STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335549	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warren Center for Rehabilitation and Nursing	42 Gurney Lane Queensbury, NY 12804

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews conducted during the survey, the facility did not ensure each resident was treated with respect, dignity and care in a manner and in an environment that promotes maintenance or enhancement of their quality of life forˆthreeˆ(3) (Resident #'sˆ6,#ˆ10ˆand #52) ofˆtwenty-three (23)ˆresidents reviewed.ˆˆSpecifically,ˆ(a.) Resident #6 was placed in their room inˆtheˆactive dying phase without staff contact or interventions. (b.) Resident #10 wasˆobservedˆusing a bedside commode without privacy curtain closed; and (c.) Resident #52 asked to use the bathroom and was told to soil their brief because staff had no time to toilet them.Findings include: The Facility's Policy Titled Resident Rights,ˆrevised 5/28/2024, documented Federal and State laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to a dignified existence; be treated with respect, kindness, and dignity.ˆ CMS Regulation 42 Code of Federal Regulations 483.1, documented certified long-term care facilities must protect resident rights, focusing on dignity, self-determination, and quality of care; the right to be treated with consideration, dignity, and respect, including a comfortable, private living environment.ˆ Resident #6Resident #6 was admitted to the facility with diagnosis of End Stage Renal Disease (a permanent kidney failure requiring regular dialysis (a procedure that filters waste and toxins from the blood) or a kidney transplant to maintain life); Dementia unspecified (symptoms of cognitive decline such as memory loss and impaired thinking), and Anxiety Disorder (a mental health condition characterized by persistent, excessive, and uncontrollable worry about every day, routine things).ˆThe Minimum Data Set (an assessment tool) dated 11/20/2025, documented they could be understood, understand others, and was cognitively intact.ˆ During an observation on 04/07/2026,ˆ04/08/2026,ˆ04/09/2026ˆandˆ04/10/2026, Resident #6 was noted to have transitioned into the active dying phase. They were in their room, lights out, no stimuli, they were across bed with feet partially hanging off bed.ˆˆOn 4/10/202, Resident #6 was restless, moaning,ˆdeep respirations, and dry mucosa. Several staff walked by room throughout day and did not enter room.ˆˆˆ The Medication Administration Record documentedˆLorazepam Concentrate two (2)ˆmilligram/milliliter.ˆˆGive 0.25 milliliterˆby mouth every six (6) hours asˆneeded forˆanxiety forˆ14 days.ˆˆMorphine Sulfate (Concentrate) Solutionˆ20ˆmilligrams/milliliter.ˆGive five (5) milligramsˆby mouth every four (4) hours asˆneeded for painˆfor 14 Days.ˆLorazepamˆ0.25 milliliterˆwas administered on 4/7/2026 at 05:10PM, 4/9/2026 at 12:34 AM, and 4/10/2026 at 09:11AM.ˆˆˆMorphine 5 milligramsˆwereˆadministered on 4/7/2026 atˆ05:10 PM, 4/8/2026 at 02:45 AM, 4/9/2026 at 02:15 PM and 4/10/2026 at 09:11AM.ˆˆ During an interview on 4/10/2026 at 02:10 PM, Administrator #1ˆwas made aware Resident #6 was restless and moaning. Theyˆstatedˆstaff should be assessing end-of-life residents throughout the day and administering comfort medications.ˆˆThey are also assessed regularly by the nurse practitioner.Record review revealed that shortly after the interview with Administrator #1, Resident #6's Lorazepam and Morphine orders wereˆdiscontinuedˆand replaced with standing routine orders for Morphine and Lorazepam every four (4) hours.ˆˆ On 4/13/3026 at 10:20 AM, Resident #6 wasˆobservedˆwith soft music playing, no (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	moaning, no facial grimace, respirations with periods of apnea.^^A fellow resident was at their bedside.^^ Resident #10Resident #10 was admitted to the facility with diagnoses of fracture of the upper end of the left humerus (a break in the top part of the left arm bone near the shoulder joint, often resulting from falls or trauma), dementia (a group of conditions that cause a progressive decline in cognitive abilities), and anxiety (mental health condition characterized by excessive fear or anxiety that interferes with daily activities). The Minimum Data Set, dated [DATE], documented the resident had moderate cognitive impairments, could be understood, and could understand others.^^^ During an observation on 4/07/2026 at 2:24 PM, Resident #10 was noted to have a bedside commode and landing strips on floor, parallel to bed on the left side.^^The landing strips were caked with brown material consistent with feces, and other stains that were unidentifiable. There were also several soiled tissues on the floor that appeared to have been meant to be in the garbage bin but instead landed on the floor.^ During an observation on 04/08/2026 10:32 AM, Resident #10 was self-toileting themselves on the bedside commode, inˆan open area, no curtains drawn,ˆattemptingˆtoˆwipe themselves.ˆThey threw tissue onto the floor instead of garbage bin.Resident #52Resident #52 was admitted to the facility with diagnoses of Malnutrition (resulting from a lack of proper nutrition), Anxiety (a feeling of fear, dread, and uneasiness, often accompanied by physical symptoms like rapid heart rate, sweating, and tension); and Depression (a serious, common mental health disorder characterized by persistent sadness, loss of interest in activities, low energy, and feelings of worthlessness lasting at least two weeks). The Minimum Data Set, dated [DATE], documented the resident had moderate cognitive impairments, could be understood, and could understand others.^^^ During an interview onˆ04/13/2026ˆatˆ10:35 AM, Resident #52ˆstatedˆthe previous evening of 4/12/2026 at approximatelyˆ11:20 PM,ˆtheyˆasked to use the toilet. A Certified Nurse aide told them theyˆwereˆin charge ofˆ20 residentsˆandˆdid not have timeˆto toilet them,ˆandˆsaid to them that they (Resident #52) shouldˆrelieve themselves in the bed.ˆResident #52 further stated thatˆˆno staff returned to their room untilˆthe 4/13/2026 day shift arrived and got them up just prior to the interview. They further stated they were unable toˆidentifyˆthe Certified Nurse Aide because they did not wear a name tag and refused toˆidentifyˆthemselves.ˆ During an interviewˆonˆ04/13/2026ˆatˆ1:48 PM, Administrator #1ˆstatedˆall residentsˆwere to be treated with dignity and respect; it was unacceptable for any staff member to refuse to toilet any resident and tell them to go in the bed. Whenˆan incident wasˆbrought to theirˆattention,ˆthey wouldˆimmediatelyˆeducate that staff member and complete an inservice.ˆ10 New York Code of Rules and Regulations 415.5(a)ˆ

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews during aˆsurvey,ˆthe facility failed to ensure residents were free from abuse, neglect, misappropriation of resident property for four (4)ˆ(Resident #6, #33, #ˆ85 and #87)ˆofˆfiveˆ(5) residents reviewed. Specifically, (a.) Resident #6 was abused when touched inappropriately by Resident #33, when Resident #33 had known inappropriate sexual behaviors. (b.) Resident #85 was neglected when rolled out of bed onto the floor during care provided by a single caregiver on 5/04/2025, when Resident #85 was care planned for a two-person caregiver for bed mobility. (c.) On 7/26/2025, Registered Nurse #2 accused Resident # 87 of consuming a crushed narcotic when the nurse left the room. Resident #87 denied taking it and felt humiliated and stated they were not given pain medication as prescribed. The nurse documented the medication was given. This resulted in mental anguish, with Resident #87 calling law enforcement. Facility was made aware but did not investigate the allegation of abuse or misappropriation of resident property (medication). (d.) Resident #87 had complex care requirements including tracheostomy /laryngectomy care that were unaddressed.The facility's Policy and Procedure titled Abuse reviewed 6/01/2024 documented theˆfacility prohibits the mistreatment, neglect, and abuse of residents/patients and misappropriation of resident/patient property by anyone including but not limited to staff, family,ˆfriendsˆand residents of the facility. The facility prohibits any exploitation of the mentally and physically disabled resident in the facility. The facility has designed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident/patient abuse, neglect, mistreatment, and/or misappropriation of property. Definitions: Neglect,ˆFailureˆof the facility, its employees or service providers to provide goods and services necessary to avoid physical harm, pain, mentalˆanguishˆor distress. Sexual Abuse,ˆnon-consensual sexual contact of any type with a resident and includes, but is not limited to, humiliation, harassment, coercion, or assault.