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

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Warren Center for Rehabilitation and Nursing | 42 Gurney Lane<br>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) |
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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**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<br>(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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review conducted during a survey, the facility failed to ensure residents were able to exercise the right to self-determination, including making choices regarding daily routines, meals, and living environment, for two (2) (Resident #9, Resident #47, and Resident #71) of three (3) residents reviewed for choices. Specifically, (a.) Resident #9 was not permitted to return to bed upon request and was not provided with meaningful meal choices; and (b.) Resident #47 was expected to have moved from their room without consent despite refusal. Findings include: Review of the facility policy titledˆ Resident Rights,ˆrevised 05/28/2024,ˆdocumented healthcare personnel shall treat all residents with kindness, respect, and dignity. The policy further documented residents have the right to self-determination; to exercise their rights without interference, coercion, discrimination, or reprisal; to participate in care planning and treatment; to choose an attending physician and participate in decision-making regarding their care; to voice grievances without fear of reprisal; and to make choices about aspects of their life in the facility.ˆ Review of the facility policy titledˆ Room Change Policy,ˆdated 05/2024,ˆdocumented residents and/or their representatives were to be involved in room change decisions, informed of the reason for the move, and have their preferences considered.ˆ Review of the facility policy titledˆ Quality of Life/Dignity, dated 05/28/2024,ˆdocumented residents were to be treated with dignity and respect and have their choices honored to the extent possible.ˆ Resident #9 Resident #9 was admitted to the facility with diagnoses including end stage renalˆdisease (kidney failure), chronic respiratory failureˆ(lungˆdisease), and adjustment disorder with mixed anxiety and depressed mood (a short-term, stress-related condition characterized by an unhealthy, emotional reaction to a stressful life event). The Minimum Data Set (an assessment tool) dated 10/13/2025, documented they could be understood, understood others, and was cognitively intact.ˆ During anˆobservation andˆinterview on 04/08/2026 at 1:54 PM,ˆResident #9 had requested to return to bed.ˆˆLicensedˆPracticalˆNurse #1ˆstatedˆthe resident was not their patient.ˆAdditionalˆstaff alsoˆindicatedˆtheˆresident wasˆnot assigned to them when the resident requestedˆassistance.ˆLicensedˆPracticalˆNurse #1ˆstatedˆthe resident could not return to bed due to requiring a Hoyer lift. During an interview on 04/08/2026 at 3:22 PM, Director of Nursing #1 and Administrator #1ˆstatedˆresidents would have been able to return to bed whenever requested and there was no limitation related to Hoyer lift use.ˆ Resident #47Resident #47 was admitted to the facility with diagnoses includingˆsepsis (a blood infection), major depressive disorder (a serious, common mental health condition characterized by persistent severe sadness, low energy, and loss of interest in activities), andˆmalnutritionˆ(poor nutrition). Review of the Minimum Data Set, dated [DATE],ˆdocumentedˆthat the resident documented they could be understood, understood others, and was cognitively intact. During an interview on 04/09/2026 at 1:58 PM, Resident #47 statedˆthey were told they needed to move out of their room and wereˆnot provided with a choice. The residentˆstatedˆtheyˆhad recently been moved and had been informed that lack of their signature or consent would not prevent the move, as the room was needed for another resident.Record review verified the residentˆhadˆrefused to sign the room change documentation. Record reviewˆdid notˆinclude documentation the resident's refusal was honored or that the resident was provided with a meaningful opportunity to choose. During an interview on 04/09/2026 at 1:58 PM,ˆUnit Secretaryˆ#1 stated Resident #47 would have to move to a new room. Theyˆstatedˆthat Resident #47 had refused to sign the room change consent form and therefore another staff member signed as a witness to the notification of room change.ˆUnit Secretaryˆ#1ˆstatedˆthe move wasˆrequiredˆbased on directiveˆreceived via email from corporate requiring a (specific gender) bed beˆopenedˆwithin the facility.ˆUnit Secretaryˆ#1ˆstatedˆtheˆresidentˆhad no choice in the matter andˆwould be moved regardless of<br>(continued on next page) |

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| F 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | their desire to stay in the room theyˆwere in.ˆ During aˆtelephoneˆinterview on 04/09/2026 at 4:38 PM, Corporate Staff #1 stated room changes were managed at the facility level and residentsˆretainedˆthe right to refuse a room change. If a residentˆhadˆdeclined a room change, the facility would not be expected to force the move and should instead adjust admissions accordingly.ˆCorporate Staff #1ˆstatedˆto move a residentˆfrom their room against their consent would be a violation of their resident rights.ˆThey furtherˆstatedˆthere were very fewˆlegitimate reasons to move a resident out of their roomˆand accommodating an outside admission would not meet the criteriaˆfor aˆroom change.ˆ During an interview on 04/10/2026 at 12:02 PM, Director of Nursingˆ#1 statedˆResident #47'sˆplannedˆroom changeˆwasˆto accommodate anˆoutsideˆadmission and acknowledgedˆthe residentsˆlack ofˆconsent. Director ofˆNursing #1 agreedˆthere had been multiple room changes forˆaccommodationˆreasons,ˆhowever in several cases there was documentedˆresidentˆrefusal toˆsignˆconsent withˆaˆsubsequentˆnon-consentingˆmove resulting. Director of Nursing #1 referred to paper copies of consent to move for one (1)ˆresident. Record review revealed there was no evidence produced that paper copies of consent to move. ˆDuring an interview on 04/10/2026 at 1:22 PM, anˆadditionalˆresidentˆ[number withheld for privacy] statedˆnotification was given that a move wasˆrequiredˆto accommodate another resident and no choice was provided. The residentˆstatedˆrefusal to sign theˆagreement,ˆbut relocation occurredˆregardless,ˆand the move was believed to be retaliatory following a prior disagreement. The residentˆstatedˆlaw enforcement was contacted due to concerns belongings were being removed without permission.ˆ During an interview on 04/15/2026 at 10:17 AM, Registered Nurseˆ#1ˆstated residents should not be moved without consent; however, acknowledged residents were movedˆoftenˆto accommodate admissions and staff followed directionˆregardingˆroom changes.ˆThey acknowledged the lack of homelike feeling for residents when they move soˆoften,ˆand it can cause adjustment issues with the elderly. 10 New York Codes, Rules, and Regulations: 415.3(b)(1) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**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<br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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<br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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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| | 335549 | A. Building<br>B. Wing | 04/15/2026 |

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| Warren Center for Rehabilitation and Nursing | 42 Gurney Lane<br>Queensbury, NY 12804 |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>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 floorˆon 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<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**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<br>(continued on next page) |

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| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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<br>(continued on next page) |

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| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>Based on observation, record review, and interviews conducted during the survey, the facility did not ensure drugs and biologicals were labeled and stored in accordance with professional standards of practice for one (1) of two (2) medication carts (South Unit)ˆ and one (1) of one (1)ˆ(South Unit)ˆmedication room reviewed.ˆˆSpecifically,ˆthere were three (3) unopened insulin pens delivered 2 days prior that state keep refrigerated until opened.ˆˆˆTwoˆ(2) opened insulinˆkwikˆpens with no open and orˆexpirationˆdates.ˆˆOne (1) inhaler with no open and noˆexpirationˆdates, One (1) inhaler with noˆexpirationˆdate.ˆˆOne (1) box of hard candy in bottom of the medication cart andˆtheˆmedication room narcotic lock box #2, inside lock was left open.ˆˆ Findings include:ˆ The Facility's Policy and Procedure titled Medicationˆ Administration revisedˆ12/2019, documented Medications shall be administered in a safe andˆtimelyˆmanner, and as prescribed.ˆˆ8.ˆTheˆexpirationˆdate on the medication label must be checked prior toˆadministration. When opening a multi-dose container, the date shall be recorded on the container. Refer to Pharmacy guidance forˆexpirationˆof opened medications.ˆ The Facility's Policy and Procedureˆtitledˆ Medication Storage andˆlabeling revisedˆ1/21/2026, documented this facility will store Medications safely and securely and in a manner thatˆmaintainsˆthe integrity of theˆproductˆin accordance withˆmanufacturer's recommendations, current standards of practice and federal andˆstate regulations.ˆ4.ˆMedications will be stored in an orderly, organized manner in a clean area.ˆ7.ˆmedications (including ophthalmic,ˆearˆdrops and house stockˆmedications)ˆmay be used until theˆlisted manufacturerˆexpirationˆdate unless otherwise specificallyˆindicatedˆor labeled.ˆ8. Medication injection pens including insulin pens and cartridges are single patient use only and will beˆlabeled and stored for resident individual use.ˆˆ9. A multi-dose vial or injection pen that has been opened or accessed (e.g., needle-punctured) should beˆdated and discarded within 28 days unless the manufacturer specifies a different date for that openedˆvial or injection penˆa. If a multi-dose vial has not been opened or accessed (e.g., needle-punctured), it should beˆdiscarded according to the manufacturer'sˆexpirationˆdate.ˆˆb. The manufacturer'sˆexpirationˆdate refers to the date after which an unopened multi-dose vialˆshould not be used. The beyond-use-date refers to the date after which an opened multi-doseˆvial should not be used. The beyond-use-date should not exceed the manufacturer'sˆoriginalˆexpirationˆdate.ˆ10. Insulin storage requirements for vials, injection pens and cartridges will follow MIFU andˆincludeˆbut isˆnot limitedˆtoˆa. Do not freeze. (Frozen insulin should be discarded)ˆb. Do not use insulin beyond theˆexpirationˆdate stamped on the vial, pen, or cartridge that isˆsupplied from the drug manufacturer.ˆc. Do not use insulin beyond the Discard On date listed on the auxiliary label.ˆd. Do not expose insulin to direct heat or light.ˆe. Unopened, not-in-use insulin should be stored in a refrigerator at a temperature of 36-46 F orˆas per MIFU.ˆf. Opened, in-use insulin should be stored at room temperature below 86 F or as per MIFU.ˆˆ NYS Bureau of Narcotic Enforcement (BNE) regulations (10 NYCRR Part 80) requireˆSchedule II, III, and IV substances must be in a stationary, locked double cabinet with separate keys for each, or equivalent secure storage.ˆ During an observation onˆ04/13/2026ˆatˆ10:15 AM, the South Unit medication cart contained one (1)ˆTrelegyˆEllipta inhalerˆˆdated 3/26/2026 withˆno expiration date;ˆˆone (1) Ventolin inhaler with no open and or expiration date;ˆone (1) fluticasone/salmeˆ250 microgramˆopened 4/10 with no expiration date, and two (2)ˆLantusˆinsulin pens with no open or expiration dates.ˆˆThe South unit cart also was noted to haveˆunopened two (2)ˆLantusˆsolarˆinsulin pensˆand One (1)ˆnovologˆinsulin pen.ˆˆˆ During an interview onˆ04/13/2026 at 10:15ˆAM,ˆLicensed Practical Nurse #1 was unable to verbalizeˆexpirationˆdate of inhalers.ˆLicensed Practical Nurse #1ˆstatedˆthe fluticasone was brought in from home by the resident's family and found in resident's room.ˆˆLicensed Practical Nurseˆ#1ˆput the fluticasone in<br>(continued on next page) |

