STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335526	A. Building B. Wing	07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Rehabilitation and Nursing Center	120 Highland Avenue Middletown, NY 10940

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews during recertification and abbreviated (NY00374708) surveys conducted from 6/25/2025-7/03/2025, the facility did not ensure residents had the right to receive visitors of their choosing at the time of their choosing for 1 of 2 residents (Resident #25) reviewed for choices. Specifically, the facility restricted Resident #25's friend's visitation based on the resident's family member and the Administrator's wishes.Findings include: The facility policy, Resident Visitation, dated 5/2017, last reviewed 2/2025 documented all residents have the right to receive visitors of his or her own choosing at the time of his or her own choosing, subject to the residents right to deny visitation, and in a manner that does not impose on the rights of another resident. Supervised visits will depend on each residents' individual needs, safety, & issues (concern) at the time decisions are made. Resident #25 had diagnoses including adult failure to thrive, hypertension and interstitial lung disease. The Social Work Director note dated 2/18/25 documented that the Administrator and social worker contacted Residents #25's friend because the residents' family member requested visitation limitations due to variety of reasons regarding the residents' finances. The friend was informed of the visitation limitations and did not express any issues and/or concerns at this time.The Social Work Director note dated 3/24/25 documented staff received a call from the resident's family member regarding the resident's friend using the resident's debit card. The family member stated the friend was a [NAME] and Resident #25 was not in the right mind to let someone use their money. The 3/31/2025 quarterly Minimum Data Set (assessment tool) documented the resident had severely impaired cognition. The Psychiatric notes dated 4/09/2025 and 4/23/2025 documented the resident was alert, able to focus and answer questions appropriate, had a confused thought process, fair judgement, fair insight, and fair impulse control.On 5/13/2025, a New York Supreme Court judge ordered that a temporary guardian be appointed over Resident #25, pursuant to Mental Hygiene Law 81.21 through a petition filed by the Social Worker Director and the facility. The temporary guardian was ordered to take all steps to insure the safeguarding of the accounts, personal property, and assets of Resident #25. In addition, the temporary guardian was ordered to determine who shall provide personal care and assistance to Resident #25 including aides, nurses and other health care providers.On 6/30/25 at 9:45 AM, Resident #25 stated during an interview they wanted to see their friend and they never said they did not want to see their friend.On 06/30/25 at 4:08 PM, the Social Work Director stated during an interview that the family member was not the health care proxy, did not have a guardianship or hold a power of attorney.On 7/01/25 at 11:09 AM, Licensed Practical Nurse #20 stated during an interview that Resident #25 was a pleasant person and had issues with their friend visiting. Licensed Practical Nurse #20 stated that sometime 2-3 months ago, Resident #25 told them they wanted their friend to visit. There was drama between the friend, Resident #25's family member and the facility. They stated Resident #25 told them that their family member says the friend cannot visit here. On 7/02/25 at 12:02 PM, the Administrator stated during an interview that in March 2025, Resident #25 wanted to meet with their friend and give them cash. The friend was waiting outside the facility and the Administrator restricted Resident #25 and did not allow the visit to occur. Resident #25 was unable to meet with their friend and the friend left the facility. The Administrator stated they believed Resident #25 was being taken advantage of and with their severely impaired cognition and financial concerns, put restrictions on the visits. The Administrator stated they offered supervised visits to the friend, but they did not accept. The Administrator stated they told Resident #25 about supervised visits but Resident #25 stated it was their money and they wanted to see their friend. The Administrator stated they felt it was necessary and appropriate to restrict the friend for safety of Resident #25.On 7/03/25 at 11:03 AM, Certified Nurse Aide #16 stated during an interview that Resident #25 had spoken about wanting to visit or see their friend, but the facility would not allow it. They stated Resident #25 was sad and angry about not being able to see their friend and always stated they did not know why the facility would not allow it.10 NYCRR 483.10(f)(4)