ˆ 4. The Administrator and Director of Nursingˆare responsible forˆinvestigation and reporting. They are also ultimately responsible for the following as they relate to abuse, neglect, and/or misappropriation of property standards and procedures: a. Implementation b. ongoing monitoring c. Reporting d.ˆInvestigationˆ5. Incidents and allegations of abuse, neglect, misappropriation of property and exploitationˆwill beˆreported to the Quality Assurance Performance Improvement (QAPI) Committee for tracking, trending, and corrective action.ˆ (a.)Resident #6 was admitted to the facility with diagnosis of End Stage Renal Disease (a permanent kidney failure requiring regular dialysis, a procedure that filters waste and toxins from the blood, or a kidney transplant to maintain life);ˆDementia unspecified (symptoms of cognitive decline such as memory loss and impaired thinking),ˆand Anxiety Disorder (a mental health condition characterized by persistent, excessive, and uncontrollable worry about every day, routine things).ˆThe Minimum Data Set (an assessment tool) dated 11/20/2025, documented they could be understood, understand others, and was cognitively intact.ˆ Resident #33 was admitted to the facility with diagnosis of Major Depressive Disorderˆ(a serious, common mental health disorder characterized by a persistent, intense, and long-lasting depressed mood or loss of interest in activities),ˆ Dementia Unspecified Moderate (symptoms of cognitive decline such as memory loss and impaired thinking), and Other Sexual Dysfunction. The Minimum Data Set (an assessment tool) dated 05/20/2025, documented they could be understood, understand others, and was cognitively intact.ˆˆ The Facility Investigation dated 8/9/2025 documented during an activity, Resident #6 extended a handshake greeting to Resident #33.ˆˆInstead of handshake, Resident #33 reached and touched Resident #6 left breast.ˆˆResident #6 propelled backwards to remove themselves from the situation and came inside. Resident #6 verbalized distressed feelings related to the incident.ˆˆ The Comprehensive Care Plan for Resident #33 dated 7/2022, documented Resident with behaviors of touching themselves in public areas, staring at (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	women, verbalization of sexual comments, inappropriate touching of staff and residents. Interventions:ˆ effective 8/25/2025, one on one (1:1) supervision when out of bed; effective 4/23/2024 Distract Resident with preferred activities such as Legos, Hot wheels, toys, music. Evaluate side effects of medications; RESOLVED 10/31/2024: Resident was on one to one (1:1) during 7 AM to 11 PM. 10/31/2024: Initiate psychology evaluation as needed.ˆ Review of Psychiatric Notes dated 8/28/2025 documented, psychiatric symptoms are not currently stabilized and Gradual Dose Reduction was Contraindicated. They were started on Olanzapine on 12/16/2024, but there had not been anyˆsignificant changeˆin their sexually inappropriate behavior; Olanzapine was increased to five (5) milligrams dailyˆafterˆthe resident touched a female's breast. Assessment: Resident #33 denied making sexual remarks orˆdemonstratingˆsexual behaviors.ˆˆˆ During an interview on 04/14/2026 at 11:47 AM, Regional Director of Nursing #1 stated Resident #33 had not had any sexual behaviors toward other residents until the August 2025 incident.ˆ (b.)Resident #85 was admitted to the facility with diagnosis of Morbid Obesityˆ(a weight 80-100 pounds over ideal levels, posing severe health risks); Lymphedema (a chronic condition characterized by the buildup of protein-rich lymph fluid in body tissues, causing swelling, usually in the arms or legs); and General Anxiety Disorder (a mental health condition characterized by persistent, excessive, and uncontrollable worry about every day, routine things). The Minimum Data Set, dated [DATE], documented they could be understood, understand others, and was cognitively intact.ˆˆ Resident #85's Care Kardex (an electronic system that contains directions for providing resident-specific care) dated 5/01/2025 documented mobility roll left and rightˆrequired two (2) staff assistance, and for both staff to provide hands-on care.ˆˆ The Facility's Incident and Accident report dated 5/04/2025, documented Resident #85 wasˆobservedˆlying on their left side on the side of the bed. Resident #85 had full range of motion in all four (4) extremities and was without injury. When a Certified Nurse Aide provided incontinenceˆcare without a second staff member, Resident #85 was turned onto their left side and slipped off the side of the bed onto the floor.Resident #85's Comprehensive Care Plan did not have a Care Plan reflecting falls on 5/04/2025.ˆˆThe Care Plan was canceled as of 1/16/2026, documenting the resident was at risk for falls and had an actual fall related to Deconditioning, Gait/balance problems, Immobility.ˆ During an interview on 04/14/2026 at 1:18 PM, Regional Director of Nursing #1ˆstated a checklist is completed whenever there is a fall; front-line staff notify a Registered Nurse for an assessment. The Registered Nurse would assess resident injury and skin integrity and then the provider is notified. Afterwards, an incident report is completed and reviewed during morning meeting and each incident report was investigated.ˆˆˆ During an interview on 04/14/2026 at 1:18 PM, Director of Nursing #1ˆstatedˆthey signed off on the fall progress noted dated 5/04/2025. The incident report was completed and there was no further investigation as theyˆdeemedˆthere was no injury and non-reportable to the Department of Health.ˆˆDirector of Nursing #1 stated there were no statements collected.Record review from document supplied by Regional Director #1 revealed a generated Resident #85's Care Kardex for 5/2025, documenting Resident #85 was a two (2)-person caregiver for rolling left and rolling right. Director of Nursing #1 had no response as to why only one (1) care giver was present at time of incident, nor why the incident had no further investigation for care plan violation and was not reported to the Department of Health.ˆ (c.)Resident #87 was admitted to the facility with diagnoses of malignant neoplasm of the head,ˆfaceˆand neck (cancer in the head or neck), presence of an artificial laryngectomy tubeˆ(anˆartificial airway in the neck), and cirrhosis of the liver (a liver disease). The Minimum Data Set, dated [DATE], documented they could be understood, understand others, and was cognitively intact.ˆ Record reviewˆdatedˆ07/26/2025 documented Registered Nurse #2 placed a crushed narcotic (oxycodone) in a medication cup in resident #87's room and briefly left the area. Upon return, the medication was no longer present. The nurse assumed that the resident had taken the medication and confronted the resident with this accusation. Resident #87 denied taking the medication. Registered Nurse #2 then signed for the medication as having been administered. Registered Nurse #2 did not record any incident in the (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident record.ˆFollowing the incident, Resident #87 became visibly upset and distressed following the accusation, crying, andˆsubsequentlyˆcontacted law enforcement. Police responded to the facility on [DATE]; however, the matter was deferred to the facility for internal investigation, and no formal police report was completed.ˆThere was no documented evidence that the facility investigated the allegations of abuse or misappropriation of resident property (medication).ˆˆ Review of the Medication Administration Record dated 07/25/2025 through 07/27/2025ˆidentifiedˆthat oxycodone was documented as administered, with entries signed as given by Registered Nurse #2.ˆ During an interview on 04/15/2026 at 10:51 AM, Medical Director #1ˆstatedˆthey were not notified of the missing narcotic medication or the missed dose. They further stated Registered Nurse #2 should not have signed for it as given if the facts were unclear. Theyˆstatedˆthey would have administered anotherˆone-timeˆdose as the story had lacked credibility.ˆ (d.)Review of Resident #87'sˆcomprehensiveˆcare plan dated 03/24/2026 through 03/26/2026ˆidentifiedˆthe resident had multiple high-risk clinical needs, including airway management related to a tracheotomy/artificial larynx, enteral nutrition, cancer-related pain, impaired communication, decreased mobility, and fall risk. Interventions included monitoring respiratory status, managing secretions, providing suctioning as needed,ˆmaintainingˆairway patency, administering tube feedings, managing pain, andˆassistingˆwith activities of daily living. The care plan reflected the need for ongoing monitoring, staffˆassistance, andˆtimelyˆintervention across multiple disciplines.ˆ Review of Resident #87's physician orders on the Order Summary Report dated 04/09/2026, reflecting active orders as of 07/26/2025,ˆidentifiedˆthe resident had a diagnosisˆindicatingˆan altered airway (presence of artificial larynx/tracheotomy). However, there were no physician orders for tracheostomy or laryngectomy care, including suctioning, stoma care, humidification, or respiratory therapy involvement. Additionally, there were no orders for required bedside emergency airway supplies, such as a spare tube, obturator, suction equipment, or emergency airway instructions. Orders during this period were limited to general care, including medications, wound care, enteral feeding, and routine monitoring.ˆ Overall, record reviewˆidentifiedˆa discrepancy between the resident's documented clinical condition and care plan needs, and the absence of corresponding physician orders to support airway management and emergency preparedness, as well as inconsistencies in medication administration documentation.ˆ 10 New York Codes, Rules, and Regulations 415.4 (b)(1)(i)ˆ

