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	05/22/2026

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 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** Based on observation, interview, and record reviews the facility failed to ensure residents' rights to a dignified existence for two (2) of five (5) residents (Resident #11 and #152) reviewed for dignity and one (1) of 11 residents (Resident #97) observed during dining. Specifically, 1) Resident #11's uncovered nephrostomy drain bag was visible from the hallway 2) Resident #125 was observed dressed in a ripped/torn hospital gown and 3) Residents were served drinks in disposable plastic cups during meals. Additionally, Certified Nurse Aide #8 stood while they assisted Resident #97 with feeding during lunch on 05/17/2026. The findings included: The policy titled Dignity last reviewed 04/2025 documented that all residents are always treated with dignity and respect. When assisting with care, residents are supported in exercising their rights including being provided with a dignified dining experience. Staff are expected to promote dignity, including keeping drainage bags covered. Demeaning practice that compromises dignity is prohibited. 1) Resident #11 had diagnoses that included but were not limited to multiple sclerosis, calculus of kidney and hypothyroidism. The care plan titled Resident with left side nephrostomy tube dated 12/29/2025 documented the nephrostomy bag is to be changed each week and to record the output each shift. The quarterly Minimum Data Set Assessment (assessment tool) dated 04/18/2026 documented Resident #11 had moderately impaired cognition. The Care Plan for resident with left side nephrostomy tube dated 12/29/2025 documented the nephrostomy bag is to be changed each week and to record the output each shift. During observations on 5/18/2026 at 11:16 AM and 5/20/2026 at 9:07 AM, Resident #11's uncovered covered nephrostomy drain bag was hanging on the left side of the bed and visible from the hallway. During an interview on 5/20/2026 at 9:10 AM, the Director of Nursing stated the nephrostomy drain bag should be covered. They stated the cover must have fallen off. They stated this was a dignity issue. During an interview on 5/20/2026 at 1:11 PM, Nurse Manager #2 stated the drain bag should have been covered since it could be seen. They stated certified nurse aides received training on nephrostomy and catheter bags and there should have been a dignity cover on the bag. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) Resident #125 had diagnoses that included but were not limited to Parkinsons Disease, type II diabetes mellitus, and depression. The quarterly Minimum Data Set assessment dated [DATE] documented Resident #125 was cognitively intact and received supervision or touching assistance with upper body dressing. During an observation on 05/18/2026 at 1:42 PM Resident #125 was sitting in a wheelchair in hospital gown, ripped in the front. On the same day at 3:04 PM, Resident #125 was on the elevator in a wheelchair in same hospital gown with a rip on the front of the gown. During an interview on 05/20/2026 at 8:50 AM, the Director of Housekeeping stated when facility gowns were washed and dried, staff inspected for rips or tears when items were folded. They stated if a gown was damaged, the staff would put it in a closed container for the supervisor to inventory/dispose of the damaged gown and a new gown would be ordered. They stated laundry staff may occasionally put a damaged gown back into rotation if they don't see it while folding. They stated maybe once a year there is a complaint about a ripped gown. During an observation and interview on 05/21/2026 at 9:40 AM, Resident #125 stated that they can sometimes dress themself but at times required assistance from the certified nurse aide. Resident #125 stated that they did not remember what they were wearing on Sunday (5/17/2026) and if it was torn/ ripped. During an interview on 05/21/2026 at 10:31 AM, Certified Nursing Aide #23 stated they were assigned to Resident #125 on Sunday, 05/17/2026 and that Resident #125 generally dressed independently. During an interview on 05/22/2026 at 11:06 AM, the Director of Nursing stated that facility gowns could have been torn by residents, especially if they pull at the gown near the snaps. They stated if a certified nurse aide noticed a gown was torn or soiled in any way, they were instructed to change it as soon as possible and throw the damaged gown away. 3) During an observation on 05/17/2026 starting at 12:40PM in the 2 East Dining Room, all residents in the dining room were served cold drinks in disposable plastic cups. During an interview on 05/17/2026 at 1:10PM, Certified Nurse Aide #8 stated they always used disposable plastic cups for the cold drinks for residents. During an observation in the 1 East Dining Room on 05/18/2026 at 12:37 PM, all juices and soda were served to residents in disposable plastic cups during lunch. During additional observations of meal services on all units on 05/17/2026 and 05/18/2026 residents were served milk, juice and water in disposable plastic cups. During an interview on 05/19/2026 at 1:08 PM the Food Service Director stated the beverage carts were sent to the units with handled cups for hot beverages only. They stated nursing staff used the disposable plastic cups from the medication cart to serve the cold beverages. The Food Service Director stated they asked the food service company about this procedure and were told it was okay to use the disposable plastic cups. During an observation on 05/20/2026 at 8:57 AM, breakfast was being served in the 1 East dining (continued on next page)

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Achieve Rehab and Nursing Facility	170 Lake Street Liberty, NY 12754

