STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335490	A. Building B. Wing	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethel Nursing Home Company Inc	17 Narragansett Avenue Ossining, NY 10562

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that an injury of unknown origin was reported to the State Agency immediately, but not later than two hours for one of two residents (Resident #6) reviewed for injury of unknown origin. Specifically, on 08-30-2025 Resident #6 was transferred to the hospital after they complained of right hip pain with right leg swelling and abduction of the right knee. On 08-31-2025 at 2:26 AM the facility was made aware that Resident #6 was diagnosed with a right hip fracture. The State Agency was not notified until 09-01-2025 at 1:19 PM. The findings include: Resident #6 had diagnoses including dementia, osteoporosis, and anxiety. The quarterly Minimum Data Set (assessment tool) dated 06-27-2025 documented Resident #6 had severe cognitive impairment and was dependent on staff for daily living activities. The Incident Report dated 08-30-2025 at 9:30 PM documented Resident #6 complained of right hip pain while being repositioned in a wheelchair and continued to complain of pain. The report documented that the resident was guarding the right hip, and the physician was notified. An order was obtained for radiographic imaging of the right hip to rule out a fracture. The resident was later observed with swelling of the right thigh and the right knee adducted (turned inward toward the body). The physician was notified and ordered transfer to the hospital for further evaluation. The investigation revealed no evidence to support abuse. The Nursing Progress Note dated 08-31-2025 at 2:26 AM documented that the resident was admitted to the hospital with a right hip fracture. The Incident Report submitted to the State Agency on 09-01-2025 at 1:19 PM documented that the allegation type was injury of unknown source. The report documented. Resident #6 complained of pain during the day shift. Acetaminophen was administered, and the physician was notified. The report documented radiographic imaging was ordered. During the evening shift, the resident continued to complain of pain. The physician was notified again and ordered transfer to the hospital for further evaluation. The report documented follow-up communication with the hospital, which confirmed the resident sustained a right distal femur fracture. During an interview on 06-18-2026 at 9:37 AM, the Administrator stated that the facility received notification from the hospital on [DATE] at 2:26 AM that Resident #6 had sustained a fracture. The Administrator stated they were responsible for reporting incidents to the State Agency. The Administrator stated the incident was not reported within the required two-hour timeframe. They stated the report submitted on 09-01-2025 at 1:19 PM was late. 10 New York Code Rules Regulations 415.4(b)(2)

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure that a thorough and/or accurate investigation was conducted for one of one resident (Resident #51) reviewed for abuse. Specifically, the Investigative Summary statement from Registered Nurse Supervisor #11 documented the wrong incident date and incorrect initials for Certified Nurse Aide #4 after Resident #51 called 911 on 05/01/2026 and accused staff of abuse.The findings include:The policy titled Abuse Prevention and Reporting last reviewed 3/2026 documented that any employee or volunteer that suspects hears about or witness's resident abuse, neglect or misappropriation of resident's property must complete an Accident/Incident Report.Resident #51 was admitted to facility with diagnoses of vascular dementia, anxiety and depression. The 4/29/2026 Baseline Care Plan for behavior documented that the resident had a history of trauma. Assist of one for bowel and bladder care, assist of one for transfer.The 5-day Minimum Data Set (an assessment tool) dated 5/01/2026, documented that Resident #51 had intact cognition, and required substantial to maximal assist for toileting and transfer. The undated and unsigned Investigative Summary documented incident occurred 04/30/2026. On 04/30/2026 at approximately 4 PM the assigned Certified Nurse Aide #4 saw Resident #51 inside another resident room wheeling towards the bed. A resident in that room was also assigned to the same aide as Resident #51. The aide explained that this was not Resident #51's room and the resident became upset when the aide attempted to help Resident #51 to return to their room. On 05/01/2026 at 9:30 AM it was reported to the Administrator and Minimum Data Set Coordinator that the resident called 911 (police) accusing staff of abuse. Two police officers arrived at approximately 9:30 AM and