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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 record review and interviews during a survey, the facility did not ensure that all alleged violations involving neglect were reported within 24 hours after the allegation was made for one (1) (Resident #85) of five (5) residents reviewed for abuse. Specifically, Resident #85 was neglected when rolled out of bed onto the floor during care provided by a single caregiver on 5/04/2025; Resident #85 was care planned for a two-person caregiver for bed mobility. The incident was not reported to the New York State Department of Health. Findings Include: Cross reference to F-600The Facility's Policy and Procedure Titled Accident-Incidents reviewed 6/01/2024, documented: 12. Director of Nursing and Administrator are responsible to review Incident / Investigation and Conclusion to determine if incident requires reporting to outside agencies such as Department of Health, Office of Inspector General, CMS, etcetera. Evaluation: 13. All incidents and Accidents will be evaluated when applicable by the interdisciplinary team. 14. The team will review the investigation and continue if necessary, discuss and determine from the investigation the root causes, make recommendations for additional intervention, education and conclude the investigation. 14.1 The team will write an interdisciplinary team note discussing above. Resident #85 was admitted to the facility with diagnosis of Morbid Obesityˆ(a weight 80-100 pounds over ideal levels, posing severe health risks); Lymphedema (a chronic condition characterized by the buildup of protein-rich lymph fluid in body tissues, causing swelling, usually in the arms or legs); and General Anxiety Disorder (a mental health condition characterized by persistent, excessive, and uncontrollable worry about every day, routine things). The Minimum Data Set, dated [DATE], documented they could be understood, understand others, and was cognitively intact.ˆˆ Resident #85's Care Kardex (an electronic system that contains directions for providing resident-specific care) dated 5/01/2025 documented mobility roll left and rightˆrequired two (2) staff assistance, and for both staff to provide hands-on care.ˆˆ The Facility's Incident and Accident report dated 5/04/2025, documented Resident #85 wasˆobservedˆlying on their left side on the side of the bed. Resident #85 had full range of motion in all four (4) extremities and was without injury. When a Certified Nurse Aide provided incontinenceˆcare without a second staff member, Resident #85 was turned onto their left side and slipped off the side of the bed onto the floor.Record review revealed no documented evidence that the incident was reported to the New York State Department of Health. During an interview on 04/14/2026 at 1:18 PM, Director of Nursing #1ˆstatedˆit was deemed non-reportable to the Department of Health. 10 New York Codes, Rules, and Regulations 415.4(b)(2)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews conducted during a survey, the facilityˆfailedˆtoˆensure that a resident's discharge wasˆappropriate basedˆon the resident's clinical status at the time of discharge (because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility) forˆone (1) (Resident #83) of three (3) residents reviewed.ˆSpecifically, Resident #83 had diagnoses including chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make It difficult to breathe) and was discharged to home despite waiting on results of a lab test:ˆcoronavirus disease (COVID)/influenza (flu) swab takenˆdays prior to discharge. Theˆfacility did notˆobtainˆor review results of diagnostic testing (COVID/Flu) ordered prior to discharge. The facility did not ensure a physician evaluation confirmed clinical stabilityˆfor dischargeˆafter cough syrup and COVID/Flu test were ordered. The resident was admitted to the hospital two (2) days after discharge withˆaˆdiagnosis ofˆinfluenza.ˆ Findings include:ˆˆ The facility policy titled Discharge-Transfer/Discharge Process effective 4/28/2026, documentedˆthe facility would coordinate a safe transfer or discharge for residents leaving the facility.ˆWhen a resident was transferred or discharged from the facility, pertinent informationˆregardingˆthe transfer/discharge would be documented in the clinical record, including the discharge/transfer destination, reason for discharge/transfer, and summary of the resident's current medical status.ˆIf a residentˆwasˆbeing discharged to the community, the resident and/or their representative would be provided withˆwritten interdisciplinary discharge instructions that summarize their medical, physical, and psychosocial condition at the time of discharge.ˆˆ Resident #83Resident #83 was admitted to the facility with diagnoses of type two (2) diabetes (an endocrine system dysfunction causing unregulated blood glucose levels), chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make It difficult to breathe), and pulmonary hypertension (a serious, chronic disease characterized by highˆblood pressure in the arteries of the lungs, causing the right side of the heart to work too hard). The Minimum Data Set (an assessment tool) dated 12/29/2025, documented the resident was cognitively intact, could be understood, and could understand others.ˆˆ A complaint made to the Department of Health onˆ01/29/2026 at 3:15 PMˆdocumentedˆthe Resident #83 was scheduledˆto be discharged from the facility on 1/09/2026 followingˆcompletion of their rehabilitation stay at the facility. Complainantˆ#1ˆstatedˆas 1/09/2026 approached, Resident #83 became increasingly ill, incapacitated, andˆwasˆin no condition to be sent home. Theyˆstatedˆthe facility packed the resident into an ambulette and sent them home vomiting, which resulted in a near immediate hospitalization.ˆComplainant #1ˆstatedˆthey hadˆattemptedˆto stopˆor postponeˆthe discharge until Resident #83ˆwas evenˆsomewhat lessˆill, but the facility did not listen.ˆˆ During an interview on 04/13/2026ˆatˆ9:03 AM,ˆComplainant #1ˆstatedˆResident #83 was so sick when they were sent home, and should not have sent the resident home like that. Theyˆstatedˆthat once the resident was home, theirˆcough did not get better. Theyˆstatedˆ Resident #83 was sent home on a Friday and the next day Complainant #1 had the resident sent back to the hospital, where they tested positive for influenza. Complainant #1ˆstatedˆthe facility had told them the resident tested negative for influenza, but they did not believe the facility tested the resident. Theyˆstatedˆ Resident #83 wasˆvery sickˆand weak.A physician treatment encounter note dated 12/31/2026 at 12:00 AM documented Resident #83 was clinically stable to discharge home with family.ˆˆ A transfer/discharge notice dated 1/09/2026ˆcompleted for Resident #83, documented theˆresident'sˆhealth had improved sufficiently so the resident no longer needed the services provided by the facility as evidenced by successful completion of sub-acute rehabilitation.ˆIt was documented that theˆresidentˆwould not sign the noticeˆand Administrator #1 was a witness to this.ˆ Complainant #1 was informedˆverbally about the noticeˆon 1/06/2026.ˆˆ A physician order wasˆinitiatedˆon 1/06/2026 at 5:16 PM (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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	forˆGuaifenesinˆLiquid 100ˆmilligram/5 milliliters, give 10 milliliters by mouth every four (4) hours as needed for cough.ˆˆ Review of Resident #83's Medication Administration Record for January 2026, documented the resident was administered the cough medicine on 1/07/2026 at 11:35 AM and 1/08/2026 at 4:35 PM.