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room. Juice and milk were being served to residents in disposable plastic cups. During an interview on 05/22/2026 at 1:01 PM, the Administrator stated they were not aware that disposable plastic cups were being used. They stated they were ordering new cups. They stated disposable plastic cups did not promote dignity. 10 New York Code Rules Regulations 415.3(d)(1)(i)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the residents' right to a safe, clean, comfortable, and homelike environment on four (4) of four (4) units (1 East, 2 East, 1 West, and 2 West) reviewed for environment. Specifically, 1)1 East, rooms [ROOM NUMBERS] had malfunctioning air conditioners, and room [ROOM NUMBER] had a sharp sink edge; 2) 2 East, room [ROOM NUMBER] had a sink that continuously dripped; 3) 2 West, room [ROOM NUMBER] had worn and peeling wallpaper under the sink and the endcaps on the handrails outside of room [ROOM NUMBER] were loose and not affixed properly. Additionally, on 1 West, the wall and wallpaper in the common area near the sink were damaged and the wallpaper was peeling up. The findings included:The Homelike Environment policy last reviewed 02/2026 documented that residents are provided with a safe, clean, comfortable and homelike environment. Staff provides person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences. 1) During an interview on 05/18/2026 at 9:29 AM, Resident #134 stated that their air conditioner was broken and wanted it fixed.During resident council on 05/18/2026 at 10:26AM, Resident #134 stated that the air conditioner in their room was not functioning properly. They stated they resided in room [ROOM NUMBER]. Resident #127 stated they resided in room [ROOM NUMBER] and that their air conditioner was not working and was not fixed as requested. During an observation on 05/18/2026 at 1:58 PM, the edge of the sink in room [ROOM NUMBER] was observed to be rough and unfinished.During an observation and interview on 05/19/2026 at 10:18 AM in room [ROOM NUMBER], Resident #127 was sitting in their wheelchair. They stated that it was hot. A loud rattling noise was heard when the air conditioner was turned on. They stated they told maintenance but had not heard back. They stated they did not use the air conditioner even though the room was warm because of the loud noise.During an observation on 05/19/2026 at 1:41 PM on the 1 East Unit, the edging of the sink in room [ROOM NUMBER] had an exposed sharp edge on the underside of the sink cabinet. 2) During an observation on 05/17/2026 at 9:34 AM, the sink in room [ROOM NUMBER] was running. Resident #91 stated the sink would not turn off and was noisy. They stated maintenance was aware and tried fixing it, but it was still broken. During an observation and interview on 05/18/2026 at 09:23 AM, Resident #91 was out of bed in a wheelchair in their room. Water was running from the faucet in the room. An attempt was made to turn off the water, but it continued to run. Resident #91 stated the building was antique and things did not get repaired when they were broken.During an observation on 05/19/2026 at 11:35 AM, the faucet in room [ROOM NUMBER] had running water that could not be turned off.3) During an observation on 05/19/2026 at 11:20 AM on 2 [NAME] in room [ROOM NUMBER], the wallpaper was peeling under the sink. In the hallway between rooms [ROOM NUMBERS], six end caps for the handrails were loose and not secured.During an interview on 05/19/2026 at 12:22 PM, Certified Nurse Aide #28 stated that any staff member could report something in need of repair. There was an electronic form, and it went directly to maintenance.During an interview on 05/19/2026 at 12:27 PM Licensed Practical Nurse #14 stated that there was a form that any staff member could complete if maintenance was needed for a repair. During an interview on 05/19/2026 at 12:54 PM, Registered Nurse Unit Manager #25 stated that there was an electronic program to report issues to maintenance. They stated they were aware of the dripping water from the sink in room [ROOM NUMBER] but Resident #91 would not allow them to fix the problem and wanted it to remain that way. During an interview and walking rounds starting on 05/19/2026 at 1:35 PM, the Director of Maintenance stated that they were not aware of the sharp edge in room [ROOM NUMBER] but when observed with this surveyor, they stated it would need a protective edge applied. They stated they spoke with the resident in room [ROOM NUMBER] today and would be checking the air conditioning in that room. They stated they were aware of the problem in room [ROOM NUMBER] and (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	were working to fix the air conditioning issue. They stated they had repaired the dripping sink in room [ROOM NUMBER] in the past but would have to check it again. They stated that the end caps for the handrails needed to be affixed and would make sure that it was completed. They stated that room [ROOM NUMBER] was one of the oldest rooms so they were not surprised that the wallpaper was peeling up and needed repair. They stated that they do daily rounding, but more for safety checks not for repairs. They expected staff to complete a request for maintenance service if something was observed or reported as broken.10 New York Code Regulations Rules 415.3

