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	02/06/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews conducted during a Survey (2566010), the facility did not ensure that the resident's family representative was notified of a change in condition for one (Resident #1) of three(3) residents reviewed for notification of changes in condition for end of life care. Specifically, from [DATE] through [DATE], Resident #1 was prescribed Tramadol 50 mg for pain management. On [DATE], Tramadol was discontinued, and Resident #1 was prescribed morphine 5 mg every 6 hours as needed for pain and end-of-life care. On [DATE], the resident's morphine dosage was increased to 10 mg every 3 hours as needed for pain. Review of the medical record revealed no documented evidence of communication with the resident's family representative from [DATE] through [DATE] regarding changes in the resident's treatment, medication regimen, and health status. Resident #1 representative stated in an interview that they were only notified of a decline in the residents' health/change in treatment regimen on [DATE] when they called the facility to follow up on the resident. Resident #1 expired on [DATE].The Findings are: The Facility policy titled Change in Resident Status Notification, effective [DATE], documented that the resident's attending physician, or designee and Responsible Party will be notified by the Nurse Manager/Nursing Supervisor/Designee when there is a significant change in the resident's physical, mental, or psychosocial/emotional status and in any situation which requires a change in the Resident's plan of care, medication, or treatment regimen. Resident #1 was admitted with diagnoses including dementia, cerebral infarction, and heart failure. The [DATE] Quarterly Minimum Data Set (MDS) documented that Resident #1 had severely impaired cognition. Physician orders dated [DATE] through [DATE] documented that Resident #1 was prescribed tramadol 50 milligrams by mouth every morning and every bedtime for pain for 30 days. Physician orders dated [DATE] through [DATE] documented that Resident #1 was prescribed oxycodone 5 milligrams by mouth every six hours as needed for pain. Physician orders dated [DATE] through [DATE] documented that Resident #1 was prescribed morphine sulfate 5 milligrams every six hours as needed for pain, shortness of breath, and restlessness related to end-of-life hospice care. Physician orders dated [DATE] documented that Resident #1 was prescribed morphine sulfate 10 milligrams buccally every three hours as needed for pain, shortness of breath, and restlessness related to end-of-life hospice care. Physician orders dated [DATE] documented that Resident #1 was placed on two liters of oxygen via nasal cannula for low oxygen levels. Physician orders dated [DATE] documented that Resident #1 was prescribed acetaminophen suppository 650 milligrams, insert one suppository rectally one time for fever for one day. The [DATE] at 02:26 PM nursing progress note for Resident #1 documented that the writer received a telephone call from a hospice nurse regarding the resident's condition and pain regimen. The note documented that the writer advised they would follow up with the nurse practitioner in the morning to discuss the resident's pain regimen due to increased pain noted by the hospice aide. Review of Resident #1's medical record revealed no documented evidence that the resident's family (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	representative was notified of the resident's increased pain or the discussion regarding potential changes to the pain management regimen at that time. The [DATE] at 04:24 PM nursing progress note for Resident #1 documented that Resident #1's designated family representative contacted the facility for an update and was informed of an increase in the resident's morphine dosage to address increased pain. The nursing progress notes for Resident #1 dated [DATE] at 08:47 AM documented that the resident expired, with the time of death recorded at approximately 8:09 AM. During an interview conducted on [DATE] at 12:00 PM, the Complainant stated that they were not notified when Resident #1 was started on morphine and were unaware that the resident was receiving morphine prior to [DATE]. The Complainant stated that they contacted the facility on [DATE] to follow up regarding the declination of the pneumonia vaccine, and during that call, the individual who answered the phone, whom they believed to be nursing staff, told them that Resident #1 was declining, that the resident had been in that condition for approximately one week, and that changes had been made to the resident's medication. The complainant stated that [DATE] was the first time they were informed of the resident's morphine use and changes to medication. During an interview on [DATE] at 03:34 PM, Nurse Practitioner #1 stated that family representatives are expected to be notified of changes in a resident's condition and medication regimen. Nurse Practitioner #1 stated that an increase in morphine dosage from 5 milligrams to 10 milligrams, reflects increased pain requiring additional intervention and such changes represent a significant change requiring family notification. Nurse Practitioner #1 stated that a change from lower-dose of pain management to higher-dose morphine is a significant change and that families should be notified when this occurs. During an interview on [DATE] at 01:13 PM, Licensed Practical Nurse Unit Manager #1 stated that staff are expected to document when there are significant changes in a resident's condition, including medication changes, and to notify the resident's family representative and document the notification. In the presence of the surveyor and the Director of Nursing, Licensed Practical Nurse Unit Manager #1 reviewed the progress notes for Resident #1 and was unable to identify documentation indicating that the resident's family representative had been notified of the medication changes. During an interview on [DATE] at 01:30 PM, the Director of Nursing stated that any changes in a resident's condition, including medications and health status, must be documented and that families must be notified, and that they expect all communication and changes to be documented in the progress notes. In the presence of the surveyor and Licensed Practical Nurse Unit Manager #1, the Director of Nursing reviewed the resident's progress notes and was unable to provide documented evidence that the resident's family representative had been notified of the changes. 10NYCRR 415.3