ˆˆ A Medication Administration Note dated 1/07/2026 at 1:13 PM documentedˆ Guaifenesin ˆLiquid 100 milligram/5 milliliters, give 10ˆmilliliters ˆby mouth every four (4) hours as needed for cough. It further documented as needed administration was ineffective.ˆˆ A Medication Administration Note dated 1/08/2026 at 5:49 PM, documentedˆGuaifenesinˆliquid 100 milligram/5 milliliters, give 10ˆmilliliters ˆby mouth every four (4) hours as needed for cough.ˆIt furtherˆdocumented as needed administration was effective.ˆˆˆ A physician order dated 1/07/2026 at 4:45 PM, documentedˆcoronavirus disease (COVID)/influenza (flu)ˆswab,ˆone time only for check for one (1) day.ˆˆ Review of Resident #83's Medication Administration Record for January 2026, documented the covid, flu swab was completed on 1/07/2026 at 4:47 PM by Registered Nurse #1.ˆˆ There was no documented evidenceˆas to why cough syrup and a COVID/Flu swab were ordered for Resident #83ˆprior to discharge. There was also noˆdocumentationˆthat results were obtained fromˆResident #83's COVID/flu swab.ˆThere was no documented evidence that a medical providerˆsaw Resident #83ˆafter their treatment encounter on 12/31/2026ˆafter cough medicine and a COVID/Flu swab were ordered toˆdetermineˆthe resident'sˆclinicalˆstatus prior to discharge.ˆˆ Hospital Record for Resident #83, with encounter date of 1/10/2026, documented the resident was admitted from the emergency department on 1/11/2026. It documented that the chief complaint was shortness of breath/weakness. The assessment/plan documented Resident #83 was aˆ[AGE] year oldˆ(gender) with past medical history of congestive heart failure, chronic kidney disease, type two (2) diabetes, pulmonary hypertension, hypoxic respiratory failure who presentedˆin the emergency room for evaluation of one (1) week of history of malaise, weakness, cough, and shortness of breath. A chest x-ray showed pulmonary congestion, viral panel was positive for influenza, and a blood test used to diagnose and assess the severity of congestiveˆheatˆfailure was elevated. Presentation was consistent withˆacute onˆchronic heart failure exacerbation (sudden, dangerous worsening of symptoms like shortness of breath, fatigue, and swelling due to rapid fluid accumulation) in the setting of viral pneumonia (a lung infection caused by viruses that cause respiratory inflammation, often resulting in fever, dry cough, headache and fatigue).ˆˆ During an interview onˆ4/10/2026ˆatˆ11:02 AM, Administrator #1ˆstatedˆthey were covering social workˆresponsibilitiesˆfrom September 2025 to February 2026 when the new social worker was hired. Theyˆstatedˆ Resident #83 was sent home with their discharge instructionsˆand they called the resident throughout the day because Complainant #1 was not there.ˆTheyˆstatedˆwhen they spoke with the resident after discharge, the resident wasˆanxious, butˆwas not in respiratory distressˆand had everything they needed which included a concentrator, food, andˆappropriate services.ˆTheyˆstated Complainant #1 did meet the resident at the home and set upˆtheir oxygen.ˆAdministrator #1ˆstated Resident #83 had no acute signs or symptoms of respiratory distress at the time of discharge. Theyˆstatedˆper Complainant #1 request, theyˆchecked the resident for COVID/Fluˆandˆprobablyˆorderedˆcough syrup. Theyˆstatedˆgiven the resident'sˆanxiety,ˆthey completed the tests to appease Complainant #1.ˆAdministrator #1 furtherˆstatedˆthey would notˆhave sent Resident #83ˆhomeˆif the resident was sick or had a change in condition.ˆˆ During an interview onˆ4/13/2026ˆatˆ12:32 PM, Registered Nurse #1 stated Resident #83ˆhad a cough andˆcongestion one (1) or two (2) weeks prior to discharge. Theyˆstated Complainant #1 had requested aˆcoronavirus disease (COVID)/influenza (flu) test, but by the timeˆthe resident was getting ready for discharge, the resident was feeling better. Theyˆstatedˆ Resident #83 had some anxieties about going home.ˆRegisteredˆNurse #1ˆstatedˆthey never received the results of the COVID/flu swab.ˆTheyˆstatedˆthe resident was weanedˆdown to their baseline oxygen saturations. Theyˆstatedˆ Resident #83 suffered from anxiety and would often say that they could notˆbreathe.ˆRegistered Nurse #1ˆstatedˆthey were putting a lot of ordersˆinˆfor cough medicine (continued on next page)

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	335549	A. Building B. Wing	04/15/2026

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Warren Center for Rehabilitation and Nursing	42 Gurney Lane Queensbury, NY 12804

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	around that time for other residents on the unit. Theyˆstatedˆtheˆresident wasˆfeeling betterˆand excited to be discharged to home.ˆˆ During an interview onˆ4/14/2026ˆatˆ10:03 AM,ˆRehabilitation Manager #1ˆstatedˆaround the time of discharge, Resident #83 said they were not feeling well and the facility wasˆtesting them forˆcoronavirus disease (COVID)/influenza (flu).ˆˆ During an interview onˆ4/14/2026ˆatˆ10:52 AM, Registered Nurse #1ˆstatedˆthe facility hadˆa rapidˆcoronavirusˆtest, but not a rapidˆinfluenzaˆtest.ˆTests results would typically come back the same day if processed at the hospital, or it would take four (4) or five (5) if the hospital sent it to an outside lab.ˆRegistered Nurse #1 statedˆResident #83 was havingˆsymptomsˆso they got the respiratory panel forˆcoronavirus,ˆinfluenza, andˆrespiratory syncytial virus (RSV, a common virus that usually causes mild, cold-like symptoms, but can lead to severe lung infections, especially in infants, older adults, and those with weakened immune systems), but theˆresident'sˆsymptoms were starting to resolve.ˆTheyˆstatedˆthey did not rememberˆdoing the testˆand they were uncertainˆif itˆwas sentˆout.ˆTheyˆstatedˆbecause the resident was no longer showing symptoms,ˆ it was no longerˆindicatedˆwhen questioned about the results of the test.ˆˆˆ During an interview onˆ4/14/2026ˆatˆ12:19 PM, Director of Nursing #1ˆstatedˆwhen Resident #83 was about to be discharge,ˆtheirˆfamily memberˆwanted the resident to be tested forˆcoronavirus disease (COVID)/influenza (flu).ˆTheyˆstatedˆon the day of discharge the resident was tearful, but gratefulˆand had no respiratory symptoms. Director of Nursing #1ˆstatedˆthey were not aware that Resident #83 received cough medicineˆthe days prior to discharge. Theyˆstatedˆif aˆcoronavirus disease (COVID)/influenza (flu)swabˆwas completed it should have been sent out.ˆTheyˆstatedˆthe order would have been cancelled if it were not completed.ˆTheyˆstatedˆthey could not assume that the test was not sent to the lab, butˆtest results could not beˆfound.ˆˆ During an interview onˆ4/15/2026ˆatˆ1:59 PM, Administrator #1ˆstatedˆthe hospital hadˆstartedˆshippingˆrespiratory panels to outside labs, whichˆhadˆa four (4) day turn around.ˆThey would not have gotten the results prior toˆdischargeˆand the resident had no symptoms.ˆTheyˆstatedˆthey sawˆthat the resident went to the hospital and was diagnosed with theˆinfluenza after discharge.During an interview on 4/15/2026 at 11:33 AM, Medical Director #1 statedˆinfluenzaˆwas more severe than COVID.ˆTheyˆstatedˆthey did not just completeˆcoronavirus disease (COVID)/influenza (flu)ˆswabs;ˆit wasˆusually based on symptoms.ˆWhen discussingˆResident #83,ˆMedical Director #1ˆstatedˆit sounded like there was more to their situationˆthan what wasˆindicated.ˆTheyˆstatedˆthey would expect documentation forˆrationale for a COVID/fluˆswab to be completed and for cough medicineˆordered.ˆˆTheyˆstatedˆdischarge planningˆcontinued upˆuntil the resident went home.10 New York Codes, Rules, and Regulations: 483.21(c)(1)