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to ensure that residents received adequate supervision to remain free from sexual abuse for one (Resident #80) of one reviewed for abuse. Specifically, on 03/12/2026, Maintenance Worker #9 observed the visitor of Resident #66 (roommate of Resident #80) lying on top of Resident #80 with their hands beneath Resident #80's blouse while touching their breasts. Subsequently, Resident #80 was transferred to the hospital on [DATE] for evaluation and returned to the facility. On 03/16/2026, there was documented evidence that Resident #80 reported severe difficulty sleeping, with no sleep the previous night. This resulted in actual psychosocial harm that was not Immediate Jeopardy. The findings include:The facility's policy and procedure titled Abuse of Residents policy revised 10/24/2025, documented that all residents have the right to be free from abuse, neglect, exploitation, and misappropriation. The facility prohibits any form of abuse physical, verbal, sexual, mental, or psychological by anyone, including employees, consultants, volunteers, family members, or other residents. Resident #80 had diagnoses that included, but were not limited to, non-Alzheimer's dementia (loss of memory, thinking or reasoning skills), anxiety, Schizophrenia (chronic, severe brain disorder that causes individuals to interpret reality abnormally), and encephalopathy (malfunction of the brain that alters structure).The 11/22/2025 quarterly Minimum Data Set (a resident assessment tool) documented that the resident was cognitively intact and that they had feelings of being down, depressed, or hopeless.The Care Plan for impaired cognition initiated 01/05/2026 documented discussion with family/caregivers regarding capabilities and needs. Discuss concerns about confusion, disease process, placement with family/caregivers. There was no documented evidence that the Comprehensive Care Plan addressed risk of abuse.The Facility Visitor and Guest Log documented the visitor of Resident # 66 signed into the facility on [DATE], 03/04/2026, 03/08/2026, 03/11/2026, and 03/12/2026. The Incident Report dated 03/12/2026 documented the visitor of Resident #66 signed in to the facility and was later found on top of Resident #80 (both fully clothed). Maintenance Worker #9 intervened, and nursing staff assessed the resident. Resident #80 denied being touched below the waist or genitals and had no injuries. Law enforcement arrived, and Resident #80 was sent to the emergency room, where no trauma or abuse was found. A rape kit was performed at the hospital with family consent in the emergency room, confirming no trauma. The Assistant Director of Nursing/Nurse Managers #2 progress note dated 03/12/2026 at 5:03 PM, documented that at approximately 1:40 PM, Maintenance Worker #9 reported the visitor of Resident #66 was observed on top of Resident #80. Resident #80 was interviewed and reported feeling okay. Resident #80 stated the visitor was on top of them, kissed them, and went under their blouse. Resident #80 stated they asked the visitor to stop, but the visitor did not stop. Resident #80 was evaluated for pain or discomfort. No obvious signs of injury were observed. Resident #80's vital signs were at baseline. Resident #80 was to be evaluated in the emergency room.The emergency room progress note dated 03/12/2026 at 6:25 PM, documented the resident son is at bedside along with advocates, The resident with power of attorney, makes decisions on resident's behalf considering dementia. Informed of need for head-to-toe exam, including potentially conducting a rape kit. Residents' son states they would like to peruse a rape kit including internal exam.The court order dated 05/13/2026 documented the visitor of Resident #66 should stay away from Resident #80.Psychiatrist Nurse Practitioner #2's progress note dated 03/16/2026 at 4:28 PM, documented that the resident's primary complaints were worsening insomnia and schizophrenia. The residents' mood was good, and they denied feeling down, depressed, anxious, or experiencing auditory or visual hallucinations. The resident reported severe difficulty sleeping, with no sleep the previous night, but reported eating well.During an observation and interview on 05/17/2026 at 10:49 AM, Resident #80 was resting in bed. Resident #80 stated they had no recollection of a visitor (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	entering the room, crawling on top of them, or touching their breasts. During an interview on 05/19/2026 at 12:38 PM, Maintenance Worker #9 stated they were doing monthly rounds to check call bells on 03/12/2026. They stated when they entered Resident #80's room, the visitor of Resident # 66 was present and asked them a question about the television. Maintenance Worker #9 stated they stepped out of the room but then remembered they needed to check the other call bell. They stated when they re-entered Resident #80's room, the visitor of Resident #66 was leaning on top of Resident #80, with their hands under Resident #80's blouse, and they were touching Resident #80. Maintenance Worker #9 stated the room privacy curtain was closed. They stated they shouted at the visitor of Resident #66, who then left, and the incident was reported to Licensed Practical Nurse Supervisor # 10. During an interview on 05/19/2026 at 1:49 PM, Registered Nurse Unit Manager # 6 stated after the alleged sexual abuse incident, the Administrator asked them to assess Resident #80. They stated after Resident #80 undressed themselves, they conducted a head-to-toe assessment and asked Resident #80 where they had been touched. They stated Resident #80 pointed to their breast. They stated there was no redness, bruising, or abnormality on Resident #80's body. They stated Resident #80 reported that the person had not touched anything below their waist. They stated at the time the Director of Nursing was on their way to the facility.During an interview on 05/19/2026 at 2:00 PM, the Assistant Director of Nursing/Licensed Practical Nurse Unit Manager #2 stated that on 03/12/2026, Maintenance Worker #9 reported that the visitor of Resident #66 was on top of Resident #80 and was told to leave. The Assistant Director of Nursing/Licensed Practical Nurse Unit Manager #2 and Licensed Practical Nurse supervisor #10 asked Resident #80 if they were uncomfortable after the incident and Resident #80 told them a visitor got on top of them, went under their blouse, and touched their breast, but nothing else happened. They stated Resident #80 told them that they asked the visitor of Resident #66 to stop, but they did not stop. They stated the Director of Nursing and Administrator called 911, and Resident #80 was sent out to the hospital. During a telephone interview on 05/20/2026 at 9:29 AM, Police Officer # 1 stated they received a call about the sexual assault of Resident # 80. Police Officer # 1 stated Maintenance Worker # 9 saw the visitor on top of Resident # 80, with hands under the Resident #80 blouse, and asked, What are you doing? They stated Resident #66's visitor was alone with Resident #80. They stated they interviewed Resident #66's visitor at their job, and they admitted to climbing on top of Resident #80 and kissing them. Police Officer #1 stated an order of protection was issued. During an interview on 05/20/2026 at 10:50 AM, the Director of Nursing stated their arrival occurred within 15 minutes to the facility after the incident. They stated Police Officer # 1 and the Administrator responded to the 03/12/2026 incident. The Director of Nursing stated they were told the visitor of Resident #66 was on top of Resident #80, who was fully dressed. They stated Assistant Director of Nursing/Licensed Practical Nurse Unit Manager #2 confirmed the visitor of Resident #66 left the facility. They stated to avoid contamination; Registered Nurse Unit Manager #6 assessed the top half of Resident #80. They stated after they spoke with Police Officer #1 and Emergency Medical Services and Resident #80 was sent to the hospital. During an interview on 05/20/2026 at 11:05 AM, the Administrator stated they received a text