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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 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 conducted during the recertification and abbreviated (NY00354392) the facility did not ensure the resident's right to a safe, clean, comfortable environment and reasonable care for the protection of resident property from loss or theft. This was evident for 1 (Unit 2) of 2 resident units and 1 (Resident #5) of 3 residents investigated for abuse. Specifically, 1) Unit 2 was observed with peeling wallpaper, floors covered in dirt, debris, a floor mat emanating a strong odor of urine, a soiled wheelchair, and radiators throughout the unit with air vent grates and metal conductor fins heavily covered and soiled in dirt, debris, dust, and dried crusty food and liquids, and 2) Resident #5's personal food was taken and eaten by staff while being stored in the dining room refrigerator designated only for resident food. The findings are:The facility policy titled Facility Cleaning – Housekeeping dated 10/2024 documented dust mop and then wet mop floors daily using the approved diluted cleaning agent in mop water. The policy did not document a cleaning process for heat/air conditioning radiators throughout resident rooms and common areas. The facility policy titled Environmental – Room of the Day dated 2/2025 documented all resident rooms and common areas would be terminally cleaned at least monthly and resident care environments were inspected for cleanliness and safety on an ongoing basis. Housekeeping was responsible for cleaning and disinfecting all horizontal surfaces including and not limited to windowsills, sinks, and overbed tables. The facility policy titled Terminal Room Cleaning dated 3/25/2025 documented resident rooms were terminally cleaned after a resident has been discharged and during infection outbreaks. The facility policy titled Food Preparation – Food Brought by Family/Visitor dated 6/2025 documented food brought by family/visitors that is left with the resident to consume later will be labeled and stored in a manner that it is clearly distinguishable from facility-prepared food. The housekeeping staff will discard perishable foods after 72 hours. 1) From 6/25/2025 at 10:33 AM to 7/03/2025 at 12:00 PM, Unit 2 was observed with the following: - a brown dried spill stain approximately 12 inches X 12 inches on the hallway floors near the double doors at the beginning of the hallway to room [ROOM NUMBER]; - warped, sagging, and peeling wallpaper held up by tape and thumbtacks near the double doors at the beginning of hallway to room [ROOM NUMBER]; - all floor to ceiling glass balcony doors and windows in the floor dining room were covered with fingerprints, grease stains, were cloudy, dusty, and dirty; - all heating/air conditioning radiators in the dining room and hallways had air vent grates and metal conductor fins covered with dirt, grime, dust, dried food, and dried crusty liquids or varying colors; - Resident #27 had a wheelchair soiled with dried crusty food particles and dried spilled food and drink stains; (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- room [ROOM NUMBER]D contained a large floor mat at the bedside with several tears in the vinyl exposing the internal foam. The floor mat had a strong foul urine odor emanating from it that was noticeable upon entering room [ROOM NUMBER]. On 7/01/2025 at 1:03 PM, Certified Nurse Aide #38 was interviewed in room [ROOM NUMBER] and stated they did not initially notice the urine odor coming from the room because they were desensitized because they were regularly around foul odors working in the facility. Certified Nurse Aide #38 stated the foul odor was coming from 236D’s floor mat. Certified Nurse Aide #38 stated they were unaware of a cleaning schedule for floor mats, or which department was responsible for cleaning them. The housekeeping department brought the mats to the unit upon request for fall risk residents. The Certified Nurse Aide #38 stated they were unaware whether housekeeping was made aware of the floor mat odor and torn vinyl. On 7/01/2025 at 2:10 PM, Registered Nurse #17, Unit 2 Manager, was interviewed and stated they spot-checked resident wheelchairs for cleanliness and directed staff to clean the wheelchairs when soiled. Registered Nurse #17 stated they did not keep a record of when wheelchairs were cleaned. After observing Resident #27’s wheelchair, Registered Nurse #17 stated the wheelchair was noticeably soiled with food stains from previous meals and required cleaning. During an interview on 07/02/25 at 3:45 PM Interview Certified Nurse Aide #15 stated no one cleaned the wheelchairs. If they noticed something on it, they would spot clean them, otherwise no other department would clean it. On 7/03/2025 at 12:00 PM, the Facilities Director was interviewed and stated floor mats were stored with the Maintenance Department in the basement. The nursing staff were responsible for placing a request for floor mats and the Maintenance staff were responsible for delivering the mats to the unit. Mats were cleaned before being placed in resident rooms. 