talked to the resident. According to the Registered Nurse Supervisor, police stated that the resident was not able to state as to when, who and how abuse occurred so the two police officers left. The Administrator called the Registered Nurse Supervisor at approximately 7:15 AM and asked they not assign the same aide that the resident had on 04/30/2026 due to allegations and until an investigation was completed. The Conclusion documented Resident #51 was noted to have intermittent confusion and noted to have emotional lability thus showing on and off agitation and refusal of care which is most likely secondary to her diagnosis of Alzheimer's and vascular dementia. Resident somehow wheeled themself to room thinking it was their room which is in the exact same placement of their room but in a different hallway. The resident became upset when the aide explained about the room to them. The resident may have interpreted it as the aide not wanting to care for resident. The smell of feces was only evident when the occupational therapist was talking to Resident #51, and they agreed to be toileted Allegation of abuse was not substantiated. Registered Nurse Supervisor #11 statement documented the wrong incident date (04/03/2026) and incorrect initials for Certified Nurse Aide #4.During an interview on 06/17/2026 at 11:31 AM, The Interim Director of Nursing stated that it was the responsibility of the Administrator and Director of Nursing to review Accident/Incident Summaries and ensure they were accurate. They further stated when the Administrator and Interim Director of Nursing reviewed Registered Nurse Supervisor #11's statement, they must have overlooked the errors.During an interview on 6/18/2026 at 11:27 AM, The Administrator stated it was the responsibility of the Director of Nursing and Administrator to review the Investigative Summary for accuracy. 10 New [NAME] Code Rules and Regulations 415.3(b)(1-8)

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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 interview and record review the facility failed to ensure that the resident environment remains as free of accident hazards as is possible and/or that each resident receives adequate supervision to prevent accidents for one of two residents (Resident #1) reviewed for accidents. Specifically, the comprehensive Care Plan did not include interventions to address supervision for Resident #1 who was assessed as at risk for elopement, was able to remove their wander guard and exit the building unsupervised on the morning of 06/22/2025. Additionally, there was no consistent documented evidence that every 15-minute monitoring x 48 hours was implemented as per the comprehensive Care Plan after Resident #1eloped on 06/22/2025. The Findings are:The Policy and Procedure for elopement prevention and follow up procedures last revised 11/22/2022 documented in the staff responsibilities: Staff who are assigned the responsibility of resident care must maintain constant awareness of the whereabouts of the resident(s) assigned to them. All facility staff must be alert to wandering residents and aware of which residents are potential elopement risks at all times.Resident #1 had diagnoses including but not limited to Schizophrenia, mild cognitive impairment, and adult failure to thrive.The Physician Order dated 08/20/2024 documented use wander guard -on right wrist. Check every shift for placement.The Care Plan for risk for elopement dated 08/20/2024 documented new wander-guard system installed. Use wander-guard/location monitor daily. Wander-guard placed on left wrist. Avoid possible triggering events, elopement assessment, provide emotional support and refer to psychologist. There was no documented evidence in the risk for elopement Care Plan to address supervision of Resident #1. The quarterly Minimum Data Set, dated [DATE] documented Resident #1 had moderately impaired cognition, no behaviors, received antipsychotic medications, and had a daily wander/elopement alarm.The 05/13/2025 Elopement Assessment documented Resident #1 was an elopement risk.The Incident and Accident Report dated 06/22/2025 at 07:25 AM signed by Registered Nurse Supervisor # 3 documented during rounds Resident #1 was not in their room, a search was conducted and Resident # 1 was found outside the building. Resident #1 was brought back to the unit, upon assessment no injuries found and resident denies pain. Resident removed the wander guard.The Incident and Accident Statement dated 06/22/2025 written by the Minimum Data Set Nurse documented that during an interview Resident #1 revealed to them that they removed the wander guard and placed it inside the drawer. The resident stated they can't get in the elevator to go down. It further documented that the clip to the