message from Assistant Director of Nursing/Licensed Practical Nurse Unit Manager #2, which reported that the visitor of Resident #66 was involved in an incident with Resident #80. They stated that they could not remember whether the police officer spoke to Resident #80, and that Resident #80's family member had been notified and was upset. They stated that they had interacted with the visitor of Resident #66 in the past and had observed no red flags. They stated Resident #66 attended therapy on the day of the incident, and Resident #80 was left in the room with the visitor of Resident #66. During a telephone interview on 05/20/2026 at 11:45 AM, Psychiatric Nurse Practitioner #2 stated Resident #80 had encephalopathy which caused memory impairment. They stated that many of their contacts with Resident #80 were appropriate. They stated after the incident, they asked Resident #80 whether they were hurt and provided emotional support. They stated that due to memory impairment, Resident #80's account of the incident became confused. They stated the resident had a blunted effect and did (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	not recall or remember what happened because of the resident's liver disease. During a follow-up interview on 05/21/2026 at 11:00 AM, Psychiatric Nurse Practitioner #2 stated they came to the facility once a week to see residents. They stated that the sexual assault, in theory, would have effect on quality of life. However, it was difficult to assess this in Resident #80 because of dementia with cognitive decline. They stated Resident #80 minimized their feelings by saying it was okay. During an interview on 05/20/2026 at 12:55 PM, Social Service Assistant #4 stated they visited Resident # 80 after the sexual abuse incident to provide support and ensure Resident # 80 felt safe in the facility. Social Service Assistant #4 stated Resident # 80 did not remember the sexual abuse incident. 10 New York Codes Regulations and Rules 415.4(b)(1)(i)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, record reviews and interviews, the facility failed to ensure that a resident who was unable to carry out activities of daily living received the necessary services to maintain personal hygiene for two (2) of three (3) residents (Resident #12 and #16) reviewed for activities of daily living. Specifically, 1) there was no documented evidence that toileting hygiene was consistently provided for Resident #12 on multiple dates in January, February, March and April 2026 and 2) Resident #16 required staff assistance with personal hygiene and was observed on three (3) occasions with dirty and stained fingernails and long facial hair. The findings include: The facility policy Activities of Daily Living Documentation, last reviewed 5/2024, documented it is the responsibility of the certified nurse aide to sign the activities of daily living flow sheet at the end of each shift. 1) Resident #12 had diagnosis that included but were not limited to left leg below knee amputation, acute congestive heart failure and acute respiratory failure with hypoxia. The Annual Minimum Data Set Assessment (assessment tool) dated 3/31/2026 documented Resident #12 had intact cognition and was dependent on the staff for toileting hygiene. The Care Plan for resident has an activity of daily living self-care performance deficit dated 5/20/2026, documented Resident #12 was dependent with two (2) staff members for toileting hygiene. The certified nurse aide Documentation Survey Report for January 2026 documented 24 shifts for toileting hygiene and 11 shifts for was Resident visualized every two (2) hours that were not documented as being performed or completed. The certified nurse aide Documentation Survey Report for February 2026 documented 20 shifts for toileting hygiene and 13 shifts for was Resident visualized every two (2) hours that were not documented as being performed or completed. The certified nurse aide Documentation Survey Report for March 2026 documented 28 shifts for toileting hygiene and 28 shifts for was Resident visualized every two (2) hours that were not documented as being performed or completed. The certified nurse aide Documentation Survey Report for April 2026 documented 25 shifts for toileting hygiene and 29 shifts for was Resident visualized every two (2) hours that were not documented as being performed or completed. During an interview on 5/22/2026 at 8:43 AM, Resident #12 stated the certified nurse aides were not checking on them every two (2) hours. They must ring the call bell when needed and it takes a while to be cleaned even after talking to the certified nurse aides. During an interview on 5/22/2026 at 9:03 AM, Unit Manager #7 stated they expect all staff to document every shift and expect documentation to be completed. If it is not documented, it did not happen. If the task is not completed, then they expect the staff to document why it was not done. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/22/2026 at 9:56 AM, the Director of Nursing stated they expected all documentation to be done by staff each shift. If it was not documented, then it did not occur. 2) Resident #16 was admitted with diagnoses including atrial fibrillation, peripheral vascular disease and ischemic heart disease. The 3/31/2026 admission Minimum Data Set documented Resident #27 had minimal cognitive impairment and needed maximum assistance with toileting hygiene and bathing. There was no plan of care to address the residents' Activities of Daily Living needs. The certified nurse aide Kardex, documented showers were given on Mondays and Thursdays and the resident required substantial assistance from one member of staff with showering twice a week. During an interview on 5/18/2026 at 12:04 PM Resident #16 stated they wanted their nails cut because they were too dirty and long. They stated they wanted their face shaved because the hair was long and they wanted to look clean. During an observation on 5/18/2026 at 12:04PM Resident #16 was in bed, their fingernails were long with a brown substance under the nails and on the cuticles. Resident #16 had grown hair on their face and there was a urine odor in the room. During observations on 5/19/2026 at 11:33AM and 5/20/2026 at 9:51AM Resident #16 had overgrown facial hair, long nails with a brown substance on the cuticles and under the nails. The certified nurse aide Daily Assignment sheets for the month of April revealed there were nine (9) opportunities for a shower and the resident was provided four (4) showers, two (2) wash ups and three days were blank and not signed. During an interview on 05/20/2026 at 9:53 AM Certified Nurse Aide #23 stated they had the resident on their assignment and did not know if the resident received showers. They stated a bed bath (wash up) did not include nails and a shave. During an interview on 5/20/2026 at 10:15AM Certified Nurse Aide#24 stated they had the resident on their assignment on 5/18/2026 and did not give the resident a shower on 5/18/26 as scheduled because the resident wanted to sleep longer. They stated they provided a bed bath. They stated they did not shave or care for the residents' nails. They stated they were aware of the dirty nails and stated the resident often had feces under their nails. They stated they did not inform the nurse of the bed bath because they were in a rush. They stated they should have let the nurse know. During an interview on 05/20/2026 at 10:12 AM Registered Nurse Unit Manager #25 stated certified nurse aides were to look at the shower sheets daily to check their assignments and determine who will need a shower. They stated nails and shaves were to be performed on shower days. They stated certified nurse aides were supposed to let them know if the resident refuses showers. They stated certified nurse aides also needed to document on the shower sheets why a shower did not occur. They stated showers and clean hands were important because it makes residents feel good. They stated they were not aware of so many missed showers. They stated they were responsible for ensuring care was given. (continued on next page)