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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 interview and record review conducted during a survey, the facility failed to ensure that Comprehensive Care Plans were reviewed and/or revised to reflect the resident's current condition for one (1) (Resident #85) of six (6) reviewed for accidents. Specifically, for Resident #85, there was no documented evidence that the Comprehensive Care Plan was reviewed and/or revised after a fall that occurred on 5/04/2026. Findings include: The facility policy titled Care Plans- Comprehensive last reviewed 8/02/2024, documented a comprehensive, person-centered care plan that included measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs was developed and implemented for each resident. It documented that assessments of residents were ongoing and care plans were revised as information about the residents and the residents' conditions changed. The interdisciplinary team reviewed and updated the care plan when there was a significant change in the residents' condition and when the desired outcome was not met. The facility policy titled Fall Management and Prevention last revised 1/2023, documented the interdisciplinary team identified and implemented appropriate interventions to reduce the risk of falls or injuries while maximizing dignity and independence. The staff would review and revise interdisciplinary care plan when a change was identified, after an event. Resident #85 was admitted to the facility with diagnoses of end stage renal disease (a condition where the kidneys can no longer effectively filter waste and excess fluid from the blood), type 2 diabetes (an endocrine dysfunction causing unregulated blood glucose levels), and chronic respiratory failure (a condition where the lungs cannot adequately exchange oxygen and carbon dioxide). The Minimum Data Set (an assessment tool) dated 10/13/2026, documented the resident was cognitively intact, could be understood, and could understand others, An Initial Event assessment dated [DATE] at 8:16 PM, documented Resident #85 was turned on their left side on the side of the bed when they slipped off the side of the bed onto the floor, while the Certified Nurse Aide was providing incontinence care. The resident did not hit their head. Interventions initiated to decrease risk for falls included: (a.) occupational therapy evaluation and treatment as indicated, physical therapy evaluation and treatment as indicated, non-skid socks, and bed in lowest position. Resident #85's Comprehensive Care Plan for Falls, documented the resident was at risk for falls/has had an actual fall related to deconditioning, gait/balance problems, and immobility. There was no documented evidence that Resident #85's Comprehensive Care Plan was reviewed and/or revised after a fall that occurred on 5/04/2026. During an interview on 4/14/2026 at 1:18 PM, Director of Nursing #1 stated when a resident was found on the floor an incident and accident report was completed with statements. Incident and accident reports were brought to morning meeting and discussed with the interdisciplinary team and closed out by the interdisciplinary team. They stated the care plan was updated once agreed upon interventions were put into place. 10 New York Codes, Rules, and Regulations: 415.11(c)(2)(i-iii)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review conducted during a survey, the facility failed toˆensure thatˆresident environments were as free from accidents or hazards as possible forˆthree (3) (Resident #'s 19, 31, 71) ofˆsix (6)ˆresidentsˆreviewed for accident and hazards. Specifically,ˆ(a.)ˆfor Resident #19, medications were observedˆat their bedside; (b.)ˆResident #31 was at risk for falls and a fall/tripping hazard was observed in their room; (c.)ˆResident #71 had medications in their room that were notˆordered by a physician.Findings include:ˆˆ The facility policy titled Medication Administration last reviewed 12/2019 documented medications shall be administered in a safe andˆtimelyˆmanner, and as prescribed. Only ˆpersonsˆlicensed orˆpermittedˆby the State to prepare, administer and document administration of medications may do so.ˆˆ The facility policy titled Fall Management and Prevention last revised 1/2023, documented the interdisciplinary teamˆidentifiedˆand implementedˆappropriate interventionsˆto reduce the risk of falls or injuries while maximizing dignity and independence.ˆ The facility policy titled Accident-Incidents last reviewed 6/01/2024, documented it was the policy of the facility to monitor and evaluate all occurrences of accident or incidents or adverse events occurring on the facility's premises which was not consistent with the routine operation of the facility or care of a particular resident. An incident was any occurrence not consistent with the routine operation of the center, normal careˆof theˆresident, aˆhappening involving visitors, malfunctioning equipment, or observation of a condition which might be a safety hazard. The occurrence may be a fall, skin tear, bruise, new pressure ulcer and may involve abuse, neglect, and mistreatment or an injury of unknown origin.ˆˆ During an observation on 04/08/2026 at 3:38 PM, a medication cup that contained a cream and crushed medication was on Resident #19's bedside table, accessible to residents, visitors and staff.During an observation on 4/08/2026 at 3:25 PM, collagen peptides, alpha lipoic acid,ˆaspercremeˆwereˆobservedˆat Resident #71's bedside and/or in their window, accessible to residents, visitors and staff.ˆˆ During an interview on 4/08/2026 at 3:25 PM, Resident #71ˆstatedˆthey took collagen peptides and alpha lipoic acid to help with wound healing. TheyˆstatedˆIt was brought in by their family.ˆˆ Record review revealed the facility provided care for residents with diminished cognitive status. During an interview on 4/09/2026 at 12:00 PM, Director of Nursing #1ˆstatedˆthere were no residents in the facility that self-administered their medications.ˆ During an interview on 4/09/2026 at 12:20 PM, Administrator #1 stated self-administered medications would need to be locked up. Resident #31 was admitted to the facility with diagnoses of left femur fracture (serious, high-energy injury, a crack or break in the longest and strongest bone in the body), acute respiratory failure (lungs cannot release enough oxygen into the blood or remove carbon dioxide), and hypertension (high blood pressure). The Minimum Data Set (an assessment tool) dated 4/01/2026, documented the resident was cognitively intact, could be understood, and could understand others.ˆˆ During an observation onˆ4/08/2026ˆatˆ12:25 PM,ˆtwo (2)ˆfloorˆmatsˆ(about two (2) inches thick)ˆwereˆobservedˆstackedˆon top of each laying on the flooˆon the right side of Resident #31's bedˆ(right side when standing at the foot of bed).ˆThe resident was in bed. There was a sign on Resident #31's wardrobe thatˆdocumentedˆcallˆdon't ˆfall.ˆˆ During an interview on 4/08/2026 at 12:25 PM, Resident #31ˆstatedˆthey were at the facility for rehabilitation afterˆthey fad a fallˆand broke their femur.ˆˆ During an observation onˆ4/10/2026ˆatˆ12:47 PM, the floorˆmatsˆwereˆobservedˆin the same position as on 4/08/2026. Resident #31 wasˆobservedˆin bed eating their lunch. Their walkerˆwasˆobservedˆby the wardrobe.ˆˆ Resident #31'sˆComprehensiveˆCareˆPlan for Fallsˆdated 1/12/2026, documented the resident was at risk for falls/has had an actual fall related to history of falls, ambulating withoutˆassistance, rolling out of bed. The goal was:ˆresidentˆwould be free from injury through the next review date.ˆSome interventions included:ˆensure resident was wearingˆappropriate footwearˆfor (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	movement,ˆmaintainˆclutter-free environment, upper perimeter mattress, bed in lowest position, and non-skidˆsocks asˆindicated.ˆˆ Resident #31's Comprehensive Care Plan for Self-Care and Mobility dated 1/22/2026 documentedˆthe residentˆrequiredˆassistanceˆwith self-care and mobility related to altered weight baring status, fracture, impaired balance, and limited mobility.ˆThe goalˆwasˆresident's self-care and mobility would improve through the review date.ˆˆAnˆinterventionˆincluded: sit toˆstandˆpartial assist of 1 staff (helper completes less than half of the activity, helper uses own strength to lift or hold the resident's body, arms, or legs, the resident completes more than half of the activity using own physical strength).ˆˆˆ During an observation onˆ4/13/2026ˆatˆ12:08 PM, Resident #31 wasˆobservedˆin their roomˆwalking to and from the bathroom unattended. They placed their oxygen on after they returned from the bathroom.ˆThe 2 floorˆmatsˆwereˆobservedˆsitting up against the wall under the window.ˆˆ During an interview onˆ4/13/2026ˆatˆ12:10 PM, Certified Nurse Aide #2ˆstatedˆthey were not sure ifˆResident #31 hadˆhad any fallsˆsince admission.ˆTheyˆstatedˆthey were not sure if the resident had floor mats before moving to their new room.ˆTheyˆstatedˆfloor mats should be on both sides of the bed when a resident was in bed. Certified Nurse Aide #2 furtherˆstatedˆthey should not be stacked on top of each otherˆand left on the side of the bed.ˆˆ During an interview onˆ4/13/2026ˆatˆ12:22 PM, Registered Nurse #1 statedˆResident #31 had one fall on 3/03/2026 where theyˆrolled out of theˆright side of the bed.ˆThey added a perimeter mattress to the resident's care plan.ˆRegistered Nurse #1 did not see floor mats in Resident #31's care plan. Theyˆstatedˆfloor mats go on both sides of the bed and should only be put down if the resident was in bed.ˆIf a residentˆwasˆnot in bed, they would push them to the side. Theyˆstatedˆthey were not aware of anyˆreason whyˆ2 floor matsˆmightˆbe stacked on top of each other and placed on one side of the bed. Theyˆstatedˆthey would not think that it was safe and that Resident #31 was a fall risk.ˆˆ During an interview onˆ4/14/2026ˆatˆ12:05 PM, Director or Nursing #1ˆstatedˆthey had one (1) fall, where they rolled out of bed. They added anˆupper perimeter mattress forˆspatialˆawareness.ˆTheyˆstatedˆthey, the Assistant Director of Nursing, and the Unit Manager wouldˆdetermineˆwhat interventionsˆto put into place after aˆfall andˆthen put the intervention in the care plan.ˆTheyˆstatedˆthey were not sure how floorˆmats were put in Resident #31's room.ˆˆDirector of Nursing #1ˆstatedˆthe floor mats stacked on top of each other could put theˆresidentˆatˆaˆhigher risk for falls.ˆˆ During an interview onˆ4/15/2026ˆatˆ1:02 PM, Registered Nurse #1ˆstatedˆtheyˆremovedˆtheˆfloor mats fromˆResident #83'sˆroom.ˆTheyˆstatedˆthe floor mats were put in the resident's room by mistake.ˆˆ During an interview onˆ4/15/2026ˆatˆ1:57 PM, Administrator #1 statedˆfloorˆmats couldˆbecome a tripping hazard as someone becomes independent.ˆˆ ˆ10 New York Codes, Rules, and Regulations 415.12(h)(2)ˆˆ