2) Resident #5 had diagnoses of Diabetes Mellitus and anxiety. The Quarterly Minimum Data Set 3.0 assessment dated [DATE] documented Resident #5 was cognitively intact and did not display mood or behavior symptoms. On 06/26/25 at 11:22 AM, Resident #5 was interviewed and stated they stored their personal food in a refrigerator in the floor dining room. In 9/2024, they retrieved their food from the fridge and found that part was missing. The facility investigated and informed Resident #5 a staff member was caught on camera taking the resident’s meal from the refrigerator, eating some, and then putting the bag of leftover food back into the refrigerator. The facility reimbursed Resident #5 for the expense of the meal. Resident #5 stated they experienced no further personal food storage concerns since 9/2024. The facility Summary of Investigation dated 9/13/2024 documented Resident #5 reported an allegation of misappropriation of property. Licensed Practical Nurse #7’s statement documented Resident #5 reported to them that they placed a bag of food in the dining room refrigerator on 9/11/2024 and not all their food was there when the resident went to retrieve it on 9/12/2024. The Registered Nurse statement documented they observed a staff member on surveillance camera on 9/12/204 at 1 AM removing Resident #5’s bag of food from the dining room refrigerator, eating a portion of the food inside the bag, and then returning the bag to the refrigerator. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A facility Memorandum dated 9/12/2024 documented all staff were reminded that refrigerators in floor dining rooms were for dietary and resident use only. Staff were to use the refrigerator in the staff lunchroom. Staff removal or consumption of resident food items was considered misappropriation of the resident’s personal property. Violators will be terminated from employment. A sign-in sheet documented Licensed Practical Nurse #7’s signature along with 19 other nursing staff. The Nursing Home Facility Incident Report Submission completed by the facility Administrator and dated 9/14/2024 at 10:34 PM documented the facility attempted to obtain Certified Nurse Aide #33’s statement on 9/13/2025 and the aide decided to resign effective immediately from facility employment. The facility documented Resident #5 did experience misappropriation of property. On 6/27/2025 at 12:06 PM, the unit dining room refrigerator was observed with a combination lock on the outside of the door that was disengaged and unlocked. The refrigerator was opened with Licensed Practical Nurse #36 present and an unlabeled, undated navy-blue canvas lunch bag and black plastic bag were observed on the door. The refrigerator door also contained an undated bottle of sweet Vidalia onion salad dressing labeled with Licensed Practical Nurse #7’s name. Licensed Practical Nurse #36 was interviewed at the time and stated neither bag was labeled with a date or name, and they did not know who they belonged to or how long they were in the refrigerator. Licensed Practical Nurse #36 stated staff were provided with inservice a few months ago and were reminded that no staff food was to be kept in the dining room refrigerators and any refrigerator food items must be labeled and dated. Licensed Practical Nurse #36 removed the black plastic bag from the refrigerator, opened it, and removed a large round unlabeled, undated plastic container filled with cooked pasta. Licensed Practical Nurse #36 stated the pasta possible belonged to Resident #5 but since there was no date or name, the container would be discarded. During the same observation, Licensed Practical Nurse #7 observed the refrigerator and confirmed the salad dressing was theirs. Licensed Practical Nurse #7 was interviewed and stated no staff food items should be in the dining room refrigerator and the facility had a staff lunchroom with refrigerator on the ground floor. Licensed Practical Nurse #7 stated all items should be labeled and dated and resident’s personal food was only kept for 3 days before being discarded. The dietary staff were responsible for checking and maintaining the dining room refrigerator. Licensed Practical Nurse #7 stated they did not place their salad dressing in the refrigerator and denied placing it there. Licensed Practical Nurse #7 the removed the navy-blue canvas lunch bag from the refrigerator and removed its contents – a moldy and rotted baby carrot and fuzzy, mold-covered plastic fork inside a plastic lunch container and a small round clear plastic container with a creamy white substance. Licensed Practical Nurse #7 opened the round clear plastic container, and a strong putrid, sour, foul odor emanated from the contents. The food contents were unidentifiable and was covered in white and black mold. License Practical Nurse #7 stated they were unable to identify what the substance was or who it belonged to but the navy-blue bag and its contents and the salad dressing would both be discarded. On 7/01/2025 at 1:31 PM, Certified Nurse Aide #34 was interviewed and stated they recalled receiving inservice a few months ago regarding the dining room refrigerators. Staff stored their personal food items in the staff refrigerator and the dining room refrigerators were only for resident food items. 10 NYCRR 415.5(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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. (continued on next page)