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| | 335549 | A. Building<br>B. Wing | 04/15/2026 |

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| Warren Center for Rehabilitation and Nursing | 42 Gurney Lane<br>Queensbury, NY 12804 |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | the medication cart for safe keeping.ˆThey alsoˆstatedˆthe three unopened insulin pens were delivered over the weekend and they had not been able to put them in the refrigerator yet.ˆ During an observation onˆ04/13/2026 at 10:30ˆAM, the South Unit Medication Room Narcotic Lock Boxˆ#2's inside lock was left unlocked.ˆˆ During anˆinterviewˆon 04/13/2026 at 10:30 AM,ˆLicensed Practical Nurse #1ˆstatedˆthe lock is broken as it sometimes catches and locks and there are times that it does not.ˆThis is not the first time this has happened to her, she states.ˆˆLicensed Practical Nurse #1ˆstatedˆwhen medication storage locks areˆbroken,ˆthey callˆmaintenance or put in a work order, for which she has not done yet.ˆˆ During an interview onˆ04/13/2026ˆatˆ12:14 PM, Director of Nursing #1ˆstatedˆthe medicationˆis responsible forˆlabeling medications upon opening. All insulins should be labeledˆwhenˆopened with date and time opened.ˆˆMedications with shortenedˆexpirationˆdates after opening such as insulin, eye drops and inhalers are reviewed during new hire nurse orientation and with annual competencies.ˆˆIf a narcotic lock box is brokenˆtheˆmedicationˆnurse should notify the Director of Nursing.ˆ During an interview onˆ04/13/2026ˆatˆ1:59 PM, Administrator #1ˆstatedˆnew lock boxes were recentlyˆpurchasedˆorˆtheˆmedication rooms. The nursing staff are aware that narcotics are toˆbeˆdouble locked at all times.ˆA Narcotic Log Inservice covering process for signing out narcotics was conducted on 1/8/2026 and 1/9/026.ˆˆGoing forward a narcotic book audit will be conducted by the Director of Nursing in addition to 1:1 in-service on the floors.ˆˆ ˆ 10 New York Codes, Rules, and Regulations 415.18(d)ˆ |

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Allow residents to self-administer drugs if determined clinically appropriate.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation,ˆinterview, and record review conducted during aˆsurvey,ˆthe facilityˆfailed toˆensure residents could safely self-administer medication when clinicallyˆappropriate forˆtwo (2) (Resident #'s 19 and 71)ˆofˆtwo (2) residents reviewedˆforˆmedication administration.ˆSpecifically,ˆ(a.)ˆResident #19 had medications in their room, but the resident was not assessed for their ability to self-administer medication,ˆandˆthereˆwas no documentation from theˆphysicianˆor in the resident's care plan that they could self-administer medications; and (b.)ˆResident #71ˆhadˆmedications in their room that were not ordered by a physicianˆand they reportedˆtaking/using the medications.ˆˆ ˆ Findings include:ˆˆ The facility policy titled Medication-Self Administration last revised 7/2019, documentedˆresidentsˆmay request to keep medications at bedside for self-administrationˆin accordance withˆresident rights.ˆUnder procedures, it was documented thatˆ(1.) staff and practitioner would assess each resident's mental and physical abilities to determine whetherˆself-administering medications was clinically appropriate for the resident upon request; (2.) general evaluation of decision-making capacityˆwould be conductedˆand the nurse would perform a more specific skill assessment; (3.)ˆif a resident was determined to be unsafe self-administering medications, nursing staff may determine that the residentˆcouldˆself-administer medications with assistance from the nurse, by storing the medication in the med-cart and observing the resident self-administer their medications at the correct time; (4.) self-administered medicationˆwere toˆbe stored in a safeˆand secure place, which was not accessible by other residents;ˆ(5.) staff should identify and give to the charge nurse any medications found at the bedside thatˆwere not authorized for self-administration, for return to the family or responsible party; (6.) the staff and the practitioner would periodicallyˆreevaluate a resident's ability to continue to self-administer medications.ˆˆ Resident #19ˆˆˆ Resident #19 was admitted to the facility with diagnoses of paroxysmal atrial fibrillation (a condition characterized by rapid, irregular heartbeats that start and stop abruptly),ˆhypertension (high blood pressure), and depression (a mental health condition characterized by persistent sadness, loss of interest, and other symptoms that significantly impair daily life).ˆ The Minimum Data Set (an assessment tool) dated 1/20/2026, documented the resident was cognitively intact, could be understood, and could understand others.ˆˆ During an observation onˆ4/08/2026ˆatˆ3:38 PM, a medication cup wasˆobservedˆat Resident #19's bedside with cream/crushed medication inside.ˆˆ A review of Resident #19's medical record did not include documentation that the resident was assessed for their ability to self-administer their medications.ˆ A review of Resident #19's medical record did not include documentation from the resident's physician that the resident could self-administer their medications.ˆ A review of Resident #19's care plan did not include documentation the resident could self-administer their medications.ˆ Resident #71ˆˆ Resident #71 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), Sequelae of Guillain-Barre syndrome (long-term or permanent residual health issues arising from peripheral nerve damage, lasting beyond the acute phase of the disease),ˆ and congestive heart failure (a weakened heart condition that causes fluid buildup in feet, arms, lungs, and other organs). The Minimum Data Set, dated [DATE], documented the resident was cognitively intact, could be understood, and could understand others.ˆ During an observation on 4/08/2026 at 3:25 PM,ˆcollagen peptides, alphaˆlipoicˆacid (antioxidant),ˆand aspercreme (pain reliever)ˆwereˆobservedˆat Resident #71's bedsideˆand/orˆin their window.ˆˆ During anˆinterviewˆon 4/08/2026 at 3:25 PM,ˆResident #71ˆstatedˆthey took collagen peptides and alphaˆlipoicˆacid to help with wound healing. Theyˆstatedˆit wasˆbrought in by their family.ˆˆ Resident #71's Medication Administration Record for April 2026 did not include orders for collagen peptides, alpha lipoic acid, orˆaspercremeˆ During an interview on 4/09/2026 at 12:00 PM, Director of Nursing #1ˆstatedˆthere were no residents in the<br>(continued on next page) |