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review during a survey, the facility failed to ensure respiratory care services were provided in accordance with professional standards for 2 of 2 residents (Resident #87 and #7) with a tracheostomy (surgical opening in the neck necessary for breathing). The facility failed to support a clean environment or the maintenance of the availability of required tracheostomy supplies. The facility failed to ensure the availability of an Ambu bag (rescue breathing device) at the bedside for residents with a tracheostomy. The facility had not ensured staff consistently performed, documented, and demonstrated competent tracheostomy care in accordance with facility policy. This deficient practice had the potential to result in ineffective airway management, increased risk for infection, and compromised respiratory status. This failure had the potential to affect the resident's ability to receive timely emergency airway support. Findings include: The facility policy titled Tracheostomy Care, revised 12/02/2024, documented, tracheostomy care was to be provided in accordance with standards of practice to maintain airway patency, prevent respiratory infection, and maintain skin integrity. Care was to be performed by competent licensed staff based on assessed needs. Staff were responsible for maintaining a clean environment; ensure required supplies and equipment, including suction equipment, oxygen source, and essential airway devices (Ambu bag) at the bedside, were available and functional; perform routine and as-needed tracheostomy care and suctioning; monitor for respiratory distress; utilize appropriate personal protective equipment; and document care provided in the clinical record. Resident #7 was admitted to the facility on [DATE] with a diagnoses of malignant neoplasm of the larynx (throat cancer), tracheostomy (surgical opening in neck for breathing), and human immunodeficiency virus (a communicable disease). The 01/28/2026 Minimum Data Set (an assessment tool) documented, the Resident was cognitively intact, required substantial to maximal assistance with activities of daily living, and received suctioning and tracheostomy care. The care plan initiated on 04/09/2026 documented the need for an Ambu bag at bedside. During an observation on 04/08/2026 at 2:55 PM, Resident #7 reported staff had not performed tracheostomy care. A suction catheter was observed uncovered, cloudy liquid was present in the canaster, and tubing lacked date identification. During an observation on 04/10/2026 at 12:23 PM, Resident #7 stated they did not receive tracheostomy care and had not been suctioned despite having felt the need. The resident stated they felt the staff were not skilled to perform the care. Review of the 04/10/2026 Treatment Administration Record documented the care had been completed. During tracheostomy care observation and interview 04/13/2026 at 11:05 AM, Licensed Practical Nurse #2 Unit Manager entered the resident's room. The tracheostomy care setup appeared untouched. A deep suction catheter was observed uncovered and placed on top of the half full cloudy suction canister, with a used urinal located directly below. A bottle of water connected to the trach collar was present without a date. The resident stated staff did not know how to perform tracheostomy care and reported limited access to staff able to perform suctioning. The Licensed Practical Nurse was unable to locate necessary tracheostomy supplies in the room and was unaware of available supply sources. The Licensed Practical Nurse asked the resident where the supplies were and the resident responded by writing on the white board a message that indicated that they had not had the correct supplies in months. The Licensed Practical Nurse stated they had thought they had come in. They further described prior tracheostomy care as simply wiping the stoma opening. They had been unable to clearly describe the complete tracheostomy care procedures and admitted they and most of the other nurses needed to refresh their tracheostomy skills. Licensed Practical Nurse stated the resident could perform their own tracheostomy care to which the resident responded they were not comfortable doing their own care. An attempt to contact the Respiratory Therapist with the contact email provided by the facility was not returned. During an observation and interview on 04/13/2026 at 11:34 AM, Licensed Practical Nurse #4 was unable to identify the presence of an Ambu (continued on next page)

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During an interview on 04/15/2026 at 10:13 AM Registered Nurse #1 stated that the resident should have had clean and covered supplies and that tracheostomy care consists of more than just cleaning a site. If a nurse was simply cleaning the site it would not be considered complete and should not have been signed for. Ambu bag should be at bedside if not they would have to get the code cart from a distance away down the hall which was not safe. Registered Nurse #1stated that this is a most important crucial measure and would be imperative in the case of a freshly post-operative tracheotomy. During an interview on 04/15/2026 at 11:18 AM Medical Director stated the staff should be dating and changing the respiratory equipment for a tracheostomy resident per protocol to prevent infection. Care should be provided daily and if there were any staff lacking the skills to perform tracheostomy care they should receive training prior to working with the resident. All policies should be followed and the lack of an Ambu bag at bedside was not competent practice. Resident #87 was admitted to the facility on [DATE] with diagnoses including malignant neoplasm of the head, face and neck (cancer in the head or neck), presence of an artificial laryngectomy tube (an artificial airway in the neck), and cirrhosis of the liver (liver disease). The 07/26/2025 Minimum Data Set (an assessment tool) documented the resident was cognitively intact, with no evidence of hallucinations, delusions, or behavioral symptoms. The 07/25/2025 care plan identified pain related to medical conditions, with interventions including monitoring pain levels, administering prescribed analgesics, and evaluating effectiveness. The care plan also identified respiratory needs related to the presence of an artificial airway, with interventions including monitoring respiratory status, observing for signs and symptoms of respiratory distress or changes in secretions, and providing suctioning as ordered. During an interview on 04/08/2026 at 3:11 PM, the resident's health care proxy expressed Resident #87s concerns regarding staff competency to manage the resident's laryngectomy tube, including suctioning and airway care. The health care proxy reported that the resident did not have the ability to independently manage care and expressed concerns regarding the facility's ability to meet the resident's respiratory needs. The health care proxy further reported being unable to recall whether emergency airway equipment, including an Ambu bag, was present at the bedside. During a telephone interview on 04/09/2026 at 4:38 PM, Corporate Registered Nurse #1, reported determinations regarding a facility's ability to meet a resident's clinical needs were made by the facility's nursing and clinical staff and not by corporate staff. If a facility accepted a resident with a tracheostomy or similar airway needs, the decision reflected the facility's determination that it had the capacity and competency to provide the required level of care. During an interview on 04/15/2026 at 11:18 AM Medical Director reported tracheostomy care was assumed to be provided by the facility and should have been delivered with appropriate care. The Medical Director reported the facility would not accept a resident with a tracheostomy at the time of the interview and stated concerns regarding the facility's ability to provide such care. The Medical Director further reported the identified lack of ability to provide appropriate tracheostomy care should have been thoroughly investigated. During an interview on 04/15/2026 at 12:56 PM, the Director of Nursing reported the facility was able to provide tracheostomy care. They reported unawareness of why the resident stated there were no supplies in the room and indicated supplies were available. They had been unaware that an Ambu bag was not present at the bedside and stated this should not have occurred. They further stated that the resident was able to have performed their own care. The Licensed Practical Nurse should not have touched a soiled cannula with bare hands and that respiratory care items should have been appropriately dated. 10 New York Codes, Rules, and Regulations: 415.12(c)