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review conducted during the recertification and abbreviated (NY00354392) surveys from 6/25/2025 to 7/3/2025, the facility did not ensure a resident's right to be free from misappropriation of property. This was evident for 1 (Resident #5) of 3 residents investigated for abuse. Specifically, Resident #5's personal food was not stored safely and was eaten by staff, and facility staff diverted Resident #5's income directly to the facility without the resident's consent or knowledge. The findings are:The facility policy titled Abuse Prevention dated 5/23/2023 documented examples of misappropriation of resident property included identity theft, theft of money from bank accounts, and unauthorized or coerced purchases from resident's funds. The facility policy titled Food Preparation - Food Brought by Family/Visitor dated 6/2025 documented food brought by family/visitors that is left with the resident to consume later will be labeled and stored in a manner that it is clearly distinguishable from facility-prepared food. The housekeeping staff will discard perishable foods after 72 hours. A sample of the facility's current admission Agreement documented the facility provided reasonable security and locked storage upon request for resident personal property. The facility can only insure (to a maximum of $100) against the loss of valuable items if deposited with management (this limitation does not include the facilities management of resident funds).Resident #5 had diagnoses of Diabetes Mellitus and anxiety. The Quarterly Minimum Data Set 3.0 assessment dated [DATE] documented Resident #5 was cognitively intact and did not display mood or behavior symptoms.On 06/26/25 at 11:22 AM, Resident #5 was interviewed and stated they stored their personal food in a refrigerator in the floor dining room. In 9/2024, they retrieved their food from the fridge and found that part was missing. The facility investigated and informed Resident #5 a staff member was caught on camera taking the resident's meal from the refrigerator, eating some, and then putting the bag of leftover food back into the refrigerator. The facility reimbursed Resident #5 for the expense of the meal. Resident #5 stated they experienced no further personal food storage concerns since 9/2024. 6/25/2025 at 12:43 PM, Resident #5 was interviewed and stated the facility took their monthly income check without their consent or knowledge. Resident #5 stated they did not receive a 6/2025 deposit into their personal bank account as they normally did every preceding month since their admission to the facility. Resident #5 and their Representative spoke with the Finance Coordinator and was informed their monthly income check had been diverted to the facility's bank account because Resident #5 owed money to the facility. Resident #5 stated the Finance Coordinator reported that the Former Finance Coordinators took control of their income and made the changes. Resident #5 stated they were distrustful of the facility and was upset and frustrated by the situation because the Finance Coordinator told them there was nothing that could be done to address their concerns because the Former Finance Coordinator stopped working for the facility 2 months ago. Resident #5 stated the facility made no effort to inform them of monies owed, offer a payment plan, discuss other options, obtain their consent to make changes to their monthly income, and inform them after changes were made. The Comprehensive Care Plan related to psychosocial wellbeing was initiated 5/20/2025 and documented Resident #5 was at risk for a psychosocial wellbeing problem and interventions included increasing communication between resident and caregivers about care and living environment. The Comprehensive Care Plan related to mood initiated 6/11/2020 documented staff were to identify and reinforce Resident #5's strengths and positive coping skills.The facility Summary of Investigation dated 9/13/2024 documented Resident #5 reported an allegation of misappropriation of property. Licensed Practical Nurse #7's statement documented Resident #5 reported to them that they placed a bag of food in the dining room refrigerator on 9/11/2024 and not all their food was there when the resident went to retrieve it on 9/12/2024. The Registered Nurse statement documented they observed a staff member on surveillance camera on 9/12/204 at 1 AM removing Resident #5's bag of food from the dining room refrigerator, eating a portion of the food inside the bag, and then returning the bag to the refrigerator. A facility Memorandum dated 9/12/2024 documented all staff were reminded that refrigerators in floor dining rooms were for dietary and resident use only. Staff were to use the refrigerator in the staff lunchroom. Staff removal or consumption of resident food items was considered misappropriation of the resident's personal property. Violators will be terminated from employment. A sign-in sheet documented Licensed Practical Nurse #7's signature along with 19 other nursing staff. The Nursing Home Facility Incident Report Submission completed by the facility Administrator and dated 9/14/2024 at 10:34 PM documented the facility attempted to obtain Certified Nurse

