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	04/03/2026

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews conducted during the Abbreviated Survey the facility did not ensure the services provided were consistent with professional standards of medication administration that include obtaining physician clarification when the ordered medication could not be dispensed as written prior to administration, for one (Resident #2) of three residents reviewed for medication administration. Specifically, Resident #2 was re-admitted to the facility on [DATE] with a physician's order for Clozapine 100 milligrams, give 1.75 tablet by mouth at bedtime for psychosis. A Pharmacy clarification email provided by the Director of Nursing documented that on 01/16/2026, the pharmacy notified the facility that the medication could not be dispensed as ordered and requested that the physician be contacted to change the order. There was no evidence that the physician was contacted or that a new or clarified order was obtained by facility staff until 01/20/2026. The January 2026 Medication Administration Record revealed Licensed Practical Nurse #2 administered Clozapine to Resident #2 from 01/16/2026 through 01/19/2026. The Physician order was discontinued on 01/20/2026 and a new clarified order was written by the physician. The medication was delivered late by the pharmacy and was not administered at the scheduled time as ordered.The findings include: Review of the facility policy titled Physician Orders, dated 02/24/2025, documented that all physician orders shall be acknowledged, documented, and carried out in a timely and appropriate manner in accordance with applicable standards of practice and facility procedures. The policy further documented that physician orders shall be reviewed promptly by appropriate licensed clinical staff upon receipt. The policy also documented that any order that is unclear, incomplete, or potentially inappropriate shall be clarified with the ordering provider prior to implementation. Resident #2 was admitted with diagnoses including but not limited to dementia, depression, and psychosis. The 01/23/2026 Quarterly Minimum Data Set documented that Resident #2 had severely impaired cognition and received antipsychotic medication. Review of the 01/16/2026 physician's order documented that Resident #2 had an order for Clozapine oral tablet 100 milligrams, give 1.75 tablet by mouth at bedtime for psychosis. Review of the pharmacy clarification email, provided by the Director of Nursing, documented that on 01/16/2026 at 08:01 PM, the pharmacy communicated with the facility writing Cannot cut Clozapine 100 milligram tablets entered to give 1.75 tablets. Cannot cut tablets into 3/4. Please change this order to clozapine 100 milligrams plus clozapine 25 milligrams (give 3 tablets) to be given together. There was no documented evidence that the Physician was contacted and notified of the need for clarification of the Clozapine order. Review of January 2026 Medication Administration Record revealed Licensed Practical Nurse #2 Resident #2 received administered Clozapine to Resident #1 on 01/16 Licensed Practical Nurse #2 administered Clozapine to Resident #1 using 25 milligram tablets intended for a different physician's order, without physician authorization for the change in formulation or administration. Review of the pharmacy delivery receipt documented that 42 Clozapine 25 milligram tablets were delivered to the facility on [DATE] at 12:07 AM, which was after the scheduled administration time of 09:00 PM on 01/16/2026, and therefore were not available in the facility at the time of the ordered administration. The 01/16/2026 Physician order for Clozapine 100mg give 1.75 tablet by mouth was discontinued on 01/20/2026. Review of the (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	01/20/2026 physician's order documented that Resident #2 had an order for Clozapine oral tablet 25 milligrams, give 3 tablets by mouth one time a day for psychosis and give 3 tablets by mouth at bedtime for psychosis, to be administered with 100 milligram tablets of Clozapine to total 175 milligrams. During an interview on 03/17/2026 at 02:41 PM, Registered Nurse Unit Manager #1 stated that the pharmacy clarification email was received on 01/16/2026 and was distributed to nursing and administration. Registered Nurse Unit Manager #1 stated that at the time the email was received, they had left and was off, and they did not return to work until 01/20/2026. Registered Nurse Unit Manager #1 stated that upon returning to work, the email was reviewed, and it was identified that the physician's order had not been changed, and the issue had not been addressed. Registered Nurse Unit Manager #1 stated that they addressed and updated the order on 01/20/2026.During an interview on 03/19/2026 at 11:40 AM, Nurse Practitioner #1 stated that they were not included on the pharmacy clarification email distribution and were not notified by facility staff that the medication was unavailable as ordered. During an interview on 03/19/2026 at 05:14 PM, the Director of Nursing stated that when a medication is ordered and is not available, nursing staff are expected to contact the physician and the pharmacy to clarify the order prior to administration. The Director of Nursing stated that staff should verify orders when there are questions or when medications are not available as ordered. The Director of Nursing further stated that pharmacy clarification emails are accessible to nursing and supervisory staff, including nurse managers and Registered Nurses on duty, and could have been addressed by available staff. During an interview on 03/26/2026 at 03:20 PM, the Pharmacy Director stated that on 01/16/2026, the pharmacy notified the facility that the Clozapine 100 milligram tablet could not be cut to administer 1.75 tablets and requested that the physician be contacted to change the order. The Pharmacy Director stated that the pharmacy sent 42 Clozapine 25 milligram tablets for another physician's order to administer three tablets by mouth one time a day for psychosis, with a start date of 01/17/2026 at 09:00 AM. The Pharmacy Director stated that medications dispensed for one physician order must not be used for other medication orders, even if the dose is the same. The Pharmacy Director stated that the medications are dispensed based on insurance coverage and that using seven tablets per administration of the 175milligram dose would deplete the supply for the other doses in approximately six days. During a follow-up interview on 03/27/2026 at 02:13 PM, Licensed Practical Nurse #2 stated that Clozapine for Resident #2 was scheduled