STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335451	A. Building B. Wing	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Hill Nursing and Rehabilitation Center	99 Golden Hill Drive Kingston, NY 12401

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48847 Based on record review and interviews conducted during the abbreviated survey (NY00377486) the facility did not ensure that the resident, resident's representative(s), or ombudsman was notified of the transfer or discharge, and the reasons for the move, in writing and in a language and manner they understand for 1 (Resident #3) of 3 residents reviewed for discharge. Specifically, Resident #3 was discharged home on 3/13/2025 and there was no documented evidence that the facility provided a notice of discharge at least 30 days before the resident was discharged . a bed hold notice was not provided, the facility did not document discussions with the resident and/or the representative that included information on discharge planning and arrangements for post-discharge care. Additionally, there was no progress notes that documented the reason for discharge, the effective date of discharge, or the location of where the resident will be discharged to. There was no documented evidence that the Managed Long-Term Care were notified to assess the resident for additional hours at home as per Resident's request. Furthermore, the discharge documentation indicating that Resident #3 will be discharged on [DATE] was incomplete with no date indicating when the home care nursing services, physical and occupational therapies, or med assist was notified. The form titled Team discharge and Care Plan Summary Guide was not initiated until 3/7/2025. The findings are: The facility policy titled Transfer/Discharge Notice revised on 12/2024 documented that the facility shall provide a resident and/or the resident's representative (sponsor) with a thirty (30) day written notice of an impending transfer or discharge. The resident and/or representative (sponsor) will be notified in writing of the following information: a. The reason for the transfer or discharge; b. The effective date of the transfer or discharge; c. The location to which the resident is being transferred or discharged . The reasons for the transfer or discharge will be documented in the resident's medical record. The Facility Policy titled Notice of Transfer or Discharge, last revised October 2024, documented the facility must notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The Social Worker and Nurse Supervisors/Unit managers are responsible to ensure residents, and their representatives are notified of any transfers and discharges in a timely manner indicating reason of transfer and discharge. Notice to the Office of the State Long Term Care Ombudsman must occur at the same time the notice of discharge is provided to the resident and resident representative. (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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1 was admitted with diagnoses including but not limited to anxiety disorder, chronic obstructive pulmonary disorder, depression, and Polye osteoarthritis. The 2/1/2025 Admission 5-day Minimum Data Set (an assessment tool) documented that Resident #1 had intact cognition, and there were no reports of entry/discharge. The 5-day Minimum Data Set assessment dated [DATE] documented Resident #8 had intact cognition, required maximum assistance or was dependent on staff for most activities of daily living except eating and oral hygiene. The 2/6/2025 Social worker Progress Note documented that a Care plan meeting was held with Resident #3, family and the facility Interdisciplinary team. Resident's discharge plan is to return home. Resident #3 is requesting an assessment with their Managed Long-Term Care (MLTC -Fidelis) for increase in hours at home. Discharge Planning was to reach out to Fidelis to schedule and assessment. There was no documented evidence that Resident #3's Managed Long-Term Care (MLTC) was notified to assess Resident #3 for additional hours prior to the discharge home. The 3/11/2025 Nursing Progress note documented that Physician saw resident for a discharge visit, and Resident #3 was cleared for discharge on 3/13/2025. The 3/13/2025 Nursing Progress Note documented that Resident #3 was discharged from facility with all personal belongings, and that all medications and follow up appointments was reviewed with resident. There was no documented evidence that the facility discussed discharge with Resident #3 or their representative that included information on discharge planning and arrangements for post-discharge care. There was no documented evidence that Resident #3 was provided with a bed hold notification for discharge on 3/13/2025. The 3/13/2025 Social Worker Progress Note documented that they discharged resident home with all their personal belongings. A friend was there to transport, the daughter was made aware of discharge, and referrals were made for the visiting nurse, an aide, and Occupational Therapy/Physical Therapy. Also provided was the med assist and lifeline of the [NAME] valley contact numbers. There was no documented evidence that Resident #3 or resident representative was provided a 30-day notice prior to discharge on 3/13/2025. Upon request of records from facility on 5/9/2025, the facility was unable to provide documented evidence that the Ombudsman was notified of Resident #3's discharge on 3/13/2025. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/9/2025at 3:09 PM, the Social Worker stated that Resident #3 had an initial Care Plan meeting on 2/6/2025, where therapy addressed their goals, gathered information about who they live with, long term care options if they want to. The Social Worker stated that Resident #3 had Management Long term care (MLTC) at home and was looking for more long-term hours, and that they requested that the Managed Long-Term Care come into facility to assess to see if they could get more hours. The Social Worker stated that they were not aware of the Managed Long-Term Care coming in to assess Resident #3. The Social Worker stated that when a family comes to the Care Plan meetings, they let them know the plans for discharge if any and was able to provide documentation that they discussed discharge planning and interventions to be put in place before going home. The Social Worker stated that the Resident's family should always be involved with discharge, and that if a resident is discharged from the facility, it should always be a safe discharge, and that everything should be in place prior to discharge including the referrals for therapy, a home health care (aide in home) as well as adaptive equipment. The Social Worker stated that they do not facilitate discharges because they have a discharge liaison in the facility that handle discharges. During an interview on 5/9/2025 at 3:44 PM, Discharge Liaison #1 stated they have weekly Utilization Review meetings once a week which consists of facility