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | facility who self-administered their medications.^^ During an interview on 4/09/2026 at 12:02 PM,^Administrator^#1^stated^there were no residents at the facility that self-administered their medications. If^a resident^chose to self-administer their medications, they would have to demonstrate that they could^do it^on their own, utilize a locked box^in order to^store medications properly, and be assessed by the interdisciplinary team to determine if the resident was an appropriate candidate. They^stated^if a resident^was^determined to be^a good candidate^for self-administering their^medication, they would have a conversation with the medical provider and^the^resident. Administrator #1 stated Resident #71 showed a desire to self-administer their medications but decided not to since medications would need to be locked up. They^stated^it was discussed at^Resident #71's^care plan meeting that vitamins, antifungal powders, and over the counter medications needed medical provider orders.^^ 10 New York Codes, Rules, and Regulations: 415.3(f)(1)(vi)^ |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews during the survey, the facility did not ensure a safe, clean, comfortable, and homelike environment for two (2) (Resident #10, #41 and #58) of four (4) residentsˆreviewed. Specifically, Resident #10 had a bedside commode with soiled tissue on the floor next to their bed and commode.ˆThere were landing strips at the bedside with copious dried brown material consistent with fecal material.ˆResident #58ˆwas the roommate to Resident #10 andˆstatedˆthey were subject to soiled materials at the entrance of theirˆroom and oftenˆhad toˆcall forˆassistanceˆforˆResident #10 when they soil the floor. Findings include:ˆ The facility's Procedure titled Resident Room Cleaning documented a four-step process:ˆ 1. Knock and announce yourself. 2. Clean Bathroom. 3. Clean sink and vanity 4. Clean Roomˆˆ f) Check all corners and edges for trash and debris stuck in corners and edges.ˆˆg) Also use putty scraper to pick up anything stuck to the floor.ˆˆh) Dust all horizontal and vertical surfacesˆi) Dust mop around behind all furniture j) damp mop floor with Neutral Cleaner including hallway outside room to next room k) Spray Air Freshener in air and on privacy curtains.ˆˆ Resident #10 was admitted to the facility with diagnoses of fracture of the upper end of one (1) of the humerus bones (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 (an assessment tool) dated 3/18/2026, documented the resident had moderate cognitive impairments, could be understood, and could understand others.ˆˆˆ Resident #58ˆwas admitted to the facility with diagnosis ofˆDiabetesˆMellitusˆ(a chronic metabolic disorder characterized by consistently high blood sugar levels resulting from inadequate insulin production or the body's inability to use insulinˆeffectively),ˆOsteoarthritisˆ(chronic, degenerative joint disease, often called wear-and-tear arthritis),ˆˆandˆNon-Alzheimer'sˆDementiaˆ(a general term for cognitive decline, with Alzheimer's being the most common, Non-Alzheimer's Dementia differ from Alzheimer's by causing earlier behavioral, motor, or language changes rather than just memory loss). The Minimum Data Set, dated [DATE], documented the resident had moderate cognitive impairments, could be understood, and could understand others.ˆˆˆ During an observation on 4/07/2026 at 2:24 PM, Resident #10 was noted to haveˆa bedside commode and landing strips on floor,ˆparallel to bed on the left side.ˆThe landing strips were caked with brown materialˆconsistent with feces,ˆand otherˆstains that were unidentifiable. There were also several soiled tissues on the floor that appeared to have been meantˆto be in the garbageˆbin butˆinstead landed on the floor.ˆDuring an interview on 4/07/2026 at 2:24 PM, Resident #58ˆstatedˆtheir roommate, Resident #10, often used the commode thenˆthrows soiled tissues on the floor.ˆˆThey alsoˆstatedˆthere were times Resident #10 attempted to self-toilet but instead defecated on the floor.ˆResident #58ˆstatedˆthey call for help but it took hours before anyone comes to help.ˆˆDuring an observation on 04/08/2026 10:32 AM,ˆResidentˆ#10ˆwasˆself-toiletingˆthemselvesˆon the bedside commode,ˆinˆanˆopen area, no curtains drawn,ˆattemptingˆtoˆwipeˆthemselves.ˆˆTheyˆthrew tissue onto the floorˆinstead of garbage bin.ˆˆ During an interview onˆ04/08/2026ˆatˆ10:38 AM, Housekeeper #1ˆstatedˆthey were a floater housekeeper. They were assigned toˆResident #10's room last week and today. They had not yet cleaned Resident #10's room.ˆˆThey were not assigned to the room the previousˆday andˆwould notify maintenance to change the landing strips.ˆHousekeeper #1ˆstatedˆwhen they cleaned the rooms, theyˆstart at over-bed table, sweep,ˆmopˆand clean bathroomˆwithˆdisinfectant,ˆand that nursing picks upˆanyˆbulk.ˆThey further stated they would disinfect the bedside commode.ˆ During an interview on 04/08/2026 at 10:33 AM, Maintenance Director #1ˆstatedˆit was the responsibility of the housekeeping staff to notify maintenance of stained,ˆsoiledˆor damaged landing strips. They (continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | further statedˆMaintenance would firstˆattemptˆto clean the strips.ˆˆIf the strips were unable to beˆcleanedˆthey will be replaced.ˆˆMaintenance Director #1 stated Resident #10 had behaviors of eating chocolate cookies daily and the brown stains on the landing strips were caked up cookies, not feces.ˆ 10 New York Codes, Rules, and Regulationsˆ415.29(j)(1)ˆ |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.<br><br>**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<br>(continued on next page) |

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| F 0627<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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<br>(continued on next page) |