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	335449	A. Building B. Wing	05/22/2026

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

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10 New York Code Rules Regulation 415.12 (a)(3)

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	335449	A. Building B. Wing	05/22/2026

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice for 1 (one) of 28 residents (Resident #153) reviewed for quality of care. Specifically, for Resident #153 who received Eliquis (blood thinner) and sustained a fall on 08/20/2024, there was no documented evidence that a physician order was put in place timely to address every one-hour neuro checks and right shoulder/forearm radiographic imaging to rule out fracture as per the 08/20/2024 at 7:01 AM incident report interventions. Subsequently, there was no documented evidence that every one-hour neuro checks were conducted prior to 1:00 PM on 08/20/2024. Additionally, there was no documented evidence that right shoulder/forearm radiographic imaging was conducted prior to Resident #153's transfer to the hospital on [DATE]. The findings included:The policy titled Fall Assessment, Prevention and Management, last reviewed 10-2025, documented the resident physician and responsible party (for incapable residents) would be notified of incidents.Resident #153 had diagnoses including encephalopathy (brain dysfunction), atrial fibrillation (an irregular heartbeat), and chronic kidney disease.The 08/19/2024 Physician Order documented Eliquis 2.5 milligrams one tablet by mouth two times daily. The August 2024 Medication Administration Record documented Eliquis 2.5 milligrams one tablet two times a day was administered 08/20/2024-08/22/2024.There was no documented evidence in the Baseline and/or Comprehensive Care Plan to address goals and interventions related to administration of Eliquis. The Incident Description dated 08/20/2024 at 7:01 AM prepared by Registered Nurse #3 documented this writer was called to the unit to assess the resident on the floor. Resident was laying on the floor next to the right side of the bed. Resident slid from bed and on to the floor, in between the floor and the floor mat. Floor mats down on either side of the bed, due to resident's noted confusion and non-compliance noted from admission assessment the prior evening. Resident assessed for injuries, large 7-8-centimeter skin tear noted to anterior right forearm. Skin tear cleansed and a dressing applied. Resident was assisted back to bed, close monitoring due to the level of confusion and lack of safety awareness. The writer spoke in person to the wife, following the incident. Medical Doctor notification as per protocol. Order for right forearm and shoulder x-rays to rule out fracture. Every 30-minute safety checks placed. Residents' wife advised of resident having history of chronic pain and stiffness, decrease in range of motion to the right shoulder related to history of gunshot wound. Immediate interventions included assessment for pain, range of motion, and possible injury. The resident was safely assisted off the floor while safety precautions were maintained. Radiographic imaging of the right shoulder and right forearm was ordered. Immediate action taken; assessed for pain/range of motion and injury. X-Ray of right shoulder and right forearm. Safety checks and neuro checks x 24 hours. Every 30 minutes safety checks placed. The skin tear was cleansed, and dressing was applied. Imaging of the right shoulder and right forearm were ordered.The Physician Order dated 08/20/2024 at 1:00 PM documented neuro checks every one-hour x 24 hours status post fall out of bed, unwitnessed. Floors mats in place at all times while in bed.There was no documented evidence in the August 2024 Administration Record to indicate neuro checks were conducted on 08/20/2024 between 7:01 AM and 1:00 PM.There was no documented evidence to indicate that a Physician Order was placed for radiographic imaging of the right shoulder and right forearm to rule out fracture after a fall out of bed as per the 08/20/2024 Incident Report.There was no documented evidence in the Electronic Medical Record to indicate radiographic imaging of the right shoulder and right forearm was conducted as per the 08/20/2024 Incident Report.The 08/22/2024 admission Minimum Data Set (an assessment tool) documented Resident #153 had severe cognitive impairment and required staff assistance with activities of daily living.The 08/22/2024 Practitioner Progress Note documented the chief complaint was a fall from bed, with the family requested transfer to the Emergency Room. During interview on 05/18/2026 at 2:00 PM, Resident #153's family stated the facility did not (continued on next page)