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review conducted during the recertification and abbreviated (NY00356178) surveys conducted from 6/25/25 - 7/3/25, the facility did not ensure that Comprehensive Care Plans were reviewed and/or revised for 1 of 5 residents (Resident #345) reviewed for Accidents and 1 of 3 residents (Resident #363) reviewed for Abuse Specifically, 1. for Resident #345, there was no documented evidence the comprehensive care plan was reviewed and/or revised after a 6/22/25 fall and 2. there was no documented evidence comprehensive care plans were reviewed and/or revised to address Resident # 363's ongoing behaviors after 9/8/24, 9/12/24 and 9/22/24 episodes of physical and/or verbal aggression. The findings included:1. Resident #345's diagnoses included end stage renal disease, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, and long-term use of opioid analgesic. A care plan titled Activities of Daily Living, dated 6/17/25, documented the resident has a performance deficit and decline in physical mobility related to hemiplegia and pain. Resident requires limited assist of one staff for locomotion and toileting and transfers.A care plan titled Resident is a Risk for Falls, dated 6/17/25, documented the resident is at risk for falls (score 13) related to deconditioning, gait / balance problems, left leg bypass graft. Interventions included to anticipate and meet the resident's needs, educate the resident /family/caregiver about safety reminders and what to do if a fall occurs, and ensure the call bell is within reach. The five-day entry Minimum Data Set (a resident assessment tool) dated 6/22/25 documented Resident #345 was cognitively intact, ambulated by wheelchair, required partial to moderate assistance with toileting and transfers, and had prescribed pain medication for 10/10 pain, An Accident and Incident Report dated 6/22/25 documented the resident was last seen three minutes prior to heading to the restroom. Emergency bell heard. Upon entering the resident room, bathroom door was observed locked from the inside. Door was unlocked and resident was found on the floor with back against the toilet bowl complaining of right elbow and shoulder pain. Resident stated they slipped and hit right elbow against the wheelchair trying to transfer to the toilet. On-Call Physician notified, and X-ray of the right shoulder and elbow ordered. Resident not taken to hospital. No injuries observed at time of incident. There was no documented evidence that the care plan was reviewed and/or revised after a 6/22/25 fall. During an interview on 07/02/25 at 11:55 AM, the Director of Nursing stated resident care plans should be updated immediately after an incident and investigation. The Director of Nursing stated the Fall Care Plan was not updated to include the fall and did not include new interventions. They stated the Unit Manager, or any Registered Nurse staff, should have updated the care plan status post fall. During an interview on 07/02/25 at 01:23 PM, Registered Nurse Unit Manager #5 stated they were aware of a recent fall Resident #345 had in the bathroom. They stated the fall was not reported directly to them as they were just starting position in facility. They stated they did not update the care plan. They stated the Director of Nursing or Assistant Director of Nursing would have been responsible for updating the resident care plan. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #363 had diagnosis of Cerebral Infarction (stroke).The Comprehensive Care Plan initiated 11/27/23 documented Resident #363 is/has potential to be verbally aggressive related to dementia, ineffective coping skills, and poor impulse control and has impaired cognitive function/dementia or impaired thought processes. When the resident becomes agitated, intervene before agitation escalates and 7/10/24 observe around others and when the resident becomes agitated, intervene before agitation escalates.The Quarterly Minimum Data Set assessment dated [DATE] documented Resident #363 had moderate cognitive impairment.A Nurse Progress note dated 9/08/24 documented Resident #363 was observed going into other residents' room by the activities staff. The Nurse encouraged Resident #363 to leave the other resident's room. Resident #363 stated they could do what they wanted. Resident #363 became agitated in the hallway and threw their cup at the nurses and punched a nurse in the side. The nurse encouraged Resident #363 to keep their hands to themselves.A Nurse Progress note dated 9/12/24 documented Resident #363 was yelling at nurses and tried to hit a nurse with a hanger.A Nurse Progress note dated 9/20/24 documented Resident #363 was moved to room [ROOM NUMBER].A Nurse Progress note dated 9/22/24 documented Resident #363 became agitated and threw their breakfast tray when yelling at staff. Resident #363 was yelling, cursing, and throwing things around the room.There was no documented evidence that care plans were reviewed and/or revised to address Resident # 363's ongoing behaviors after the 9/8/24, 9/12/24 and 9/22/24 episodes of physical and/or verbal aggression. 