to be administered at 09:00 PM. Licensed Practical Nurse #2 stated that they did not have access to pharmacy clarification emails and therefore were not aware that the pharmacy had notified the facility that the Clozapine order needed to be changed. Licensed Practical Nurse #2 stated that they did not contact the physician or the pharmacy when the ordered medication was not available as written and did not obtain clarification prior to administration. Licensed Practical Nurse #2 stated that the physician's order for Clozapine 1.75 tablet was read as 175 milligrams. Licensed Practical Nurse #2 stated that Clozapine was administered late after receipt from the pharmacy. Licensed Practical Nurse #2 stated that the start date of 01/17/2026 at 09:00 AM for the Clozapine 25 milligram tablets was not identified prior to administration. Licensed Practical Nurse #2 stated that with clarification, the pharmacy typically contacts the nursing supervisor or unit; however, Licensed Practical Nurse #2 stated that no such communication was received. 10 New York Code Regulatory Reference 415.15(b)(1)(i)-(ii)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on record review and interviews conducted during the Abbreviated Survey, the facility did not ensure that a resident who was experiencing pain was assessed and provided appropriate and timely pain management, including the timely administration of medications, for one (Resident #3) of four (4) residents reviewed for pain management. Specifically, the Facility Medication Administration Audit Report dated 08/02/2025 through 08/03/2025 documented that Resident #3 was scheduled to have a pain assessment completed at 7:00 PM on 08/02/2025. There was no documentation that the pain assessment was completed as ordered. 2.The 08/02/2025 Medication Administration Audit Report also documented that Resident #3 was scheduled to receive Melatonin 10 milligrams at 8:00 PM and Gabapentin 100 milligrams at 9:00 PM on 08/02/2025. There was no documentation that the medications were administered as ordered, and the Medication Administration Record indicated a signature at 2:10am on 08/03/2025 with reference to nursing progress notes.The findings include: The facility policy titled Pain Assessment and Management dated 11/18/2025 documented that monitor the resident's pain and consequences of pain at least each shift for acute pain or significant changes in levels of chronic pain. The policy further documented to monitor the residents by performing a basic assessment with enough detail and as needed, with standardized assessment tools (e.g., approved pain scales, etc.). The policy also documented to assess the resident whenever there is a suspicion of new pain or worsening of existing pain. Resident #3 was admitted with diagnoses including but not limited to low back pain, Fibromyalgia (pain in joint), diabetic neuropathy and insomnia The 08/01/2025 Quarterly Minimum Data Set documented that Resident #3 had intact cognition. Review of physician's orders dated 06/12/2025 documented that Resident #3 was to receive Melatonin 10 milligrams, give one tablet by mouth at bedtime (9:00 PM) for insomnia. Review of physician's orders dated 05/29/2025 documented that Resident #3 was to have pain monitoring completed every shift for history of diabetic neuropathy, fibromyalgia, osteoarthritis, and low back pain. Review of the August 2025 Medication Administration Record documented that Resident #3's Melatonin was scheduled for 8:00 PM and Gabapentin 100 milligrams was scheduled for 9:00 PM on 08/02/2025. were not documented as administered as ordered. The Medication Administration Record documented code 9 which means other/see progress notes. There was no nursing progress note on 08/02/2025 from Licensed Practical Nurse #1. The Facility 2025 Medication Administration record revealed a note from Licensed Practical Nurse #1 at approximately 2:10am on 08/03/2025. Review of the Medication Administration Record documented that the pain assessment for Resident #3 scheduled for 7:00 PM was not documented as completed. A Nursing Progress note dated 08/03/2025 at 7:14AM documented Resident #3 was verbally disruptive and refused to take PO (by mouth) medications. During an interview with Resident #3 on 03/18/2026 at 4:51 PM, Resident #3 stated that they recall an incident involving a staff member and they recall yelling and arguing over their medications not been administered on time. Resident #3 also reported experiencing pain and stated that it was difficult to sleep without his medications been given timely when they requested it. During an interview on 03/19/2026 at 3:51 PM, Licensed Practical Nurse #1 stated that on 08/02/2025, upon arrival at 7:00 PM, Resident #3 was already calling out for their medication. Licensed Practical Nurse #1 stated that Resident #3 continued calling out and yelling every five minutes requesting pain medication, but they were unable to respond to Resident #3 to administer their pain medication or perform a pain assessment due to insufficient staffing including periods where they were the only staff present and responsible for call bells, medication administration, and resident care. Licensed Practical Nurse #1 stated that a pain assessment was not completed at the beginning of the shift or at the time of the residents' request. Licensed Practical Nurse #1 stated that when they brought Resident #3 their medications later in the shift at approximately 12:00 AM on 08/03/2025, Resident #3 was upset and refused the medications. Licensed Practical Nurse #1 stated that Resident #3 was calling out and ringing the call bell every five minutes for an one hour prior. They were unable to (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administer medications on time. Licensed Practical Nurse #1 stated that medications are to be documented as administered at the time however they did not complete their documentation until 2:10AM on 08/03/2025. During an interview on 03/19/2026 at 5:25 PM, the Director of Nursing stated that if a resident is requesting pain medication or exhibiting signs of pain, the resident should be assessed for pain at that time to determine pain level. The Director of Nursing stated that residents on routine pain monitoring should receive pain assessments/pain meds as ordered. The Director of Nursing stated that medications, including pain medication and sleep medication such as Melatonin, should be administered as ordered and within one hour before or after the scheduled time. They should not be administered late. The Director of Nursing further stated that medications are to be documented as administered at the time of administration. 10 NYCRR 415.12(c)