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Achieve Rehab and Nursing Facility	170 Lake Street Liberty, NY 12754

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	adequately evaluate the resident following the fall. The family reported bruising was present on the right side of the resident's body and they requested transfer to the hospital. The family further stated the facility should have recognized the severity of the resident's condition and initiated hospital transfer without requiring family insistence.During an interview on 05/19/2026 at 6:55 PM, Nurse Practitioner #1 stated Resident #153 did not sustain a head strike during the unwitnessed fall. Nurse Practitioner #1 stated although Resident #153 was prescribed Eliquis, they were not sent to the hospital after the fall because no head strike was identified. Nurse Practitioner #1 stated the resident remained at baseline, although ecchymosis and increased behaviors were observed. Nurse Practitioner #1 further stated the expectation was that Resident #153 would undergo radiographic imaging to rule out fractures. Nurse Practitioner #1 stated radiographic imaging had been ordered, and the technician was present on 08/22/2024. Nurse Practitioner #1 further stated the family expressed concern the radiographic imaging had not been completed sooner and asked that the resident be transferred to the hospital. Nurse Practitioner #1 stated they arranged transfer to the hospital for Resident #153.During an interview on 05/20/2026 at 11:58 AM, Registered Nurse #3 who assessed Resident #153, stated when the resident was found on the floor it would be considered an unwitnessed fall because no staff observed the fall. Registered Nurse #3 further stated normal practice included notifying the physician of injuries and whether the resident received anticoagulant medication. Registered Nurse #3 stated there was no recollection of whether the physician was informed that Resident #153 received anticoagulant medication. Registered Nurse #3 further stated protocol included neurological checks and safety checks every 30 minutes. Registered Nurse #3 stated radiological imaging was ordered, and they did not know why imaging had not been done. 10 New York Code Rules Regulations 415.12

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure each resident received adequate supervision and assistance devices consistent with the resident's needs to prevent accidents for two (2) of six (6) residents reviewed for accidents (Resident #92 and Resident #61). Specifically, 1) floor mats were observed by the bed and a bedside commode was observed blocking the bathroom door in the room of Resident #92 who had a history of fall on 05/06/2026. Additionally, there was no documented evidence that a physical therapy evaluation was conducted timely and 2) for Resident #61, there was no documented evidence that the resident was assessed to determine safe usage of an electric coffee pot The findings include: The policy titled Fall Assessment, Prevention and Management, last reviewed 10-2025, documented provide a safe environment to prevent falls and subsequent injuries with fall prevention measures that can be put in place per physician order, and to avoid fall mats with ambulatory residents, which could create an environmental hazard. 1) Resident #92 had diagnoses including Parkinson's Disease, Dementia, and a history of falling. The quarterly Minimum Data Set assessment dated [DATE] documented moderately impaired cognition, partial assistance with walking 10 feet and toilet transfers, and no falls since admission. The Care Plan for activities of daily living deficit dated 03/20/2026 documented partial, moderate assist for ambulation and toileting. The incident/accident summary dated 05/06/2026, documented at 7:40 AM, Licensed Practical Nurse was notified of a new black/blue ecchymotic area above Resident #92's right eye. Resident #92 stated, I fell in the bathroom, had gotten up off the floor, returned to bed, and did not report the incident to the staff. Upon assessment, Resident #92 was noted with bruising above the right eye and pain to the right side of the abdomen. Resident #92 was sent to the emergency department and computed tomography scan revealed 6th and 7th rib fracture. The care plan was reviewed with no deviation noted. The plan was to add a bedside commode upon return from the hospital, make a referral to therapy, and pain management. Resident #92 was re-admitted status post hospitalization on 05/08/2026. The Certified Nurse Aide Kardex documented that Resident #92 required maximum assistance with transfers and was coded as not applicable for ambulation. The comprehensive Care Plan was not updated to reflect Resident #92 maximum assistance for transfers after return from the hospital on [DATE]. During an observation on 05/17/2026 at 10:37 AM, Resident #92 was lying in bed with a three (3) inch blue cushion mat on door side of bed and a flat rubber type mat between the roommate's bed. Resident #92 had a white bandage/patch on the right side of their torso and stated they had fallen in the bathroom and had broken ribs. (continued on next page)

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Achieve Rehab and Nursing Facility	170 Lake Street Liberty, NY 12754