10 NYCRR 415.11(c)(2)(i-iii)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review conducted during the recertification survey from 6/25/2025 to 7/3/2025, the facility did not ensure residents unable to carry out activities of daily living received necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This was evident for 3 (Resident #54, #19, and #27) of 4 residents reviewed for activities of daily living. Specifically, 1) Resident #54 was observed with long, jagged, brown and yellow nails, 2) Resident #19 was observed in bed on multiple occasions and there was no evidence the resident was provided with the assistance to transfer out of bed to their wheelchair, and 3) Resident #27 was observed with long, jagged fingernails covered with brown crusty stains. The findings are: The facility policy titled Activities of Daily Living, Range of Motion, and Mobility dated 3/1/2025 documented care and services would be provided to maintain a resident’s current activity of daily living status based on the resident’s needs and choices. Care and services included hygiene, mobility, and transfers. 1) Resident #19 had diagnoses of Alzheimer's disease and history of right leg deep vein thrombosis. The Significant Change Minimum Data Set 3.0 assessment dated [DATE] documented Resident #19 was severely cognitively impaired, required supervision with eating, was totally dependent on staff assistance for transfers in and out of bed, and enjoyed doing things with groups of people. On 6/26/2025 at 10:08 AM, Resident #19’s Representative was interviewed and stated staff used to transfer Resident #19 out of bed to eat in the dining room and participate in group activities in the floor day room . The Representative stated staff have not taken Resident #19 out of bed in recent times, and they have not seen the resident out of bed the last several times they visited the facility. On 6/25/2025 at 11:23 AM, 6/26/2025 at 10:47 AM, 11:22 AM, and 12:17 PM, and 7/01/2025 at 12:07 PM, Resident #19 was observed lying in bed in their room. A wheelchair labeled with Resident #19’s name was observed in the resident’s shared bathroom behind a closed door. There were no observations of Resident #19 receiving the necessary assistance for staff to be transferred out of bed to their wheelchair. The Comprehensive Care Plan related to activities of daily living initiated 6/22/2020 and last reviewed 6/22/2025, documented Resident #19 had a history of right leg deep vein thrombosis (blood clot) and was totally dependent on 2 staff members and a mechanical lift for transfers out of bed. The Comprehensive Care Plan related to nutrition, initiated 6/22/2020 and last reviewed 3/10/2025, documented Resident #19 was at risk for malnutrition and dehydration. Interventions included Resident #19 would eat 2 of 3 meals in the common area. The care plan documented Resident #19 did not respond well eating in room - isolation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335526	A. Building B. Wing	07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Rehabilitation and Nursing Center	120 Highland Avenue Middletown, NY 10940

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Comprehensive Care Plan related to risk for falls initiated 6/22/2020 documented Resident #19 be encouraged to participate in activities that promote exercise and physical activity. The care plan was revised on 4/9/2022 and documented Resident #19 would be changed by the day shift in the afternoon and left in the common area for close supervision. The Baseline Care Plan dated 3/13/2025 documented Resident #19 ate their meals in the dining room. The Wound Doctor Note dated 6/18/2025 documented recommendations for Resident #19 to be out of bed for limited intervals of time, alternating activity to minimize pressure. The Bedside Kardex as of 6/30/2025 documented Resident #19 was dependent on 2 staff and mechanical lift for transfers, should be offered an out of bed nap after breakfast if sleepy, would eat 2 of 3 daily meals in the common area for a more enjoyable meal experience, should participate in activities that promote physical activity and exercise for strengthening and mobility. On 7/01/2025 at 11:25 AM, Licensed Practical Nurse #7 was interviewed and stated Wound Nurse Practitioner recommendations were reviewed by a licensed nurse and communicated to the Medical Doctor responsible for prescribing a resident’s treatment orders. Licensed Practical Nurse #7 stated nursing staff tried to get Resident #19 out of bed when possible but there was no set out-of-bed schedule or instructions for staff to follow. On 7/01/2025 at 1:17 PM, Certified Nurse Aide #6, assigned to Resident #19, was interviewed and stated the unit’s get-up schedule was changed several months ago to make the Certified Nurse Aide assignments more manageable. Resident #19 used to get out of bed and before the get-up schedule was changed. Certified Nurse Aide #6 stated unit nursing staff determined