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| F 0627<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**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 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record reviewˆduring a survey,ˆthe facilityˆfailed toˆensure necessary services were provided toˆmaintainˆgood nutrition and activities of daily living for 1 (one) of 4 (four) residents reviewed forˆactivities ofˆdaily livingˆcare (Resident #41). Specifically, For Resident #41, the facilityˆfailed toˆprovideˆappropriate assistanceˆand cueing during meals as this resident required support when eating. Findings include:ˆ Review of the facility policy titledˆ Activities of Daily LivingˆCare and Support, revised 11/6/2025 documented Activities of Daily Livingˆcare and support are to be provided in accordance with the resident's assessed needs, personal preferences, and individualized plan of care, including assistance with hygiene, mobility, toileting, and dining. The policy further documented the interdisciplinary team wouldˆhaveˆmonitoredˆ theˆ resident'sˆability to performˆActivities of Daily Livingˆand revise the plan of care asˆindicated, and the amount ofˆassistanceˆprovidedˆwouldˆhave beenˆdocumented in the clinical record.ˆ Resident #41 was admitted to the facility with a diagnosis of Traumatic Subdural Hemorrhage (bleeding on the brain), Hypertension and malnutrition (poor nutrition). The Minimum Data Set (an assessment tool) dated 3/30/2026,ˆdocumentedˆResident #41 had a severe cognitive impairment.ˆIt further documented the resident always understood was able to be understand others; requiredˆassistanceˆwith meal preparation only. The 03/23/26 care planˆdocumented theˆresident had a nutrition problem and was malnourished with 7% weight loss in 1 month. The plan was to continue their diet as ordered; monitor weights; offer snacks; evaluate intake and preferences; review meal/fluid intake; Report significant weight changes to physician. Record review of the certified nurse aide documentation intake records fromˆadmission [DATE]-[DATE] revealed poor, inconsistent intake with frequent minimal consumption and refusals and no consistent adequate intake pattern.ˆ Record review of the certified nurse aide documentation from 04/01/2026-04/13/2026 revealed frequent low or refused intake with inconsistent consumption overall, poor oral intake and a lack of sustained or adequate nutritional and fluid intake.ˆ Record Review of Resident# 41's weight since admissionˆdocumented on 03/23/2026, the resident weighedˆ137.2ˆpounds.ˆˆOn 04/10/2026, the resident weighed 134.6ˆpounds. On 04/15/2026, the resident weighed 132.1ˆpounds. During this time, Resident #42 demonstrated a 5.1-pound weight loss. During an observation on 04/08/2026 at 12:25 PM, Resident #41 wasˆin the dining area with a meal present. The resident did notˆinitiateˆeating; noˆencouragement was provided. Staff wereˆobservedˆat a distance and did not engage the resident to promote intake.ˆ During an observation on 04/10/2026 at 1:05 PM, Resident #41 was in their room with a meal trayˆcontainingˆa hotdog and vegetables. No food had been consumed. The resident remained seated in front of the tray withoutˆinitiatingˆeating and did notˆdemonstrateˆthe ability to independently begin the meal. The resident remained alone in theˆroom. Followingˆconstantˆobservation,ˆno staffˆhadˆentered the room to provide cueing, encouragement, orˆassistanceˆwithˆeating. Atˆ1:46 PM, a Certified Nurse Aid entered theˆroom,ˆremoved the uneatenˆmealˆtray andˆremarked about the uneaten foodˆand left the room.ˆ During an observation on 04/13/2026 at 12:59 PM, Resident #41 wasˆin their room with a meal tray delivered. All food items remained covered. The residentˆdemonstratedˆdifficulty initiating the task of eating, asˆevidencedˆby attempting to open containers and holding items without successfully accessing the food. The resident placed a covered bowl into a plastic bagˆcontainingˆbread, turned toward the bed, adjusted the linens, and lay down without consuming the meal.ˆˆ During an observation on 04/13/2026 at 1:23 PM, aˆCertified Nurse Aideˆ#ˆ1ˆentered the resident's room,ˆstated, You notˆgoing toˆeat? and removed the meal tray withoutˆhelping, cueing, or encouragement provided to assist the resident with consuming the meal.ˆ During an observation on 04/14/2026 at 8:45 AM, Resident #41 wasˆstanding in their room with a breakfast meal consisting of eggs, juice, cereal, and a cut muffin. The resident manipulated food items on the plate andˆinitiatedˆdrinking fluids but did not consume solid food.ˆ During an observation<br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | on 04/14/2026 at 9:25 AM,ˆCertified Nurse Aideˆ#2ˆsubsequentlyˆentered Resident #41's room, asked if the resident was finished, and removed the tray. The meal remained uneaten.ˆ During an observation on 04/15/2026 at 8:25ˆAM, Resident #41 had an early breakfast trayˆdelivered to their roomˆdue to an outside appointment. The residentˆwas ready for their appointment and had been walking around theˆfacilityˆin their coat. They had not been in their roomˆduring the time the tray wasˆdelivered,ˆand the tray remainedˆuneatenˆwhen they left the facility.ˆ During an interview on 04/08/2026 at 9:57 AM, theˆresident'sˆfamily member #2 statedˆthey hadˆdiscussed concerns with Nurse Practitionerˆ#1ˆregardingˆthe resident's weight loss and inability to feed themselves independently. Theyˆstatedˆtheˆresidentˆrequiredˆdirection and encouragement for daily functioning and did notˆinitiateˆtasks independently. They furtherˆstatedˆthe residentˆhadˆrequired encouragement to eat and expressed concerns that staffˆhadˆnot consistently providedˆsupervision orˆassistance, particularly during meals. They expressedˆconcernˆregardingˆthe resident's anxiety, unmet toileting needs, and lack of staffˆengagement. Theyˆstatedˆthey would be discussing this at the care plan meeting later that day.ˆFamily member #2 described a concern regarding Resident # 41s ability to toilet themselves independently. They described the resident occasionally soiling the bed and, in an effort, to conceal the mess they would make the bed over the soiled sheets. The family described situations where the resident flushed their incontinent briefs down the toilet causing the toilet to overflow. During an interview on 04/15/2026 at 9:08 AM, Occupational Therapist #1ˆstatedˆthey had evaluated Resident #41on 03/24/2026 andˆidentifiedˆthe resident as independent with some cognitive impairment. Their recommendation was for supervision withˆActivities of Daily Living.ˆThey had not been aware the resident was not consuming meals andˆstatedˆthey would expect to be notified for further evaluation and treatment if the resident was not able to carry out the skill of eating. Staff should report if a resident was unable to eat or toilet independently andˆindicatedˆthat if the resident had been flushing incontinence briefs, that would suggest a need for increasedˆassistance.ˆ During an interview on 04/15/2026 at 9:32 AM, Licensed Practical Nurse #3ˆstatedˆthe resident was independent sometimes, reported the resident would eat at times, andˆstatedˆthey were not aware of the resident not eating. They reported the resident was independent with toileting themselves.ˆ During an interview on 04/15/2026 at 9:36 AM, Certified Nurse Aide #1ˆstatedˆthe resident just does not eat. Certified Nurse Aide #2 said the resident did not do well in the dining room, so they changed their eating location to theirˆroom,ˆbut they stillˆdid notˆeat their meals.ˆ During an interview on 04/15/2026 at 9:38 AM, Registered Nurse #1ˆstatedˆthe resident was to have their meal prepared. If the resident was not eating meals the staff should let them know. Staff should be preparing the meal by opening the lids and encouraging consumption.ˆˆ During an interview onˆ04/15/2026ˆat 10:51 AM, Registered Dietitian #1ˆstatedˆthey were aware of the consistent decline in theˆResident #41'sˆweight. They stated on 04/14/2026, they added nutritional supplements to theˆresident'sˆmeal tray. They were aware of the resident's low intake;ˆhowever,ˆthey had not been aware of the lack ofˆassistanceˆor encouragement with the resident's mealsˆ 10 New York Codes, Rules, and Regulations: 415.12(c)ˆ |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide activities to meet all resident's needs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based onˆobservation, interview, and record reviewˆconducted during a survey, the facility failed toˆensure ongoing provision of programs to support each residentˆand their choices of activities, designed to meet the interests of and support the physical, mental, and psychosocial wellbeing forˆtwo (2) (Resident #'sˆ6 and 9) ofˆtwo (2) residents reviewed. Specifically,ˆ(a.)ˆResident #6ˆwas nearing end of life and was not provided with any stimulation or one-to-oneˆinteraction orˆvisits; and (b.) Resident #9ˆstatedˆthey felt like aˆprisonerˆand wereˆnotˆprovided withˆtime outdoorsˆper their preference.ˆAdditionally,ˆperfumeˆsampling was included on theˆactivitiesˆagenda on 4/14/2026 and couldˆhaveˆcausedˆadverse reactions for some residents.ˆˆ Findings Include:ˆˆ ˆ ˆ The facility policy titled Activity Programˆlast reviewed 5/2019, documented the facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities designed to meet the interests of and support the physical, mental, and psychosocial wellbeing of each resident.