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Warren Center for Rehabilitation and Nursing	42 Gurney Lane Queensbury, NY 12804

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviewˆduring a survey, the facilityˆfailed toˆensure licensed nursing staff, including nursing leadership,ˆpossessedˆthe competencies and skill sets necessary to provide care and oversight for residents requiring specialized clinical services and safe medication practices. This included failure to ensure staff competency in respiratory/tracheostomy care forˆtwoˆofˆtwo (2)ˆresidents reviewed for respiratory care (Residents #7 and #87), and forˆone (1)ˆresident reviewed related to a medication-related incident (Resident #87). The Director of Nursingˆfailed toˆinvestigate a serious medication-related incident,ˆfailed toˆensure physician notification of a narcotic discrepancyˆin accordance withˆfacility policy, andˆfailed toˆimplement orˆmaintainˆdisciplinary action for unsafe nursing practice. This deficient practice had the potential to affect all residents requiring skilled nursing care.ˆ Findings Include: The facility policy titled Competencies, revisedˆ01/18/2023, reviewed 12/2025, documented facility personnel shall be competent in job-specific duties and tasks. The policy documented department managersˆwere responsible forˆstaff training and competency validation. Competencies shall be completed on hire, annually, and upon change in duties or processes. The policy further documented competency validation shall be completed upon identification of performance concerns, staff shall receiveˆadditionalˆtraining when deficits areˆidentified, and competency validation and training shall be completed and documented.ˆ The facility policy titled Medication - Narcotic Management, last revised 04/2019, documented all narcotics shall be secured, accounted for, and discrepanciesˆimmediatelyˆreported to the Director of Nursing.ˆ The facility policy titled Notifications, last revised 04/2019, documented the facility shall notify the resident's physicianˆimmediatelyˆof significant changes in condition or incidents requiring physician intervention.ˆ The facility policy titled Accident -ˆIncidents,ˆ reviewedˆ06/01/2024, documented the facility shallˆmonitor, evaluate, and investigate all accidents, incidents, and adverse events. The policy documented incidents must be promptly reported to nursing supervision and evaluated. The nurse shall notify the resident's physician of the incident and any injuries. The supervisor/manager shall assess, document, and initiate investigation, including staff and witness statements, resident assessment, and determination of cause. The Director of Nursing shall review findings and ensure follow-up and appropriate actions. Documentation shall include physician notification, interventions, and corrective actions. The interdisciplinary team shall review incidents,ˆdetermineˆroot cause, and implement interventions and education.ˆ The facility policy titled Infection Prevention and Control Program, revised 01/21/2026, documented the facility shallˆmaintainˆan infection prevention and control program to provide a safe and sanitary environment and prevent transmission of infections. The policy documented the facility shall implement systems to prevent,ˆidentify, report, investigate, and control infections, and staff shall follow accepted infection control practices. The policy further documented the program includes staff education and competency related to infection control practices.ˆ Resident #7:ˆResident #7ˆwas admitted ˆto the facility on [DATE] withˆaˆdiagnosis of malignant neoplasmˆof the larynx (throat cancer), tracheostomy (surgicalˆopening in neck for breathing), and human immunodeficiencyˆvirusˆ(a communicable disease).ˆTheˆ01/28/2026 Minimum Data Setˆ(anˆassessment tool)ˆdocumented,ˆtheˆResidentˆwas cognitively intact,ˆrequiredˆsubstantial to maximalˆassistanceˆwith activities of daily living, and received suctioning and tracheostomyˆcare.ˆTheˆnewly implementedˆcare planˆinitiatedˆon 04/09/2026ˆdocumented the need forˆan Ambu bag at bedside.ˆˆˆ On 04/08/2026 at 2:55 PM, the resident wasˆobservedˆin their roomˆwith a tracheostomy. A suction catheter was uncovered and lying on top of a suction canisterˆcontainingˆcloudy fluid. No dates were present on tubing or equipment.ˆ On 04/13/2026 at 11:05 AM, the tracheostomy setup appearedˆin the same condition as (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	previouslyˆobserved. A deep suction catheter was uncovered and placed on top of a half-full suction canisterˆcontainingˆcloudy fluid, with a used urinal directly below. A bottle of water connected to the tracheostomy collar was not dated.ˆThere was noˆAmbu bagˆpresent.ˆ During an interview on 04/10/2026 at 12:23 PM, Resident #7 stated tracheostomy care and suctioning were notˆperformed,ˆand staff were not skilledˆto perform it andˆdon't ˆoffer.ˆ During an interview on 04/13/2026 at 11:05 AM, Licensed Practical Nurse #2ˆstatedˆthey personally hadˆhadˆperformedˆtracheostomy careˆon 04/12/2026; however, supplies in the room appeared unchanged. The Licensed Practical Nurseˆ#2ˆwas unable toˆlocateˆnecessary supplies, could not describe full tracheostomy care, andˆstatedˆthey hadˆrequiredˆadditionalˆtrainingˆto be competent in the proper careˆof aˆtracheostomy.ˆˆ Review of the April 2026 Treatment Administration Record documented physician orders for tracheostomy care every shift and as needed. Reviewˆidentifiedˆinconsistent documentation of care across shifts, with multiple staff initials and variability in completion of ordered treatments.ˆ Further reviewˆidentifiedˆdocumentation directing staff to encourage resident to allow staff or may self-clean, which was inconsistent with the resident's care needs and required skilled nursing interventions.ˆ Record review of Licensed Practical Nurse #2 competency recordsˆidentifiedˆcompetencies forˆinfectionˆcontrol, medicationˆadministrationˆand blood glucose monitoring; however, there was no documented evidence of competency validation for tracheostomy care or respiratoryˆequipment management.ˆ Resident #87:ˆResident #87 was admitted to the facility on [DATE] with diagnoses including malignant neoplasm of the head,ˆfaceˆand neck (cancer in the head or neck), presence of an artificial laryngectomy tube (an artificial airway in the neck), and cirrhosis of the liver (liver disease). The 07/26/2025 Minimum Data Set (an assessment tool) documented the resident was cognitively intact, with no evidence of hallucinations, delusions, or behavioral symptoms. The 07/25/2025 care planˆidentifiedˆpain related to medical conditions, with interventions including monitoring pain levels, administering prescribed analgesics, and evaluating effectiveness. The care plan alsoˆidentifiedˆrespiratory needs related to the presence of an artificial airway, with interventions including monitoring respiratory status,ˆobservingˆfor signs and symptoms of respiratory distress or changes in secretions, and providing suctioning as ordered.ˆˆ Review of theˆ07/26/2025ˆmedication administration record documented the medication had been administeredˆbyˆRegistered Nurse #2ˆat 4:00 PM.ˆTheˆresident andˆthe pain scale had been reassessed and evaluated as effective.ˆNo incident was documented in the medical record.ˆ Review of an incident statement dated 08/5/2025 documented Registered Nurse #2 placed a crushed narcotic (oxycodone) in a medication cup in Resident #87's room and left the medication unattended. Upon return, the medication was no longer present. The nurse assumed the resident had taken the medication, confronted the resident, and the resident denied taking it.ˆˆ Review of the Medication Administration Record dated 07/25/2025 through 07/27/2025 documented oxycodone as administered by Registered Nurse #2.