Resident #19 did not try to climb out of bed and did not require assistance with eating, so they were not a candidate to be on the list to come out of bed. 2) Resident #54 had diagnoses of dementia, failure to thrive, gastrostomy status. The Annual Minimum Data Set 3.0 assessment dated [DATE] documented Resident #54 was severely cognitively impaired and required assistance from staff to perform personal hygiene and grooming. The Comprehensive Care Plan related to activities of daily living initiated 1/27/2021 and last reviewed 7/30/2024 documented Resident #54 was dependent on staff to perform personal hygiene The Comprehensive Care Plan related to potential skin impairment was initiated 3/3/2021 documented Resident #54’s fingernails should be clipped, filed, and maintained. The care plan was revised and documented Resident #54 had a skin tear to their left arm on 4/7/2025 and open purpura to their left upper arm on 6/19/2025. On 7/01/2025 at 2:40 PM, Resident #54 was observed in a recliner in their room and 10 of 10 fingers were observed with long fingernails [NAME] past the tips of their fingers. Resident #54’s fingernails were stained yellow and brown, were cracked, broken, uneven, and jagged at the edges. Nail clippers were observed in the drawer to Resident #54’s bedside dresser. At 2:44 PM, Licensed Practical Nurse #37 entered the room and administered medication to Resident #54. Licensed Practical Nurse #37 did not address Resident #54’s fingernails. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/01/2025 at 3:08 PM, Certified Nurse Aide #38 was interviewed and stated they were assigned to Resident #54 and were responsible for assisting Resident #54 who was totally dependent on staff for personal hygiene, grooming, and nail care. Resident #54 had fragile skin and was risk for scratching themselves with their own nails. Certified Nurse Aide #38 stated they developed a routine of providing their assigned residents nail care every Friday. Certified Nurse Aide #38 stated they were unsure what he facility’s policy on providing resident nail care was and it was their decision to only cut resident’s nails on Friday. Certified Nurse Aide #38 observed Resident #54’s fingernails and stated they were too long because they had grown past the tips of Resident #54’s fingers. Certified Nurse #38 stated they did observe Resident #54’s nails to be long during their rounds earlier today but it was not the designated nail day – Friday. Certified Nurse Aide #38 stated they did not cut Resident #54’s nails last Friday because they floated their assignment and was not assigned to Resident #54 last Friday. 3) Resident #27 was admitted with diagnoses including Chronic Obstructive Pulmonary Disease, Major Depressive Disorder. The 4/29/25 quarterly Minimum Data Set assessment documented Resident #27 had severely impaired cognition and was dependent on staff for assistance with activities of daily living.The 4/4/25 Activities of Daily Living, self-care deficit Care Plan documented Resident #27 required extensive assist of one staff with personal hygiene and oral care.The Kardex documented showers are given on Mondays and Thursdays and the resident requires extensive assistance of one staff with showering twice a week. During an observation on 06/25/25 at 12:46 PM the resident was observed with brown substance on nails and were dirty while eating lunch. During an observation on 06/25/25 at 03:26 PM the resident was noted to have dirty fingernails caked with old food and brown substance.During an observation on 06/26/25 at12:24 PM the resident was feeding themself a peanut butter and jelly sandwich and dirty nails with dried brown substance were visible.During an interview on 07/02/25 at 3:45 PM Nurse Aid #15 was asked about Resident #27's dirty nails and they stated they have seen the dirty nails but has not tried to clean them and stated the resident often gets their hands into a lot of food and bowel movements but it is a good idea though. During an interview on 07/02/25 at 5:14 PM with Certified Nurse Aid #21 they stated the nails are done with activities sometimes and they come and clean them. Otherwise on shower day the water will run over the hands and whoever is doing the shower will clean them with a washcloth. They stated they do not know why they are dirty but should be cleaned.During an interview on 07/02/25 at 5:18 PM Registered Nurse #22 stated the Certified Nurse Aids will let the nurses know when there are dirty nails. During evening cares they will also make sure the residents hands were washed properly. Sometimes it can be a struggle to get them done but needs to be done, must be done. All say nails need to always be clean especially if the resident is eating with their hands. Nurses are supposed to make sure nails are clean. The process is nails are checked on shower days and a skin check is done by nurses. The nail assessments are part of the skin assessment. Registered Nurse#22 stated nurses are responsible to make sure the skin, hair and nails look clean after shower. During an interview on 07/03/25 at 10:12 AM Licensed Practical Nurse Unit Manager #17 stated they do not know why skin checks and nails were not done on the shower day but if it had the nails would have been addresses sooner as it is part of care. 10 NYCRR 415.12(a)(3)

