;Breo Ellipta Inhalation Aerosol Power breath activated 100-25 MCG/ACT 1 Puff inhale;Buspirone HCL oral tablet 10mg Give 1 tablet by mouth two times a day for anxiety;Cozaar Oral Tablet 25mg (Losartan Potassium) Give 1 tablet by mouth one time a day for hypertension (HTN);Donepezil HCL Oral Tablet 10mg Give 1 table by mouth one time a day for Dementia;Furosemide Oral Tablet 20mg Give 1 tablet by mouth one time a day for diuretic;Lexapro Oral Tablet 10mg Give 1 tablet by mouth one time a day for depression;Metoprolol Tartrate Oral tablet 25mg Give 1 tablet by mouth two times a day for hypertension (HTN);Nitroglycerin Transdermal Patch 24 hour 0.2 MH/HR Apply 1 patch transdermally one time a day for antianginal agent hold if SBP<106 and remove per schedule;Rivaroxaban Oral Tablet 15mg Give 1 tablet by mouth one time a day for anticoagulant, andSystane Ophthalmic Solution 0.4-0.35 Instill 2 drop in both eyes two time a day for dry eye. Review of the medication administration audit report for the following dates: 12/03/2024, 12/07/2024, 12/08/2024, 12/12/2024, 12/13/2024, 12/17/2024, 12/21/2024, 12/22/2024, 12/24/2024, 12/25/2024, 12/26/2024, 12/27/2024, and 12/31/2024 found discrepancies as to when the medications were scheduled to be administered and when the medications were documented as being administered.During an interview on 03/26/2026 at 10:00am with Registered Nurse #3 they stated that Resident #2 receives a majority of their medications at (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9:00am and some again at 5:00pm. Sometimes the computer will time out and the computer logs you out, and there are times when you have it all clicked off and then it will no longer show on the computer. It may have been a computer glitch. It is possible that the medications were given earlier and with rushing so much it did not get clicked off. Registered Nurse #3 stated that the nurses try their best to avoid this. It may state 12pm but that may not be accurate, but they cannot recall the details specifically. Clicking each one, it is possible that they might have just been late to document, and maybe the computer might have logged them out. If the actual administration of the medication takes more than 10 minutes the computer will log you out. Registered Nurse #3 stated it is hard for them to recall December 2024. Registered Nurse #3 stated that it is just so tight on time management, they are always doing everything they can to be on time. Registered Nurse #3 stated that in general they contact the appropriate person if they are late, but they did not recall those days in particular, we are just all running as fast as we can.On 12/03/2024 all medications that were scheduled to be administered at 9:00am were documented as being administered after 12pm but before 1pm, and this exact pattern occurred in the same manner on all the dates (listed above) that Registered Nurse #3 was administering medication to Resident #2. During a telephone interview on 03/26/2026 at 11:00am with the Assistant Director of Nursing they stated they believe the census on the unit where Resident #2 resides has approximately 38 to 40 residents at maximum capacity. The Assistant Director of Nursing stated on this unit one (1) nurse is administering medications to 40 residents and when that one nurse arrives at 8am, the nurse leaving has to do the narcotic count with them and that takes 10 to 15 minutes depending on the situation, then the nurse leaving must report to them regarding each resident on the unit and that can take at least 15 minutes, then the medication pass starts at about 830am. and the nurse has until 10am to administer all the medications. The Assistant Director of Nursing stated this allows for approximately 2 minutes to administer medications to each resident. The Assistant Director of Nursing stated they would like to say medications are never late, but realistically the calculation suggests that to be difficult. The Assistant Director of Nursing stated that management is aware, and it is a work in progress, and they are trying to get a third cart nurse. The Assistant Director of Nursing stated that every unit has a manager and collectively they should all be working to ensure medications are being administered on time.During an interview on 03/26/2026 at 2:19pm with the Administrator they stated that their expectation is that when a medication is late, they monitor the nurses as closely as they can and the Assistant Director of Nursing and the Director of Nursing are rounding and making sure everything is going smoothly and that the medications are not running late. The Administrator stated that when a new nurse is trained and they are running behind, they do a couple of different things, such as, the Assistant Director of Nursing or the Director of Nursing will help the nurse. The Administrator stated that they often find out about medication being administered late through their seeing it themselves or a resident tells them. The Administrator stated they have not seen an alarming trend of nurses that cannot complete the medication pass, but for those that struggle the facility provides them assistance. The Administrator stated that per their policy the nurse that administers the medication, at end of their shift, reviews the Medication Administration Record, and though there is no indication that a second nurse reviews the Medication Administration Record that same day or on the next shift, the Unit Manager runs a monthly report. During a telephone interview on 03/26/2026 at 4:04pm with Resident #2s Doctor, when asked about medication administration delays in December of 2024, they stated that it was a long time ago, that they had no memory of any medication error, and if there had been a negative outcome, they would likely recall the issue. The Doctor stated they do not believe there was ever any issue, and none with Resident #2's medications being late. The Doctor stated that they would recall, for example, if a patient had their Blood Pressure bottom out and then they got called and were told that a medication was given late. The Doctor stated they have no recollection of any history of medications being administered late. The Doctor stated that ideally medications should be given on time, and their expectation is if a medication is administered late by 4 or 5 hours they should be notified, adding that (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	there are several ways to notify them.During an interview on 03/30/2026 at 9:46am with the Pharmacy Consultant they stated that as the Pharmacy Consultant they are just looking at the medication regiment and making recommendations to the physicians, they do not open the Medication Administration Record. The Pharmacy Consultant stated that they assume that nursing would have some internal auditing. The Pharmacy Consultant stated that they look for drug interactions or dosage strength. The Pharmacy Consultant stated they do not open the Medication Administration Record when doing reviews and they do not do any training with staff, and added that any oversight would be done internally by the facility.10NYCRR S415.22(a)(1-4)