ˆ During an interview on 04/15/2026 at 10:51 AM, Medical Director #1ˆstatedˆthey were not notified of the narcoticˆdiscrepancy,ˆand the medication should not have been documented as administered if the facts wereˆunclear. They furtherˆstatedˆall staff should have been competent in all areas offered by the facility.ˆRegardingˆ tracheostomyˆcare there should be no nurse unable to perform the skills.ˆ During an interview on 04/15/2026 at 12:56 PM, the Director of Nursing acknowledged responsibility for oversight of clinical care and investigations; however, did not provide evidence that a complete investigation had been conducted or that required follow-up actions were implemented.ˆ During a telephone interview on 04/14/2026 at 2:40 PMˆlawˆofficerˆ#1ˆstatedˆthey hadˆdeferred further action basedˆon theˆstatementˆbyˆthe Director of Nursing's assured them that the facility would conduct an internal investigation. There was no evidence an investigation wasˆinitiatedˆor completed, including absence of staff interviews, fact-finding, determination of cause, or corrective actions.ˆ Further record review did notˆdemonstrateˆevidence thatˆthe Director of Nursing notified the resident's physician of the missing narcotic medication or allegation the resident consumed the (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication,ˆin accordance withˆfacility policy.ˆ Review of the comprehensive care planˆidentifiedˆthe residentˆrequiredˆairway management and monitoring; however, physician orders did not reflect airway management needs or emergency equipment.ˆ Review of the personnel file for the nurse involved did notˆdemonstrateˆdocumentation of disciplinary action. There was no evidence of corrective action, counseling, or performance intervention. There was no evidence that performance concerns resulted in competency evaluation or retraining.ˆ The facilityˆfailed toˆensure nursing staff competency in respiratory care,ˆfailed toˆensure safe medication practices, andˆfailed toˆensureˆappropriate investigation, physician notification, and corrective action. The Director of Nursingˆfailed toˆprovide oversight andˆfailed toˆaddress unsafe nursing practice, including failure to notify the physician of a narcotic discrepancyˆin accordance withˆfacility policy. These failuresˆdemonstratedˆlack of competent nursing services.ˆ 10 New York Codes, Rules, and Regulations: 415.13(a)ˆ ˆ ˆ ˆ ˆ ˆ

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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 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review during a survey, the facility failed to ensure food brought into the facility from outside sources was stored, labeled, and maintained in accordance with professional standards of practice to prevent contamination and foodborne illness, for two (2) of two (2) residents reviewed (Resident #2 and Resident # 86). Specifically, Perishable food items (milk, mayonnaise and lettuce) were observed stored in a resident's window were unrefrigerated and not maintained at a safe temperature and were not managed in accordance with facility policy. Findings Include: The facility policy titled Food - From Outside, revised 07/12/20, documented all perishable foods must have been refrigerated, labeled, and discarded within 48 hours, and that foods left without temperature control for more than 2 hours were to have been discarded. Nursing staff were responsible for having monitored resident rooms for spoilage, contamination, and safety Resident #2 Resident #2 was admitted to the facility with diagnoses which included diabetes mellitus (high blood sugar); major depressive disorder (feeling very sad for a long time); exocrine pancreatic insufficiency (body could not properly digest food). The 03/31/2026 Minimum Data Set (an assessment tool) documented the resident was understood and able to understand; was cognitively intact; required minimal assistance with activities of daily living; required moderate assistance with ambulation. The 10/07/2025 care plan documented the resident had nutritional problems related to diabetes mellitus and was on a therapeutic diet; goals included maintaining adequate intake; maintaining blood glucose levels within an acceptable range; interventions included providing counseling regarding nutritional needs; evaluating eating habits and food preferences. During an observation and interview on 04/09/2026 at 2:45 PM, a jar of mayonnaise, two cartons of milk, and a head of lettuce stored on the windowsill of Resident #2s room. The Resident stated they had used the cool air as a refrigerator. Resident #2 stated their family members brought food into the facility to provide additional food options. Staff did not provide further options or guidance regarding storage. During an observation on 04/10/2026 at 2:05 PM, continued presence of mayonnaise, two cartons of milk and lettuce on the windowsill of Resident #2. The outdoor temperature recorded during the day ranged between 67 degrees Fahrenheit and 70 degrees Fahrenheit. Resident #86 Resident #86 was admitted to the facility on [DATE] with diagnoses which included infection of right knee prosthesis with methicillin-susceptible Staphylococcus aureus (MSSA) (infection in the knee replacement caused by bacteria); primary adrenal cortical insufficiency (body does not make enough stress hormones); atrial fibrillation (irregular heartbeat). The 04/02/2025 care plan documented the resident had a central line (PICC line) (a long tube placed in a vein to give medicine or fluids) with a goal to remain free from complications; the resident received outside food from visitors with a goal to prevent adverse effects from consumption; interventions included education to visitors on safe food handling temperatures, therapeutic diet and consistency needs, food safety handout mailed to the resident's family. The care plan documented limited physical mobility with a goal to increase mobility; interventions included fall prevention measures. The care plan documented a nutritional problem related to malnutrition (not getting enough nutrition) with a goal to maintain adequate nutrition without significant weight changes; interventions included review of meal consumption; reporting significant weight changes. During a record review of a complaint received to the Department of Health, on 04/09/2026 at 9:33 AM, documentation revealed Resident #86 was diagnosed with Salmonella (food poisoning from bacteria) during the facility stay. emergency room documentation indicated the illness was related to food consumption and identified as foodborne illness. Resident #86 was discharged from the facility at the time of the survey. Review of the facility 04/2025 and 05/2025 Infection Prevention and Control Monthly Reports and associated line lists revealed no documented evidence of foodborne illness identified, tracked, or trended. Review of the 04/2026 food temperature logs revealed temperatures were routinely monitored and maintained at appropriate levels; however, there was no documentation (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of monitoring or oversight of perishable food stored in resident rooms. During an interview on 04/09/2026 at 10:00 AM, the Dietary Manager #1 stated outside food should be labeled, dated, and stored properly; however, acknowledged staff did not consistently monitor or enforce storage requirements. During an interview on 04/15/2026 at 10:00 AM, the Director of Nursing stated there should not have been any food in resident rooms that were not stored at the proper temperature. They would be checking all rooms to ensure the facility complied. Foodborne illness is a serious risk especially if the policy was not followed. During an interview on 04/15/2026 at 12:26 PM, Infection Control Nurse #1 stated it was not acceptable for a resident to have stored unrefrigerated perishable items in their room. There would have been an opportunity for bacteria growth resulting in a foodborne illness. The Infection Control Nurse further stated they only recently had been made aware of this, and the food had been removed. During an interview on 04/15/2026 at 11:20 AM, the Medical Director stated all food in the facility should have been stored at the proper temperature and under proper conditions; it was unacceptable for perishable food to be stored in resident rooms, especially on warm days, as it could become a source of foodborne illness. During an interview on 04/15/2026 at 1:39 PM, the Administrator stated it was inappropriate for residents to have perishable items stored in their room and not refrigerated; staff should have brought the concern to administration, and administration would have addressed it. 10 New York Codes, Rules, and Regulationsˆ415.19 No Notes