ˆIndividualized and group activitiesˆwere provided that: (a.) reflectedˆthe schedules, choices and rights of the residents; (b.)ˆwere offered at hours convenient to theˆresident; (c.) reflectedˆthe cultural and religious interests, hobbies, life experiences, and personal preferences of the residents; and (d.)ˆappealedˆto men and woman as well as those of various age groups residing in the facility.ˆˆ ˆ Resident #6ˆˆ ˆ Resident #6 was admitted to the facility with diagnoses ofˆend stage renal disease (a condition where the kidneys can no longer effectively filter waste and excess fluid from theˆblood),ˆhypertension (high blood pressure),ˆandˆdementia (a group of conditions that cause a progressive decline in cognitive abilities).ˆThe Minimum Data Set (an assessment tool) datedˆ4/01/2026,ˆdocumented the residentˆwas severely cognately impaired, could be understood, and could understand others.ˆˆ During an observationˆmadeˆonˆ4/08/2026ˆat 11:51 AM,ˆResident #6ˆwasˆobservedˆin their room, no activities were present,ˆandˆtheyˆhad no staff interactionsˆthroughout the morning.ˆˆ During an observation onˆ4/10/2026ˆatˆ1:44 PM, Resident #6 wasˆobservedˆin bed, their skin was dusky ash appearance,ˆthey were lethargic,ˆhad dry mucosa, and periods of apnea.ˆResident #6ˆrespondedˆto questions andˆattemptedˆto have a conversation.ˆThere were no activities present in theˆresident'sˆroom.ˆˆ During anˆinterviewˆonˆ4/10/2026ˆatˆ2:12 PM, Director of Activities #1 statedˆclergy went to see Resident #6, butˆsince family was present, they did not see them.ˆDirector of Activities #1ˆstatedˆthey normally providedˆone-to-oneˆvisitsˆwith theˆresident.ˆˆ There was no documented evidence thatˆone-to-oneˆvisits were provided to Resident #6.ˆ ˆ Resident #9ˆˆ ˆ Resident #9 was admitted to the facility with diagnoses ofˆhemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (a neurological condition causing paralysis or weakness on the left side of the body, stemming from right brain damage),ˆdementia, and depression (a mental health condition characterized by persistent sadness, loss of interest, and other symptoms that significantly impair daily life).ˆThe Minimum Data Set, dated [DATE], documented the resident was cognitively intact, could be understood and could understand others.ˆˆ During an interview onˆ4/08/2026ˆatˆ1:56 PM, Resident #9ˆstatedˆthey felt like a prisoner.ˆTheyˆstatedˆtheyˆhaveˆresidedˆat the facility for 6 years and onlyˆwentˆoutside for medical appointments.ˆResident #9ˆstatedˆthey would like to go outside and sit in the sun.ˆˆˆ During an interview onˆ4/08/2026 at 2:30 PM,ˆDirector of Activitiesˆ#1statedˆResident #9 refused to come out of their room, but theyˆprovidedˆactivities to theˆresidentˆin their room. When asked forˆtheˆlog of one-to-one visitsˆprovided to Resident #9, Director of Activities #1 was unable to produce any documentation.ˆDirector of Activities #1 stated Resident #9ˆhad not been outdoors, but they wouldˆofferˆto take the resident outside going forward. Theyˆstatedˆ Resident #9'sˆfamily member tookˆthem outside.ˆˆˆ There was no documented evidence that one-to-one visits were provided to<br>(continued on next page) |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident #9.ˆ ˆ During an observation on 4/14/2026 at 10:15 AM,ˆthe activity scheduledˆwasˆsample of perfumes and history.ˆNursing staff brought concernsˆregardingˆperfumeˆsamplingˆandˆtheˆreaction it could cause toˆsomeˆresidentsˆtoˆthe activity department andˆadvised themˆnot toˆsample perfumes.ˆThe activity was altered.ˆˆ During an interview onˆ4/14/2026ˆatˆ11:48 AM, Regional Director of Nursing #1ˆstatedˆthey did not believe thatˆthe activities calendar was reviewed before it was implemented.ˆˆTheyˆstatedˆan activity to sample perfume was not recommended as perfumes could create health hazards.ˆˆ During an interview on 4/15/2026 at 10:54 AM, Medical Director #1ˆstatedˆthat perfumeˆsamplingˆwasˆnotˆan appropriate activityˆin a skilled nursing facility setting.ˆˆ ˆ 10 New York Codes, Rules, and Regulations 415.5(f)(1)hˆ ˆˆ ˆ ˆˆ ˆˆ ˆ ˆ |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**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<br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | bag in the resident's room. They indicated where it should have been located; however, no Ambu bag was present in the room. The resident stated an Ambu bag had never been available at the bedside. Licensed Practical Nurse #4 stated the lack of the Ambu bag was unknown and they would replace it promptly. During an interview on 04/09/2026 at 10:00 AM, the Director of Nursing stated tracheostomy supplies should be maintained in a clean area and staff should be trained in proper care techniques. The Director of Nurses documented in a secure file transfer that Resident #7 and their family member provided their own tracheostomy supplies and maintained the resident had adequate correct supplies in their room. 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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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate pain management for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based onˆobservation, interview, and record reviewˆconducted during a survey, the facility failed toˆensure ongoing provision of programs to support each residentˆand their choices of activities, designed to meet the interests of and support the physical, mental, and psychosocial wellbeing forˆtwo (2) (Resident #'sˆ6 and 9) ofˆtwo (2) residents reviewed. Specifically,ˆ(a.)ˆResident #6ˆwas nearing end of life and was not provided with any stimulation or one-to-oneˆinteraction orˆvisits; and (b.) Resident #9ˆstatedˆthey felt like aˆprisonerˆand wereˆnotˆprovided withˆtime outdoorsˆper their preference.ˆAdditionally,ˆperfumeˆsampling was included on theˆactivity'sˆagenda on 4/14/2026 and couldˆhaveˆcausedˆadverse reactions for some residents.ˆˆ Findings Include:ˆˆ The facility policy titled Pain-Managementˆrevised 4/28/2025, documented the facility would recognize and manage a resident's pain in accordance with the resident's goals and preferences, current standards of practice and State and Federal Guidelines to promote and/or maintain the resident's highest practicable mental, physical, and psychosocial well-being.ˆResident's self-report of pain and non-verbal signs of pain would be evaluated using the follow scales including but not limited to: (a.) cognitively intact resident would be evaluated per self-reportˆand numerical pain scale of one to ten; and (b.) resident with cognitive impairment, or who is non-verbal would be evaluated per self-report (if able)ˆand/or pain assessment in advanced dementia (PAINAD) pain scale or [NAME] pain scale.ˆPharmacologic andˆnon-phrenologicalˆinterventions may be used to manage a resident's pain.ˆThe nursing staff would evaluate the resident for pain upon admission to the facility, quarterly, as clinicallyˆindicated, and/or with anˆonset of new pain or worsening of existing pain. The evaluation would include but was not limited to: (a.)ˆidentificationˆof the underlying cause; (b.) characteristics of pain such as location, intensity, frequency, pattern, and severity; (c.) situation or interventions that may impact on the resident's pain; and (d.) impact of pain in resident activities of daily living, sleeping, appetite, and mood.ˆBased on the interdisciplinary team's evaluation, a resident centered plan of care would be developed and updated as clinically indicated and include: (a.) resident preferences, goals and acceptable levels of pain; (b.) treatment of pain including, pharmacologic as well as non-pharmacologic interventions; and (c.) side effects, adverse consequences, and effectiveness of pain interventions.ˆPrior to administration of as needed pain medication the nurse would evaluate for and document in the clinical record: (a.)ˆlocation of pain; (b.) pain level prior to medication; (c.) pain scale used; (d.) non-pharmacologicalˆinterventions; (e.)ˆpharmacologicalˆinterventions; and (f.) effectiveness of non-pharmacologicalˆandˆpharmacologicalˆinterventions.ˆˆ ˆ Resident #10ˆˆ ˆ Resident #10 was admitted to the facility with diagnoses ofˆfracture of the upper end of the left humerusˆ(a break in the top part of the left arm bone near the shoulder joint, often resulting from falls or trauma),ˆdementia (a group of conditions that cause a progressive decline in cognitive abilities), andˆanxiety (mental health condition characterized by excessive fear or anxiety that interferes with daily activities)).ˆThe Minimum Data Set (an assessment tool) datedˆ3/18/2026, documented the resident had moderate cognitive impairments, could be understood, and could understand others.ˆˆˆ ˆ During an observation onˆ4/07/2026, Resident #10 complainedˆof painˆand theirˆleftˆhand was noted to beˆswollen.ˆˆˆˆ ˆ During an observation onˆ4/08/2026ˆat 10:45 AM, Resident #10 complained of painˆand asked what time they could get their pain medication. There was noted swelling to theirˆleftˆhand.ˆThis was reported to Licensed Practical Nurse #2 and Director of Nursing #1.ˆˆ ˆ A nursing progress note dated 4/08/2026 at 1:00 PM, documented spoke with Medical Director #1 about pain in Resident #65's hands. Medical Director reviewed current medications and orderedˆDiclofenac Sodium External Gel 1ˆ%.ˆˆ ˆ A physician order dated 4/08/2026, documentedˆDiclofenac Sodium External Gel 1 % (Diclofenac Sodium (Topical))ˆapply toˆboth hands topically every 8 hours as needed for painˆapply a small amount.