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews conducted during the Abbreviated Surveys (2566010 and 2658860), the facility did not ensure the accurate and timely completion of the admission Minimum Data Set assessment for one resident (Resident #4) of six residents reviewed. Specifically, Resident #4 was admitted to the facility on [DATE]. The federally required Comprehensive Minimum Data Set assessment, which must be completed within 14 days of admission, was not initiated as of record review conducted on 01/02/2026. The Assessment Reference Date of 12/23/2025 reflected that the Comprehensive Minimum Data Set assessment was overdue by 10 days at that time. Upon revisit on 01/27/2026, record review revealed that the Comprehensive Minimum Data Set assessment associated with the same Assessment Reference Date remained incomplete and was 35 days overdue.The findings are:The facility policy titled MDS Scheduling dated 08/01/2025 documented that the facility will establish and maintain a systematic scheduling process for Minimum Data Set assessments to meet regulatory timeframes, optimize reimbursement, and support care planning. The Assessment Reference Data is established by the MDS Coordinator within the allowable window. The ARD must be selected to ensure all required clinical data is available for accurate coding. Late Assessment Reference Data selection is not permitted and may result in financial penalties. The Minimum Data Set Coordinator will maintain an Minimum Data Set Scheduling Calendar Minimum Data Set Tracking Log. All assessments will be cross referenced with admission Discharge records Physician Orders Nursing documentation.Resident #4 was admitted to the facility with diagnoses including, but not limited to hemiplegia and hemiparesis following cerebral infarction, major depressive disorder, and type two diabetes mellitus.Review of Resident #4's Minimum Data Set tracking documentation in Electronic Medical Record (PointClickCare) revealed that a Comprehensive Minimum Data Set assessment was required to be completed within 14 days of the resident's admission. Resident was admitted on [DATE]. The Comprehensive Minimum Data Set assessment was not completed by the required timeframe of 12/23/2025. On 01/27/2026, the Comprehensive Minimum Data Set assessment was reflected in the Facility Electronic Medical Record Tracking System as incomplete and 35 days overdue.During an interview on 01/02/2026 at 03:56 PM, the Minimum Data Set coordinator stated that the Assessment Reference Date for Resident #4 was tracking under the prior admission which resulted in a discharge in August 2025. The comprehensive care plan from that admission had not been completed and closed by all disciplines. This prevented closure of the admission assessment cycle and disrupted the Minimum Data Set assessment process for the resident's current admission.During an interview on 01/02/2026 at 05:30 PM, the Administrator stated that they were unaware of any issues related to the Minimum Data Set assessments, Assessment Reference Dates, or tracking within the Electronic Medical Record system (PointClickCare) for Resident #4. The Administrator stated that the Minimum Data Set coordinator reports directly to them and they had not been notified of any delays or issues related to Resident 4's Minimum Data Set assessment process.During a follow-up interview on 01/02/2026 at 06:39 PM, the Minimum Data Set coordinator stated that they contacted the administrators of the electronic medical record system for PointClickCare regarding Resident #4's Minimum Data Set assessment process and the resident's new admission on [DATE]. The Minimum Data Set Coordinator stated that they were informed that the prior admission assessment cycle could not be closed because the comprehensive care plan from the resident's prior admission, which ended with discharge home on [DATE], had not been completed and closed by all disciplines. The Minimum Data Set coordinator stated that as a result, the Assessment Reference Date from the prior admission remained active, which interfered with completion of the Minimum Data Set assessment timely for Resident #4's current admission on [DATE].Record reviews of the electronic Minimum Data Set tracking system (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	during a revisit on 01/27/2026 revealed that the Comprehensive Minimum Data Set assessment for Resident #4 remained incomplete. The Assessment Reference Date was 35 days overdue for Resident #4's admission.During another follow up interview conducted on 01/27/2026 at 4:07 PM, the Minimum Data Set Coordinator stated that Resident #4's admission to the facility on [DATE] was a new admission and the Comprehensive Minimum Data Set assessment was required to be completed by 12/23/2025, in accordance with the federally required 14-day timeframe. The Minimum Data Set Coordinator stated that the Comprehensive Assessment was not completed as required because the admission was treated as a re-admission and the resident's admission status was not verified. The Minimum Data Set Coordinator stated that the Assessment Reference Date from the resident's prior admission remained active as the previous admission assessment cycle was not closed. This interfered with the comprehensive assessment for the current admission. The Minimum Data Set Coordinator stated that the comprehensive assessment was initiated as a late entry on 01/27/2026.Review of Resident #4's comprehensive assessment on 01/27/2026 revealed the comprehensive assessment remained incomplete because required sections had not yet been completed by other disciplines and it was 35days overdue.10 NYCRR 415.11(a)