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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 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. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews conducted during the recertification and abbreviated surveys (NY00372410), the facility did not ensure each resident received adequate supervision consistent with resident's needs to prevent accidents. This was evident for 1 of 5 residents (Resident #67) reviewed for accidents. Specifically, Resident #67 was assessed to be at high risk for falls, had multiple unwitnessed falls and complete investigations were not done to determine the root cause and/or add interventions to protect the resident. The findings included:The facility policy titled, Falls, and Fall Risk Managing Fall, last reviewed 3/25, documented: Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. If falling recurs despite initial interventions, staff will implement additional or different interventions or indicate why the current approach remains relevant. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions.Resident #67 was admitted [DATE] with diagnoses including dementia with other behavioral disturbances, encephalopathy (disease, damage, or malfunction of the brain that results in impaired brain function), repeated falls, and fracture of femur (thigh bone) following insertion of orthopedic implant. The admission Minimum Data Set (a resident assessment tool) dated 12/8/24 documented Resident #67 was moderately cognitively impaired, used a wheelchair, required substantial/maximal assistance with transfers and toileting, and had a fracture related to a fall in the six months prior to admission. A fall risk assessment dated [DATE] documented Resident #67 had one to two falls in last three months, was chairbound and had gait/balance problem while walking. The falls risk score was 15.0, indicating Resident #67 was a moderate fall risk. A Resident care plan dated 12/3/24 documented at risk for falls related to poor safely awareness. The goal was to be free of falls and interventions included to assist resident with ambulation and transfers, utilizing therapy recommendations, determine resident's ability to transfer, ensure bed is kept in lowest position, ensure call light is available to resident. Evaluate fall risk on admission and as needed. Evaluate resident's environment to identify factors known to increase risk of falls. If fall occurs, alert provider. If resident is a fall risk, initiate fall risk precautions. Utilize devices as appropriate to ensure safety (ie. bed mats, sensor alarms).The Accident and Incident reported dated 12/18/24 documented Resident #67 had an unwitnessed fall at 3:45 PM. Resident #67 was observed on the floor in their room with a laceration above their left eye. Resident #67 was transferred to hospital. The Post Fall evaluation dated 12/18/24 documented floor mats were not in place at time of fall. Contributing factors documented the resident had poor safety awareness, was oblivious to needs and safety, and on the floor at the foot of bed. A hospital Discharge summary dated [DATE] documented Resident #67 was admitted [DATE], discharged [DATE] and treated for a subdural hematoma (brain bleed) and closed fracture of right hip/displaced fracture of right femoral neck. Nursing progress notes dated 12/27/24 documented the resident returned from the hospital. The Fall Risk Evaluation documented a score of 24 indicating the resident was at high risk for falls. A Social Service note dated 12/27/24 at 1:29 PM, documented they met with the resident's representative and the representative requested the resident's bed be lowered and pats put on the floor. Made request to the Director of Nursing. A licensed practical nurse nursing note dated 2/6/25 at 12:47 PM, documented Resident #67 was observed on the floor in sitting position in the dining room at approximately 11:00 AM and the supervisor was notified. The Nurse Practitioner conducted an examination and ordered the resident's immediate transport to the emergency room for evaluation. Review of the resident's record revealed no documented evidence an accident/incident report or investigation was completed for the 2/6/24 fall at 11:00 AM.The licensed practical nurse's nursing note dated 02/06/2025 at 11:00 PM documented Resident #67 returned from hospital via ambulance at 6:15 PM. Resident #67 continued to be verbally disruptive and at 6:50 PM, was observed on the floor in resident room in sitting position at the bedside. The Supervisor was informed.The registered nurse's nursing note dated 02/07/2025 at 3:22 AM documented the resident arrived back on unit around 6:15 PM from the hospital and was placed in bed where resident was relaxing. At 6:50 PM, the resident was observed sitting on the floor at bedside. The resident could not explain what happened due to baseline confusion. On assessment, he had neither visible injury nor change in range