ˆ ˆ During an observation onˆ4/10/2026ˆatˆ1:41 PM, Resident #10 wasˆobservedˆin their room and the swelling in their handˆhadˆdecreased significantly.ˆˆ ˆ During an<br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | interview on 4/10/2026 at 1:41 PM, Resident #10ˆstatedˆtheir left stand still hurt, but not the way it used to. TheyˆstatedˆIf they kept doing what they were doing, it would get even better.ˆˆ ˆ During an interview onˆ4/08/2026, Licensed Practical Nurse #2ˆstatedˆif a residentˆwasˆcomplaining of pain theyˆwould do an assessment, collectˆdataˆandˆsend information toˆtheˆMedicalˆProvider. TheyˆstatedˆResident #10 had a standing morphine order.ˆLicensed Practical Nurse #2ˆstatedˆtheyˆcompletedˆa pain scale every shift, not prior to administering pain medications.ˆTheyˆstatedˆResident #10 had been complaining ofˆpainˆas long as they could remember.ˆTheyˆstatedˆthere have not been any otherˆinterventions for Resident #10, justˆthe morphine,ˆtheyˆstated there was no Medical Provider in the building at the time, so they would place the concern in the Medical Provider book and message the Medical Provider.ˆˆ ˆ During an interview 4/08/2026 11:11 AM, Director of Nursing #1ˆstatedˆif pain medication was routine, they did not askˆthe resident for aˆpain level. They only did for as needed pain medications.ˆIf a resident continued to complain of pain.ˆDirector of Nursing #1ˆstatedˆthey would assessˆand follow up with interventions.ˆˆ ˆ Resident #47ˆˆ ˆ Resident #47 was admitted to the facility with diagnoses of rheumatoid arthritis (a chronic, autoimmune inflammatory disorder where the immune system mistakenly attacks the join lining causing painful swelling, stiffness, and potential bone erosion or deformity), fibromyalgia (a condition that causes widespread musculoskeletal pain, fatigue, and sleep disturbance), and age-related osteoporosis (a progressive disease where bone remodeling becomes imbalanced-bone breakdown exceeds formation leading to low bone mass, structural deterioration, and brittle bones). The Minimum Data Set (an assessment tool) dated 3/24/2026, documented the resident was cognately intact, could be understood, and could understand others.ˆˆ ˆ During an interview onˆ4/08/2026ˆatˆ12:31 PM, Resident #47ˆstatedˆtheirˆpainˆwas not in control when theyˆcould notˆtakeˆtheirˆmedicationˆand for some reason no matter how hardˆthey tried they could not get theirˆpain med between the hoursˆof 3:00 PM and 11:00 PM. The resident reported on 3/04/2026 the entire day they were unable to obtain their narcotic pain medication. Theyˆstatedˆthereˆwasˆnoˆexplanationˆasˆtoˆwhyˆitˆwasˆnotˆavailableˆandˆtheirˆpainˆwasˆnot adequately controlled on that day.ˆˆ ˆ During an interview on 4/10/2026 at 10:07 AM, Resident #47ˆstatedˆthey got their pain medication the previous night, but there were so many times that they did not. Theyˆstatedˆthˆeˆmedicationsˆwereˆsignedˆforˆbutˆtheyˆsworeˆtheyˆdidˆnotˆgetˆthem. Theyˆstatedˆtheyˆaskedˆforˆpainˆmedicationˆonˆ04/05/2026ˆbutˆnoˆoneˆeverˆrespondedˆˆ During an interview onˆ4/13/2026ˆatˆ10:02 AM,ˆResidentˆ#47ˆstatedˆover the weekend when they asked for their pain medication, they got no response for hours. Theyˆstatedˆwhenˆtheyˆfinallyˆdidˆgetˆtheir medications the nurse questioned have you been missing something.ˆˆ ˆ Resident #47's Comprehensive Care Plan for Comfort dated 3/30/2026, documented the resident had a decrease in comfort related to arthritis, fibromyalgia, immobility, and peripheral vascular disease. The goal was:ˆresidentˆwould achieve pain goal of tolerable pain while at rest through next review date. Interventions included: administer medications as ordered, evaluate the effectiveness of pain interventions as needed/review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition, psychiatry consult as needed, psychology consult as needed.ˆˆ ˆ A physician order dated 3/26/2026 at 10:42 AM, documentedˆhydrocodone-acetaminophen oral tabletˆ5-325 milligram, give 1 tablet my mouth every 8 hours asˆneededˆfor pain for 14 days.ˆOrder wasˆdiscontinuedˆon 4/03/2026ˆat 3:53 PM.ˆˆ ˆ A physician order dated 3/26/2026 at 3:53 PM, documented hydrocodone-acetaminophen oral tablet 5-325 milligram, give 1 tablet my mouth every 8 hours as needed for pain for 14 days.ˆ ˆ Resident #47's Medication Administration Record for April 2026, documented the Resident did not receiveˆtheir hydrocodone-acetaminophen onˆ4/03/2026. They receivedˆacetaminophen table 325ˆmilligramsˆas needed for pain.ˆIt further documented that a pain evaluationˆwas not completed on 4/05/2026ˆfor Resident #47 and the resident did not receive any pain medication.ˆˆ ˆ A pain interview assessment dated [DATE], documentedˆResident #47ˆfrequentlyˆhad pain. Pain occasionallyˆeffectedˆtheir<br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | sleep,ˆtherapy activities, and day-to-day activities. Pain intensity through a numeric rating scale was 7.ˆˆ ˆ During an interview onˆ4/13/2026ˆat10:04 AM, Nurse Practitioner #1ˆstatedˆthey were on vacation for 2 weeks, but there was a Medical Director that signed for renewals when they were not there.ˆTheyˆstatedˆResident #47 should not have gone an entire day without receiving pain medication because the order was not renewed.ˆTheyˆstatedˆtheˆresidentˆneeded to have pain control and a lapse in reordering was on the facility.ˆˆ During an interview on 04/13/2026 at 11:00ˆAM,ˆDirector of Nursing #1ˆstatedˆas needed medication had not been given during the evening shift of 04/05/2026 andˆstatedˆthe resident must not have requested it.ˆ ˆ Resident #65ˆ ˆ Resident #65 was admitted to the facility following a left total knee replacement with diagnoses of chronic pain syndrome (a persistent condition where pain last for more than 3-6 months),ˆDorsalgiaˆ(chronic or acute pain in the back, specifically targeting the thoracic (mid-back) region, but often encompassing the neck and shoulder area), and chronic obstructive pulmonary disease (a group of lung disease that block airflow and make it difficult to breathe). 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 ˆ During an interview onˆ4/08/2026ˆatˆ3:09 PM, Resident #65ˆstatedˆthey wereˆat theˆfacility for therapy following a total knee replacement.ˆTheyˆstatedˆthey had pain medications as needed.ˆTheyˆstatedˆwhen they asked for their pain medication it took the staff upward of an hour toˆget them. Theyˆstatedˆthe other night they wanted a painˆmedˆand the Certified Nurse Aide could not find the nurse for over an hour.ˆResident #65 furtherˆstatedˆthat ice packs wereˆlimitedˆand they only had 1 ice pace since they were admitted .ˆTheyˆstated orthoˆprovided them with ice packs when they had their staples removedˆon that day.ˆˆ During an interview onˆ4/14/2026ˆatˆ9:38 AM, Resident #65ˆstatedˆon Sundayˆ4/12/2026, they asked for their painˆmedsˆand it took 2 and half hoursˆto get them.ˆTheyˆstatedˆtheir pain was atˆa 7ˆor 8.ˆˆ ˆ During an interview onˆ4/15/2026ˆatˆ9:00 AM,ˆResident #65ˆstatedˆthey were supposed to get their pain med at 7:00 AM. Theyˆstatedˆthey got it at 7:00 PM and 1:00 AM. When they spoke to the Licensed Practical Nurse, they were informed that the medication was not signed forˆtheˆMedical Provider and that they were administered the medication at 6:00 AM. Theyˆstatedˆtheir pain was at a 7. Theyˆstatedˆthey did not understand why they got the medication last night, but not this morning. When asked about the grievance, Resident #65ˆstatedˆthey spoke with Director of Nursing #1 and Licensed Practical Nurse #2 about what happened over the weekend and they agreed that the pain medication would be scheduled, but it was not implemented.ˆˆ ˆ Resident #65's Comprehensive Care Plan for Comfort dated 3/25/2026, documented alteration in comfort related to arthritis and left knee replacement. Goals included:ˆresidentˆis able toˆverbalize pain and request pain medication as needed through next review, resident will achieve pain goal of tolerable pain while at rest through next review date, and residents pain goal is to have tolerable level from pain during movement through the review date. Interventions included: administer medications as ordered, evaluate effectiveness of pain medications as needed, monitor for evidence of exacerbation of trauma, monitor for signs and symptoms of pain with each interaction, report to nurse resident complaints of pain or requests for pain treatment, reposition frequently, residentˆis able toˆverbalize pain and request pain medications as needed.ˆˆ ˆ A physician order dated 3/26/2026 at 2:45 PM, documented hydrocodone-acetaminophen tablet 7.5 325 milligram, give 1 tablet by mouth every 6 hours as needed for pain for 14 days. Order wasˆdiscontinuedˆon 4/06/2026 at 10:52 AM.ˆˆ ˆ A physician order dated 4/06/2026 at 10:52 AM, documented hydrocodone-acetaminophen tablet 7.5 325 milligram, give 1 tablet by mouth every 6 hours as needed for pain for 14 days.ˆOrder wasˆdiscontinuedˆonˆ4/14/2026ˆat 4:01 PM.ˆˆ ˆ A physician order dated 4/14/2026 atˆ4:01 PM, documented hydrocodone-acetaminophen tablet 7.5 325 milligram, give 1 tablet by mouth every 6 hours for pain for 14 days.ˆThe order was not signedˆand there was no documented evidence that the Medical Provider provided a verbal orderˆfor the medication.ˆˆ ˆ Resident #65's Medication Administration Record for Aprilˆ2026, documented the resident only received their<br>(continued on next page) |