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documented evidence in the Certified Nurse Aide Kardex and/or or Care Plan to address the use of floor mats. The Care Plan for fall risk was last updated on 05/17/2026 documented keep the call light within reach, ensure appropriate footwear, maintain a safe environment with even floors, and provide bedside commode. There was no documented evidence in the electronic record that a physical therapy evaluation was conducted before 05/19/2026 During an observation on 05/18/2026 at 9:43 AM, Resident #92's wheelchair was vacant in the doorway to their room. The bedside commode was positioned next to the bathroom door. Resident #92 was standing in the partially opened doorway of the bathroom. Both floor mats were in place on the floor to the left and right side of Resident #92's bed. During an interview on 05/20/2026 at 8:30 AM, Resident #92 stated they did not use the bedside commode and were using the bathroom in their room independently. During an interview on 05/20/2025 at 3:51 PM, the Director of Rehabilitation stated that before the fall on 05/06/2026, Resident #92 was under supervision for walking and received minimal assistance with toileting. They could not recall any floor mats in use before the fall, as they would have been in the way for Resident #92 to ambulate. The Director of Rehabilitation stated that nursing can request a bedside commode if they feel a resident needs it. During an interview on 05/20/2026 at 4:15 PM, Certified Nurse Aide #15 stated Resident #92 was toileting themself in the room independently. They stated Resident #92 parked the wheelchair in the doorway and walked to the bathroom. Certified Nurse Aide #15 stated the floor mat by the door was placed after Resident #92 fell. Certified Nurse Aide #15 stated they were aware that Resident #92 currently ambulated to the bathroom without assistance. They stated the unit manager made rounds and could decide whether the floor mat needed to stay. During an interview on 05/20/2026 at 4:24 PM, Licensed Practice Nurse #16 stated they were aware that Resident #92 walked to the bathroom in their room. They stated the floor mat and commode blocking the bathroom door would be a hazard. Licensed Practical Nurse #16 stated they should have told the unit manager of their observation but reporting it doesn't always happen right away due to being busy. During an interview on 05/20/2026 at 4:31 PM, the Assistant Director of Nursing/Nurse Manager #2 stated the floor mat should not be removed yet because if the Resident falls and there is no mat, they could be injured; if the mat stayed, it would protect Resident #92. During an interview on 05/22/2026 at 10:57 AM, the Director of Nursing stated the floor mats were not part of the plan of care, and they were not sure who implemented the mats. 2) Resident #61 had medical diagnoses that included encephalopathy (brain dysfunction), low back pain, and depression. The admission Minimum Data Set assessment, dated 03/20/2026, documented that Resident #61 had moderately impaired cognition and required staff assistance with activities of daily living, with staff providing less than half the effort during these activities. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The care plan dated 03/23/2026 documented that the resident had impaired cognitive function, dementia, and impaired thought processes related to dementia. The care plan instructed staff to administer medications as ordered and communicate with family caregivers regarding the resident's capabilities and needs. A physician order dated 04/23/2026 prescribed Aricept oral tablet 10 milligrams, one tablet by mouth at bedtime, for dementia. There was no documented evidence in the electronic health records indicating that an assessment had been completed to determine the resident's ability to use the coffee maker safely. During observations conducted on 05/17/2026 at 12:15 PM and 05/18/2026 at 9:43 AM, Resident #61 had a coffee maker in the resident's room with supplies; however, the coffee maker lacked an inspection sticker. During an interview on 05/20/2026 at 12:12 PM, Licensed Practical Nurse #7 stated that Resident #61 did not use the coffee maker. The nurse explained that family members used the coffee maker during visits; however, the resident could potentially attempt to make coffee. During an interview on 05/21/2026 at 9:59 AM, Registered Nurse Unit Manager #6 stated that Resident #61 had a coffee maker in the resident room that family members had brought in. The nurse stated that no assessment had been completed to determine whether the resident could safely operate the coffee maker. The nurse further stated that Resident #61 had not been observed preparing coffee with the machine; however, there was concern that the resident could attempt to make coffee independently. During an interview on 05/21/2026 at 10:00 AM, the Director of Nursing stated that the facility did not have a policy or assessment process regarding residents' use of coffee makers. New York Code Rules Regulations 415.12 (h)(2)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the medication error rate was less than five percent during medication administration observations on 05/19/2026, 05/20/2026, and 05/21/2026. 32 opportunities for errors were observed, two (2) errors were made, yielding a 6.25% medication administration error rate for two (2) of eight (8) residents observed (Resident #19 and Resident#40). Specifically, 1) Resident #19 was administered two and one half (2.5) milligrams of amlodipine besylate instead of one (1) (5) five milligram tablet as ordered and 2) Resident #40 was going to be administered two (2) 500 milligram tablets of magnesium until the contents of the cup were counted by this surveyor prior to administration. Additionally, they were administered one 500 milligram tablet of magnesium instead of two 250 milligram tablets. The findings included:The Medication Administration Policy dated 04/29/2026 documented that the nurse administering medication must follow the rights of medication administration including the right time, right route, right dose, right medication, right resident, and right documentation. 1)Resident #19 had diagnoses including Alzheimer's Disease, asthma, and hypertension. The quarterly Minimum Data Set, dated [DATE] documented severely impaired cognition and diagnoses included hypertension.During an observation on 05/20/2026 at 10:06AM, Licensed Practical Nurse #7 was observed administering amlodipine besylate, two and one half (2.5) milligrams to Resident #19. During the medication reconciliation, the physician order dated 05/11/2026 was reviewed and documented amlodipine besylate oral tablet, five (5) milligrams. Give 1 tablet by mouth one time a day for hypertension. During an interview on 05/21/2026 at 3:02 PM, Licensed Practical Nurse #7 stated that the incorrect dose of amlodipine besylate was administered on 05/20/2026 at 10:06AM. They administered two- and one-half milligrams (2.5), but the order was for five (5) milligrams. The order was recently changed and there was no alert on the packaging, and the blister pack containing 2.5 milligram tablets was not removed from the medication cart. They stated they should have caught it when checking the blister pack against the medication order. During an interview on 05/22/2026 at 10:01 AM, Registered Nurse Unit Manager #6 stated that the incorrect dose of amlodipine besylate was administered to Resident #19 on 05/20/2026 at 10:06AM. They stated when medication orders change, they put the order change on report and verbally tell the nurse administering medication. The incorrect medication card was not removed from the cart, and the incorrect dose was administered in error. The correct dosage was received from the pharmacy but was in the bottom drawer of the medication cart. The dose should have been confirmed before administration.During an interview on 05/22/2026 at 11:46 AM, the Director of Nursing stated that they were aware that the incorrect dose of amlodipine besylate was administered to Resident #19 on 05/20/2026 at 10:06AM. The dose in the blister pack should have been checked against the order prior to administration. They stated that when the physician orders a change in medication dose, the nurse taking the order should inform the medication administration nurse and the incorrect medication should be removed from the cart to prevent errors. 2)Resident #40 had diagnoses including hypomagnesemia, dementia, and diabetes. The quarterly Minimum Data Set, dated [DATE] documented severely impaired cognition and diagnoses included hypomagnesemia. During an observation and interview starting on 05/21/2026 at 09:09AM, Licensed Practical Nurse #22 was observed drawing up medication for Resident #40. They stated they only keep magnesium 500 milligrams in stock so they will administer one instead of two 250 milligram tablets. When this surveyor checked the count of tablets prior to administration in the medication cup, one additional tablet was observed. Licensed Practical Nurse #22 stated they had drawn up two of the magnesium tablets in error and removed one. During the medication reconciliation, the physician order dated 12/20/2025 was reviewed and documented magnesium gluconate oral tablet 250 milligrams. Give 2 tablet by mouth one time a day for supplement.During an interview on 05/22/2026 at 10:01 AM, Registered Nurse Unit Manager #6 stated that orders should be followed as written and checked prior (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to administration. The medication nurses should not substitute a medication without an order even if the dose is the same. During an interview on 05/22/2026 at 11:46 AM, the Director of Nursing stated that orders should be checked prior to administration. The medication nurse should always get an order that reflects what is being administered if a substitute is needed, even if the dose is the same. They should not make a substitution without an order. 10 NYCRR 415.12(m)(2)