wander guard was missing.The Incident and Accident Summary dated 06/22/2025 documented the resident's care plan was reviewed with new interventions implemented when appropriate. It documented the Certified Nurse Aide Accountability Record was revised. The recommendation of Interdisciplinary team concluded the probability that a medical device contributed to this occurrence is due to resident's removal of the wander guard bracelet. It further documented to monitor the care plan schedule and keep the resident in view of staff as much as practicable. The Investigative Summary documented that they ruled out abuse, mistreatment or neglect regarding this incident. It documented the staff should monitor every 15 minutes, advancing to every 30 minutes to 1 hour for 48 hours.The Care Plan for elopement was updated on 06/22/2025 to include Resident #1 was placed on every 15-minute monitoring for 48 hours for safety.The Progress Note documented on 06/22/2025 at 9:37 PM Resident continued every 15-minute safety check, observed both in bed and chair. The Progress Note documented on 06/23/2025 at 3:55 AM continued 15-minute safety check, resident stayed most of the night in their room sleeping in bed. Wander guard in place on their left wrist.The Progress Note documented on 06/24/25 at 6:01 slept quietly all night, easily arousable, cheerful, pleasant, took medication, guard in place, comfortable.During interview on 06/17/2026 at 12:40 PM, Resident #1 Health Care Proxy stated the wander guard was put on shortly after Resident #1 was admitted to facility. They stated the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident was forgetful and would walk out of their own residence. They stated the resident wandered out of facility, last year. They further stated they told Resident #1 they were going to stop by on that day and that may have triggered the resident to look for them outside. They were called by facility to inform them Resident #1 was found in parking lot in the morning a little after 8 AM. The Health Care Proxy stated Resident #1 had a wander guard and somehow, they removed it. The Health Care Proxy stated the wander guard has not been off again since the incident, and it functions properly.During interview on 06/17/2026 at 2:00 PM, the Minimum Data Set Nurse stated they joined in the search after they were alerted by Certified Nurse Aide #6 that Resident #1 was missing. They stated Resident #1 was discovered in the parking lot. They stated that it was the first time Resident #1 eloped. They stated they interviewed Resident #1 and was told they removed the wander guard and placed it in the drawer. They stated when located in the drawer the clip was observed to be broken. They further stated the elevator prevented elopement by not opening when a Resident with a wander guard attempted to enter the elevator. During interview on 06/18/2026 at 11:58 AM, Registered Nurse Supervisor #3 stated on 06/22/2026 they arrived late (07:20 AM) for their shift. They stated as they conducted rounds, they discovered Resident #1 was not in their room. Registered Nurse Supervisor #3 stated they called Registered Nurse Supervisor #13 who worked the night shift and was told Resident #1 was in front of the nursing station at the end of their shift. Registered Nurse #3 stated certified nurse aides performed a building search and Certified Nursing Assistant #6 later reported Resident #1 was discovered in the parking lot, in front of the facility. Registered Nurse Supervisor #3 stated the Health Care Proxy told them Resident #1 may have been triggered to go downstairs to look for them since they told Resident #1, they would be picking them up to take them to the store on that day. During a follow-up interview on 06/18/2026 at 12:45 PM, Registered Nurse Supervisor #3 stated after the elopement Resident #1 was observed frequently during the shift, about every fifteen minutes. During an interview on 6/18/2026 at 1:42 PM the Administrator stated they understood when Resident #1 was found the wander guard was off their wrist because Resident #1 took it off. The Administrator stated they found the wander guard in the drawer, and it was put back on Resident #1. During an interview on 6/18/2026 at 3:40 PM, the Minimum Data Set Nurse stated 15-minute monitoring was put in place right away and may have been ongoing for 2-3 days. They stated the physician was made aware, but they did not feel they needed a physician's order for monitoring They stated they were unsure of the policy. They stated the monitoring was put in place to ensure Resident #1 was in the building and safe. The Minimum Data Set Nurse stated they could not tell if consistent monitoring was done because they did not have the monitoring sheets.10 New York Code Rules and Regulations 415.12(h)(2)