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|---|---|---|---|
| | 335549 | A. Building<br>B. Wing | 04/15/2026 |

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

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | hydrocodone-acetaminophen 1 time on 4/06/2026 for a pain level of 8ˆafter they had received itˆ3 times a day the days prior. Itˆfurtherˆdocumented on Sunday 4/12/2026,ˆthey received a dose of hydrocodone-acetaminophen at 4:55 AM and not again until 1:17 PM.ˆThe Medication Administration Record did not reflect that Resident #65 received their scheduledˆhydrocodone-acetaminophenˆonˆthe evening of 4/14/2026 intoˆthe morning ofˆ4/15/2026.ˆˆ ˆ During an interview onˆ4/14/2026ˆatˆ10:42 AM, Certified Nurse Aide #2ˆstatedˆthey would tell the nurse if a residentˆindicatedˆthat they were in pain. Theyˆstatedˆsometimesˆthe nurse wouldˆgo in right away to check on the resident, but if they did not, they would follow up with the nurse to make sure theyˆcheckedˆon the resident.ˆˆ ˆ During an interview onˆ4/14/2026ˆatˆ10:46 AM, Registered Nurse #1ˆstatedˆthey had talked withˆResident #65 extensively about their pain medications. Theyˆstatedˆthey could not speak to why some of the nurses were not bringingˆthemˆin a timely manner.ˆTheyˆstatedˆthey told Resident #65 to ring the bell moreˆfrequentlyˆif they felt it was taking too long or if the message had gotten lost.ˆThey hadˆalso told Resident #65 to bring it to their attention.ˆRegistered Nurse #1ˆstatedˆthey hadˆtalked to the nursesˆaboutˆgoing in to see the resident when the pain medicationsˆwere available again. TheyˆstatedˆResidentˆ#65ˆkept sayingˆtheir pain medsˆwere due, but then theyˆwouldˆremind the resident that it was not due, it was available.ˆThey furtherˆstatedˆtypically the Medical Provider would not schedule pain medications like the one that Resident #65 was receiving.ˆˆ ˆ During an interview onˆ4/14/2026ˆat12:14 PM, Director of Nursing #1ˆstatedˆthey completed every shift painˆassessment. Theyˆstatedˆsome residentsˆassumed that the nurses were going to give the resident a pain medication rather than asking for it.ˆTheyˆstatedˆthey do have other pain medications available if medicationˆwasˆnot due, such as Tylenol or they could offer non-pharmalogicalˆoptions for pain relief.ˆˆDirector of Nursing #1ˆstatedˆsome residents did not understandˆhow as needed medications worked.ˆTheyˆstatedˆthey were not aware of Resident #65's concerns, but that there was an active grievance for theˆresidentˆthat they had not gotten to look at yet.ˆ ˆ During an interview onˆ4/14/2026ˆatˆ1:47 PM, Social Worker #1ˆstatedˆthey met with Resident #65 yesterday 4/13/2026. Theyˆstatedˆtheˆresidentˆdid not file a grievance because they already had. Theyˆstatedˆpart of the grievance was that it was taking up to 2 hours to get their pain medsˆand they had given the grievance to Director of Nursing #1.ˆˆ ˆ During an interview onˆ4/15/2026ˆatˆ10:05ˆAM, Registered Nurse #1ˆstatedˆtheyˆwere present when Director of Nursing #1ˆtalked with the Medical Provider about scheduling the pain medications for Resident #65, but the Medical Provider did not sign the order.ˆTheyˆstatedˆthe nurses that workedˆthe evening/night shiftˆgave the resident theˆmedication butˆwere not able toˆsign off forˆin the electronic medical record. Theyˆstatedˆthe nurses did document it in the narcotic book.ˆTheyˆstatedˆthe nurses were going to put in progress notes that the medication was given.ˆRegistered Nurse #1ˆstatedˆthe narcotic bookˆindicatedˆthatˆthe medication was taken at 6:00 AM for Resident #65,ˆso they were not sure why theˆresidentˆstatedˆthat they had notˆreceived it.ˆThey furtherˆstatedˆthey would speak with the Medical Provider about getting aˆone-timeˆorder for the painˆmedication, butˆneededˆto talk with the nurse to make sureˆtheˆresidentˆactually gotˆthe dose.ˆˆˆ ˆ During an interview on 4/15/2026 atˆ10:51 AM, Medical Director #1ˆstatedˆthey often received calls to renew narcotic orders. Theyˆstatedˆthey signed orders in real time, almost 100% of the time, but with narcotics, even withˆaˆsigned orderˆitˆwould sometimesˆlapse,ˆand they would need to change the order.ˆˆMedical Director #1ˆstatedˆthey reviewed medicationsˆeach and everyˆvisit.ˆTheyˆstatedˆpain managementˆwas aˆcase-by-caseˆbasis.ˆTheyˆstatedˆthe Nurse Practitionerˆwould check the resident's history and use of opioids.ˆIf a resident wasˆpost-surgery,ˆthey were more likely toˆtreatˆshort term with pain meds that were provided from the hospital.ˆThey were always looking at gradual dose reduction.ˆWhen questioned aboutˆarthriticˆpainˆthat was treated withˆmorphine,ˆtheyˆstatedˆmorphine was used for veryˆhigh-levelˆpain scale.ˆThey preferredˆto use a low dose of tramadol or oxycodoneˆrather<br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | thanˆanti-inflammatory medication in this population.ˆˆ ˆ 10 New York Codes Rules and Regulations 415.12ˆ ˆ ˆ |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>Based on observation, record review, and interviews conducted during a survey, the facility did not ensure that its medication error rate did not exceed 5 percent forˆtwoˆ(2) (Resident #9 and #22) ofˆsevenˆ(7) residentsˆobservedˆduring medication administrationˆwithˆ25ˆobservations. This resulted in a medication error rate ofˆ24ˆpercent.ˆ Findings include: ˆˆ The Facility's Policy and Procedure titled MedicationˆAdministrationˆrevisedˆ12/2019, documentedˆMedications shall be administered in a safe andˆtimelyˆmanner, and as prescribed.ˆPROCEDURE:ˆThe individual administering the medication must check the label THREE (3) times to verify the right medication, right dosage, rightˆtimeˆand right method (route) of administration before giving the medication.ˆ ˆ Resident #9 was admitted to the facility with diagnosis ofˆHemiplegiaˆ(severe or complete paralysis on one vertical side of the body, affecting the arm, leg, and sometimes the face),ˆˆHemiparesisˆ(weakness, numbness, or reduced movement on one side of the body),ˆˆfollowing Cerebral Infarction (stroke i.e.:ˆwhen blood flow to part of the brain is suddenly cut off), and Major Depressive Disorder (a serious mental health condition characterized by a persistent low mood, loss of interest in activities, and low energy).ˆˆThe Minimum Data Set (an assessment tool) dated 10/20/2025, documented they could be understood, understand others, and was cognitively intact.ˆ The Physician's Order dated 3/19/2026 documented giveˆDepakote Tablet Delayed Release 125ˆmilligrams;ˆGive 3 tablet by mouth three times a dayˆforˆMajor DepressiveˆDisorder.ˆ The Medication Administration Record documented start date of 3/31/2026 at 13:56PM.ˆ During an observation on 4/9/2026 at 9:00 AM, Registered Nurse #4 pouredˆDepakote Tablet Delayed Release 125 milligramsˆ(3ˆtablets)ˆtoˆadminister to resident #9.ˆˆThe medication blister pack instructions read:ˆˆDepakote Tablet Delayed Release 125 milligrams;ˆGiveˆthreeˆ(3)ˆtabletsˆby mouth twoˆ(2)ˆtimes a day.ˆˆThe physician order read giveˆthree (3)ˆtablets,ˆthree (3)ˆtimes a day.ˆˆWhen pointed out the discrepancy between the physician order and blister pack order, Registered Nurseˆ#4ˆstatedˆthey were told to follow what is in the computerized medicationˆadministration record.ˆˆThey then calledˆLicensedˆPractical Nurse#2,ˆwho is also the Unitˆmanager, to gain clarify.ˆˆLicensed Practical Nurse#2ˆreiterated they were also told to follow what is in the computerized Medication Administration Records.ˆˆLicensed Practical Nurse#2ˆwas unable toˆascertainˆwhich was the correct physician order.ˆˆˆ During an interview on 4/9/2026 at 10:00AM, Director of Nursing #1ˆwas also unable toˆascertainˆwhich order was the correct order.ˆˆHowever, theyˆstatedˆthat when there is an order change the facility continues to use the old medication blister pack.ˆˆWhen the old order blister pack isˆcompleted,ˆthey will place the new order with pharmacy services.ˆˆ During an interview on 4/9/2026 at 10:00AM, Administrator #1ˆlocatedˆthe order change that wasˆinitiatedˆon 3/19/2026 to increase Depakoteˆ Tablet Delayed Release 125 milligramsˆ(give 3 tablets) from two (2) times per day to three (3) times per day.ˆˆˆTheyˆstatedˆthe order change should have been sent to pharmacy and either they would send a new blister pack of medication or further instructions.ˆˆ Resident #22 was admitted to the facility with diagnosis ofˆˆAlzheimer's Disease (a progressive, irreversible neurological disorder that destroys brain cells, causing cognitive decline, memory loss, and behavioral change);ˆ,ˆosteoporosisˆ (a common bone disease characterized by weak, brittle bones with reduced mass and density); and status postˆhip fractureˆ(broken hip).ˆˆThe Minimum Data Set (an assessment tool) datedˆ2/32026, documented they could be understood, understand others, and was cognitively intact.ˆ Theˆ April 2026ˆMedication Administration Record for Resident #22 documented give Tylenol 325 milligrams two (2) tablets twice daily;ˆFerrous Sulfate 325 milligrams one (1) tablet daily;ˆVitamin D 5000unit / 125 micrograms, give five (5) tablets daily;ˆMemantineˆ5 milligrams, one (1) tablet twice daily.ˆˆSpecial instructions:ˆ Crush Medication.ˆˆˆ During an interview onˆ4/9/2026at 8:45 AM, Licensed Practical Nurse #5 was asked how the medication is administered to resident #22.ˆˆˆLicensed Practical Nurse #5ˆstatedˆthey crush resident #22 pills because that is<br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | what was written in the special instructions.^^When asked to see the physician order to crush medications,^Licensed Practical Nurse #5^stated^they were unable to find the actual physician^order,but^acknowledged that there should be an order from either physician or nurse practitioner.^^ During an interview on 4/9/2026 at 10:00AM, Director of Nursing #1^stated^that all crushed medications require a physician order.^^When^Director of Nursing #1^was asked to show surveyor the physician order,^they^were^unable to^locate^the crush medication orders for resident #22 and entered the order during the interview.^^ During an interview^on^4/15/2026^at^10:51^AM, Medical Director #1^stated^with any medication discrepancy, it is the responsibility of the medication nurse to notify the^medical director or nurse practitioner on call or on site for clarification.^^Orders must be signed in real time by the ordering^provider. The nurse entering the order must ensure the provider signs off on the order so that the mediation can be administered.^^ ^ 10 New York Codes, Rules, and Regulations 415.12 (m)(1)^ |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>Based onˆobservation, record reviewˆandˆinterviewsˆconducted during aˆsurvey,ˆtheˆfacility did not ensure residents were free from significant medication errorsˆforˆoneˆ(1) (Resident #9) of seven (7) residents reviewed, for a total of twenty-five (25) observations.ˆˆSpecifically, Resident #22 had a medication dose discrepancy for an anti-seizure medication that was not addressed for twenty-one (21) days after the order was changed.ˆˆ Findings include: The Facility's Policy and Procedure titled Medicationˆ Administration revisedˆ12/2019, documented Medications shall be administered in a safe andˆtimelyˆmanner, and as prescribed. PROCEDURE: The individual administering the medication must check the label THREE (3) times to verify the right medication, right dosage, rightˆtimeˆand right method (route) of administration before giving the medication.ˆ Resident #9 was admitted to the facility with diagnosis of Hemiplegia (severe or complete paralysis on one vertical side of the body, affecting the arm, leg, and sometimes the face),ˆ Hemiparesis (weakness, numbness, or reduced movement on one side of the body),ˆ following Cerebral Infarction (stroke i.e.: when blood flow to part of the brain is suddenly cut off), and Major Depressive Disorder (a serious mental health condition characterized by a persistent low mood, loss of interest in activities, and low energy).ˆ The Minimum Data Set (an assessment tool) dated 10/20/2025, documented they could be understood, understand others, and was cognitively intact.ˆ The Physician's Order dated 3/19/2026 documented give Depakote Tablet Delayed Release 125 milligrams; Give 3 tablet by mouth three times a day for Major Depressiveˆ Disorder.ˆ The Medication Administration Record documented start date of 3/31/2026 at 13:56PM.ˆ During an observation on 4/9/2026 at 9:00 AM, Registered Nurse #4 poured Depakote Tablet Delayed Release 125 milligrams (3ˆtablets)ˆtoˆadminister to resident #9.ˆˆThe medication blister pack instructions read:ˆ Depakote Tablet Delayed Release 125 milligrams;ˆGiveˆthreeˆ(3)ˆtabletsˆby mouth two (2) times a day.ˆˆThe physician order read give three (3) tablets, three (3) times a day.ˆˆWhen pointed out the discrepancy between the physician order and blister pack order, Registered Nurse #4ˆstatedˆthey were told to follow what is in the computerized medicationˆadministration record.ˆˆThey then called Licensed Practical Nurse#2 ,ˆwho is also the Unit manager, to gain clarify.ˆˆLicensed Practical Nurse#2 reiterated they were also told to follow what is in the computerized Medication Administration Records.ˆˆLicensed Practical Nurse#2 was unable toˆascertainˆwhich was the correct physician order.ˆˆˆ During an interview on 4/9/2026 at 10:00AM, Director of Nursing #1 was also unable toˆascertainˆwhich order was the correct order.ˆˆHowever, theyˆstatedˆthat when there is an order change the facility continues to use the old medication blister pack.ˆˆWhen the old order blister pack isˆcompleted,ˆthey will place the new order with pharmacy services.ˆˆ During an interview on 4/9/2026 at 10:00AM, Administrator #1ˆlocatedˆthe order change that wasˆinitiatedˆon 3/19/2026 to increase Depakote Tablet Delayed Release 125 milligrams (give 3 tablets) from two (2) times per day to three (3) times per day.ˆˆˆTheyˆstatedˆthe order change should have been sent to pharmacy and either they would send a new blister pack of medication or further instructions.ˆ During an interview on 4/15/2026 at 10:51 AM, Medical Director #1ˆstatedˆwith any medication discrepancy, it is the responsibility of the medication nurse to notify the medical director or nurse practitioner on call or on site for clarification.ˆˆOrders must be signed in real time by the ordering provider. The nurse entering the order must ensure the provider signs off on the order so that the mediation can be administered.ˆ ˆ 10 New York Codes, Rules, and Regulations 415.12(m)(2)ˆ |

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| F 0813<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Have a policy regarding use and storage of foods brought to residents by family and other visitors.<br><br>**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<br>(continued on next page) |

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| F 0813<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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 |

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| | 335549 | A. Building<br>B. Wing | 04/15/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Warren Center for Rehabilitation and Nursing | 42 Gurney Lane<br>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.