staff to discuss all residents, and if a Resident is nearing discharge, they discuss what adaptive equipment they may need when they go home and to make sure it is place before discharge, they set up medical services for post discharge for a safe discharge, and will make sure home cares services are in place before discharge. During an interview on 5/9/2025 at 3:51 PM, Discharge Liaison #2 stated that they notified Resident #3's Management Long term care but they never came to the facility to assess the resident before discharge as per the family members recommendation and the resident's request. Discharge Liaison #2 stated they did not write a progress note. Discharge Liaison #2 stated they notified Resident #3's family about the discharge but they did not write a progress note. They were supposed to complete their documentation before they leave the facility to be sure everything is in place. When requested, Discharge Liaison #2 was unable to provide documentation that Resident #3 or their representative was notified of discharge 30 days prior to their discharge on 3/13/2025, or that a bed hold notification was provided, and that the Ombudsman was notified. 10NYCRR 415.3(i)(1)(iii)(a-c)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 48847 Based on observations, record review, and interviews conducted during an Abbreviated Survey (NY00340219), the facility did not ensure residents were free of significant medication errors for 1 (Resident #1) of 4 residents reviewed for Medication Administration. Specifically, on 4/23/24 at 8pm, Licensed Practical Nurse #1 administered Coumadin 2mg to Resident #1 which was put on hold as per Physicians orders on 4/23/24 at 1:24 pm, due to their International Normalized Ratio (INR) being high at 3.3 (normal range 2.0-3.0). Subsequently, Resident #1's International Normalized Ratio (INR) rate increased to 7.9. Resident #1 received 2.5mg of Vitamin K (for prevention of bleeding) immediately. Resident #1's coumadin 2.5mg was discontinued until the International Normalized Ratio (INR) became therapeutic. The Findings are: The undated facility policy titled Medication Errors documented that a medication error is any event that may cause or lead to inappropriate medication use or resident harm. Types of errors include but are not limited to medication that is administered even though it has been held. Resident #1 was admitted with diagnosis including but not limited to atrial fibrillation, cervical disc degeneration, congestive heart failure, and pulmonary edema. The 4/19/24 Admission Minimum Data Set documented that Resident #1 had intact cognition and received an anticoagulant. The 4/23/24 at 1:24pm Physicians orders, documented that Resident #1's Coumadin 2mg was put on hold due to their International Normalized Ratio (INR) being 3.3. The Medication Error Report documented that on 4/23/24 at 8pm Licensed Practical Nurse #1 administered Coumadin 2mg that was put on hold as per Physicians orders from 4/23/34 at 1:24pm. The 4/24/24 at 7am Physicians orders documented that Resident #1's is to be given Phytonadione (Vitamin K) 2.5mg one time only for International Normalized Ration (INR) being 7.9 The 4/24/24 Physicians orders documented that Resident #1's Coumadin 2mg is to be discontinued International Normalized Ratio (INR) becomes therapeutic. The 4/16/24 Anticoagulant Care Plan documented that Resident #1 is on anticoagulant therapy (coumadin) related to atrial fibrillation. Interventions included administering labs as ordered, report abnormal lab results to the Medical Doctor. Anticoagulant medications as ordered by physician The 4/12/24 Medication Care Plan documented that Resident #1 utilizes medication with anticoagulation properties related to mechanical mitral valve replacement and is at increased risk for purpura, bruising, and bleeding. Interventions included doing International Normalized Ratio (INR) labs as per order, monitoring appropriate labs to assess possible bleeding as ordered, and monitoring for signs and symptoms of bleeding. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 4/23/24 at 1:55 pm Nursing Progress Note documented that the Physician saw Resident #1 for follow up visit and International Normalized Ratio was 3.3 and gave order to hold coumadin on 4/23/24 and resume 2. 5mg on 4/24/24. The 4/25/24 at 1:16 pm, a Late entry (4/24/24 at 1:08 pm) Medical Progress Note documented that Resident #1 was seen for acute care visit due to receiving a dose of Coumadin in error, and their International Normalized Ratio is 7.9 in which they received vitamin K 2.5 mg. The plan is to hold Coumadin, and to follow up with International Normalized Ratio early in the evening. During an interview on 3/20/25 at 10:17 am, the Complainant stated that Resident #1 called them early in the morning on 4/25/24 upset stating that the nurse told them that they gave them their Coumadin that was put on hold by the Physician due to an elevated International Normalized Ratio and that the nurse told them that they did not check the notes. During an interview on 3/20/25 at 12:23 pm, Licensed Practical Nurse #2 stated that they get report from the prior shift of medications on hold or discontinued but it is up to the nurses to check the electronic health records and Physicians orders prior to medication administration so that a medication error does not occur. During an interview on 3/20/25 at 2:40 pm, Physician #1 stated that they were not sure when they were notified about Licensed Practical Nurse #1 administering Resident #1's Coumadin 2mg that was held due to an elevated International Normalized Ratio and that administering the Coumadin could have harmed Resident #1 if they developed a bleed. Physician #1 stated that administering Coumadin with an elevated International Normalized Ratio can cause the resident to have a greater risk of bleeding causing them to spontaneously bleed, and drawing blood would become dangerous. Physicians #1 stated that that they were not sure if the International Normalized Ratio went up to 7.9 due to giving Coumadin with an already increased International Normalized Ratio, but Resident #1's International Normalized Ratio target range is 2-3 and Vitamin K was given immediately to quicky reduce the International Normalized Ratio. During an interview on 3/21/25 at 1:34 pm, Licensed Practical Nurse #1 stated that they mistakenly administered Resident #1 Coumadin that was on hold, and that they realized after administration. Licensed Practical Nurse #1 stated that they did see the physicians order that it was on hold but gave it by accident because they were overwhelmed because they were working alone. During an interview on 3/24/25 at 5:27 pm, the Director of Nursing stated that nurses should follow Physicians orders and do the 5 rights of medication administration prior to administering medications. The Director of Nursing stated that if Coumadin is given with an elevated International Normalized Ratio, the resident has a risk of bleeding out. 10 NYCRR 415.12(m)(2)