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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. Based on observation, record review, and interviews conducted during an Abbreviated Survey (2566010 and 2658860), the facility did not ensure a system was in place to easily identify residents to prevent accidents for two (Residents #2 and #5) of seven residents reviewed. Specifically, 1) on 10/27/2025, during the provision of routine podiatry services, the podiatrist identified Resident #2 by the incorrect name based on the identification band provided to the resident by the facility. Resident #2 was wearing another resident's identification wristband. 2) On 01/02/2026, Resident #5, who was newly admitted and was severely cognitively impaired, was observed without an identification wristband in place. Certified Nurse Aide #1 was asked by the surveyor to identify Resident #5(who was assigned to them) and was unable to identify Resident #5. The findings are: The facility policy titled Resident Identification System, effective 06/07/2023, documented that a resident identification system is used to help facility personnel provide medical and nursing care. During observation on 01/02/2026 at 12:05 PM with the Registered Nurse Unit Manager #1 on the dementia unit, Resident #2 and Resident #5 and other residents were observed without identification wristbands. Resident #5 was admitted with diagnoses including, but not limited to, dementia, myocardial infarction, and peripheral vascular disease. The 12/17/2025 Comprehensive Minimum Data Set documented that Resident #5 had severely impaired cognition. On 01/02/2026 at 12:15 PM, Resident #5 was observed without an identification wristband, name tag, or any other form of resident identifier. During an interview on 01/02/2026 at 12:15 PM, Certified Nurse Aide #1 was asked to identify Resident #5. Certified Nurse Aide #1 was unable to identify Resident #5 and stated that residents are supposed to wear identification wristbands for identification. Certified Nurse Aide #1 stated they were unable to identify Resident #5 because the resident was a new admission and had no identification band. Certified Nurse Aide #5 was the assigned staff to care for Resident #5 on 01/02/2026. Resident #2 was admitted with diagnoses including, but not limited to, anxiety disorder, intracardiac thrombosis, and major depressive disorder. The 12/08/2025 five-day Minimum Data Set documented that Resident #2 had intact cognition. During an interview on 01/02/2026 at 12:27 PM, Resident #2 stated concerns regarding resident identification and described an incident when they were issued and wore another resident's identification wristband. Resident #2 stated that the identification wristband belonged to another resident with a similar last name. The wristbands were mixed up and when the podiatrist came in to provide service, they called them by the name on the identification band, and it was the wrong name. During an interview on 01/02/2026 at 12:20 PM, Registered Nurse Unit Manager #1 stated that a family member reported concerns that Resident #2 was wearing another resident's identification wristband. Registered Nurse Unit Manager #1 stated that an incident or accident report was not completed because the incorrect identification wristband was worn for a brief period however Registered Nurse Unit Manager #1 was unable to provide the time frame the incorrect identification wristband was on Resident #2. Registered Nurse Unit Manager #1 also stated that Resident #5 was a new admission and that identification wristbands are included in the admission packet and are expected to be applied to all residents upon admission. Registered Nurse Unit Manager #1 stated they did not complete the admission for Resident #5 and therefore could not explain why an identification wristband was not applied. During an interview on 01/02/2026 at 12:24 PM, Certified Nurse Aide #3 stated that they identify residents by asking residents their names. When asked how residents are identified if they are unable to state their name, Certified Nurse Aide #3 stated that they rely on identification wristbands. Certified Nurse Aide #3 further stated that when floating to other units, identification wristbands are relied upon primarily to identify residents. During an interview on 01/02/2026 at 03:17 PM, the Director of (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing stated that residents are expected to have identification wristbands applied and that nursing staff are responsible for checking identification wristbands to ensure right resident before providing care. The Director of Nursing stated that certified nurse aides rely on identification wristbands to identify residents because they do not have access to resident photographs in the electronic health records. The Director of Nursing stated that on one occasion Resident #2 was found wearing an incorrect identification wristband. The Director of Nursing was unable to identify the staff member who applied the incorrect identification wristband or confirm the length of time the incorrect identification wristband was in place. The Director of Nursing further stated that identification wristbands may fall off or break and may not be identified and therefore replacing them is not always done promptly. During an interview on 01/02/2026 at 05:13 PM, the Administrator stated that residents are expected to have identification wristbands applied for identification purposes. The Administrator stated that resident photographs are available in the Medication Administration Record and the Treatment Administration Record. The Administrator did not identify an alternate method in place to ensure resident identification when identification wristbands are missing or not present. The Administrator stated that identification wristbands are relied upon by certified nurse aides, visitors, and other staff in the facility who do not have access to the electronic health records to identify residents. The Administrator did not describe a process to ensure continued resident identification when identification wristbands fall off or break. The Administrator stated that the issue related to identification wristbands would be addressed with the team on 01/05/2026. 10 NYCRR 415.12(h)(1)