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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. Based on observation, interview, and record review, the facility failed to ensure a safe, sanitary, and comfortable environment was maintained to help prevent the development and transmission of communicable diseases and infections for all residents when reviewing the water management plan and three (3) of eight (8) residents (Resident #95, Resident#124, and Resident #157) reviewed for medication administration. Specifically, 1) a water management plan was missing and not provided at the time of the survey; 2) on 05/19/2026, after using the community glucometer on Resident #65, Licensed Practical Nurse #14 was stopped and asked to sanitize the glucometer before using it on Resident #124; 3) on 05/21/2026, after administering medications to Resident #40, Licensed Practical Nurse #22 did not sanitize their hands prior to medication administration for Resident #95. Additionally, when administering dorzolamide eye drops to Resident #157, Licensed Practical Nurse #7 used the same tissue to wipe both eyes after administration of the medication. The findings included:1) Review on 5/20/26 at 11:10 AM of the facility legionella logs revealed that a water management plan was missing and not provided at the time of survey.During an interview with the Director of Maintenance on 05/20/2026 at approximately 1:40 PM, the Director of Maintenance stated that the legionella water management plan could not be located. 2) During an observation and interview starting on 05/19/2026 at 12:01PM, Licensed Practical Nurse #14 performed a fingerstick on Resident #65 using a community glucometer. At 12:07 PM they prepared the same glucometer to perform a fingerstick on Resident #124 but failed to sanitize the glucometer. This surveyor stopped Licensed Practical Nurse #14 before proceeding into the room. Licensed Practical Nurse #14 stated that they should have sanitized the shared equipment and would do so now before performing the fingerstick. 3) During an observation starting on 05/21/2026 at 9:09 AM, Licensed Practical Nurse # 22 administered medications to Resident #40. After the medication administration for Resident #40, at 9:22AM they prepared and administered medications to Resident #95 without sanitizing their hands. During an interview on 05/21/2026 at 9:27 AM, Licensed Practical Nurse #22 stated that they were distracted and did not provide hand hygiene between Resident #40 and Resident #95 when administering their medications. They should have sanitized their hands between the two residentsDuring an interview on 05/21/2026 at 9:37 AM, Registered Unit Manager #6/Interim Infection Preventionist stated that nurses should sanitize their hands between residents when medications are administered. Community equipment should be wiped down with the available sanitizing wipes between residents. They also stated that when nurses administer eye drops, a separate tissue should be used for each eye when wiping the eyes after administration. During an interview on 05/22/2026 at 11:46 AM, the Director of Nursing stated nurses should sanitize their hands between residents when administering medication. Shared equipment should also be sanitized between residents. 10 New York Code Rules Regulations