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| F 0838<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review conducted during the survey, the facility did not ensure the facility-wide assessment was updated to determine what resources were necessary to ensure residents were able to maintain or attain their highest practicable physical, functional, mental, and psychosocial well-being and meet current professional standards of practice. Specifically, the Facility assessment dated [DATE], documented under Special Treatment and Conditions, the number/average or range of residents were zero (0). The facility actually had one (1) active (#7) and one (1) discharged (#87) tracheostomy resident at the time of review. Findings include: The Facility assessment dated [DATE] documented Part 2:Services and Care We Offer Based on our Residents' Needs: Other special care needs - Dialysis, hospice, ostomy care, tracheostomy care, bariatric care, palliative care, end of life care. Facility assessment dated [DATE], documented under Special Treatment and Conditions, the number/average or range of residents were zero (0). Resident #7 was admitted to the facility with diagnosis of Malignant Neoplasm of Larynx (cancer of voice box) status post Laryngectomy with tracheotomy (removal of larynx/voice box with a surgical procedure that creates an opening in the neck allowing direct airflow to the lungs, bypassing the mouth and nose); Chronic Obstructive Pulmonary Disease (a condition involving constriction of the airways and difficulty or discomfort in breathing). The Minimum Data Set (an assessment tool) dated 01/28/2026, documented they could be understood, understand others, and was cognitively intact.^ Resident #7's Comprehensive Care Plan dated 10/21/2025 documented resident is at risk for/has an alteration in respiratory system related to Chronic stable laryngectomy patient, Ambu bag (a hand-held, self-inflating device used to provide positive pressure ventilation to patients who are not breathing or breathing inadequately) and suction setup at bedside. Intervention created on 4/7/2026 documented provide tracheotomy stoma care daily and as needed using aseptic technique.as resident tolerates, and respect wishes to self-administer cleansing and apply HME (A Heat and Moisture Exchanger; a passive humidification device used in tracheostomy care that sits on top of the tracheostomy tube. and use an air compressor / Licensed Vocational Nurse (LVN) set up for humidified therapy. During an observation on 4/13/2026 at 11:00 AM, there was no Ambu bag at resident #7's bedside. In addition, Licensed Practical Nurse # 2 was observed attempting to provide tracheotomy care, but required direction from the resident in how to perform care. Resident #87 was admitted to the facility with diagnoses of 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 (a liver disease). The Minimum Data Set (an assessment tool) dated 07/26/2025, documented they could be understood, understand others, and was cognitively intact. Review of Resident #87's comprehensive care plan dated 03/24/2026 through 03/26/2026 identified the 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, maintaining airway patency, administering tube feedings, managing pain, and assisting with activities of daily living. The care plan reflected the need for ongoing monitoring, staff assistance, and timely intervention across multiple disciplines. Review of Resident #87's physician orders on the Order Summary Report dated 04/09/2026, reflecting active orders as of 07/26/2025, identified the resident had a diagnosis indicating an 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.<br>(continued on next page) |

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| F 0838<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Orders during this period were limited to general care, including medications, wound care, enteral feeding, and routine monitoring. Overall, the record review identified a 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. During an interview on 4/15/2026 at 10:51 AM, Medical Director #1 stated, they would not accept any resident without staff having appropriate training to care for each resident, and if they were unable to obtain the necessary supplies for that resident. The Facility Assessment is updated to reflect staffing needs. During an interview on 04/15/2026 at 1:31 PM, The Facility Assessment is updated annually and as needed. It was brought to the attention of the Administrator that the Facility assessment dated [DATE] documented zero (0) tracheostomy residents. The census includes one (1) active resident and one (1) discharged , resident. ˆ 10 New York Code of Rules and Regulations 415.26 |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>Based on observation, interview, and record review conducted during a survey, the facility failed to maintain records in accordance with accepted professional standards and practices, as accurately documented and completed for two (2) (Resident #'s 65 and 84) of 23 residents reviewed. Specifically, (a.) for Resident #65, there was no documentation in the electronic medical record that a verbal order was received from the Medical Provider to schedule the resident's pain medication and no documentation that the nurses administered the resident's pain medication after the order was changed on 4/14/2026; and (b.) for Resident #84 there was missing documentation in the Certified Nurse Aide tasks record that care was provided to the resident. Additionally, the narcotic book shift count for the south unit was signed in advance. The findings include: The facility policy titled Charting and Documentation- CNA dated 3/2020, documented all services provided to the resident, or any changes in the resident's medical or mental condition shall be documented in the resident's medical record. Certified Nursing Assistants may make entries in the resident's medical chart of all care rendered to the residents. Certified Nurse Aides were encouraged to document care as close to completion of task as possible, but if not, must be documented by the end of their shift. The facility policy titled Medication-Narcotic Management last reviewed 4/2019, documented narcotics and schedule II medications would be counted with two (2) professional nurses at the beginning and end of each shift. Documentation that a count was completed and accurate would be completed at the beginning and end of each shift. Resident #65 Resident #65 was admitted to the facility following a left total knee replacement with diagnoses of chronic pain syndrome (a persistent condition where pain lasts for more than 3-6 months), Dorsalgia (chronic or acute pain in the back, specifically targeting the thoracic (mid-back) region, but often encompassing the neck and shoulder area), and chronic obstructive pulmonary disease (a group of lung disease that block airflow and make it difficult to breathe). The Minimum Data Set (an assessment tool) dated 4/01/2026, documented the resident was cognitively intact, could be understood, and could understand others. During an interview on 4/15/2026 at 9:00 AM, Resident #65 stated they were supposed to get their pain med at 7:00 AM. They stated they got it at 7:00 PM on 4/14/2026 and 1:00 AM on 4/15/2026. When they spoke to the Licensed Practical Nurse, they were informed that the medication was not signed for the Medical Provider and that they were administered the medication at 6:00 AM. They stated their pain was at a 7. They stated they did not understand why they got the medication last night, but not this morning. Resident #65 stated they spoke with Director of Nursing #1 and Licensed Practical Nurse #2 about what happened over the weekend with it taking over 2 hours to receive their pain medication and they agreed that the pain medication would be scheduled, but it was not implemented. A physician order dated 4/14/2026 at 4:01 PM, documented hydrocodone-acetaminophen tablet 7.5 325 milligram, give 1 tablet by mouth every 6 hours for pain for 14 days. The order was not signed and there was no documented evidence that the Medical Provider provided a verbal order for the medication. Resident #65's Medication Administration Record for April 2026, did not reflect that Resident #65 received their scheduled hydrocodone-acetaminophen on the evening of 4/14/2026 into the morning of 4/15/2026. During an interview on 4/15/2026 at 10:05 AM, Registered Nurse #1 stated they were present when Director of Nursing #1 talked with the Medical Provider about scheduling the pain medication for Resident #65, but the Medical Provider did not sign the order. They confirmed that there was no documentation in the electronic medical record that Nurse Practitioner #1 gave a verbal order to schedule the pain medication. Registered Nurse #1 stated the nurses that worked the evening and night shifts gave the resident the medication but could not sign off for it in the electronic medical record because the order was not signed for. They stated the nurses did document it in the narcotic book. They stated the nurses were going to come in and put in progress notes that the medication was given, since they had not done so. Registered Nurse #1 stated the nurses should have called the (continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | on call Registered Nurse or the Medical Provider. During an interview on 4/15/2026 at 10:42 AM, Director of Nursing #1 stated they called Nurse Practitioner #1 with Registered Nurse #1 and Regional Director of Nursing #1 present and received the order to schedule Resident #65's pain medication. They stated the order was entered and transcribed by Registered Nurse #1. They stated the order was updated to reflect a new order and the Medical Provider did not sign it. They stated 2 nurses made the same error and the nurses should have reached out to the Medical Provider. Resident #84 Resident #84 was admitted to the facility with diagnoses of Rhabdomyolysis (a serious, potentially life-threatening medical condition involving the rapid breakdown of damaged skeletal muscle, Atherosclerotic heart disease (a chronic condition caused by plaque buildup that narrows and hardens arteries, limiting oxygen-rich blood flow to the heart), and chronic obstructive pulmonary disease (a group of lung disease that block airflow and make it difficult to breath). The Minimum Date Set (an assessment tool) dated 3/02/2026, documented the resident was cognitively intact, could be understood and could understand others. A complaint received by the New York State Department of Health on 3/04/2026, documented Resident #84 was left stuck in their wheelchair all day, staff would not assist them to the bathroom or with care. It further documented that Resident #84 was told they could not walk, but staff were not present to check if they needed assistance. Resident #84's Comprehensive Care Plan for Self-Care and Mobility dated 2/25/2026, documented the resident required assistance with self-care and mobility related to immobility. The goal was Resident #84's self-care and mobility status would improve through next review. Some interventions included: the resident required partial assist of 1 staff for toilet transfers; supervision or verbal cues or touching assist of 1 staff for toileting hygiene; and supervision or verbal cues or touching assist of 1 for sit to stand. A review of the Documentation Survey Report for February 2025 (Certified Nurse Aides task record) for Resident #84, documented an intervention/task titled Care Provided. Each day and shift recorded if care was provided. Care included tasks such as toileting hygiene, toilet transfer, dressing, and bathing. During the month of February 2026, there was no documentation to support that care was provided to Resident #84 on 2/26/2026 day shift (7:00 AM to 3:00 PM), 2/27/2026 evening shift (3:00 PM to 11:00 PM), and 2/28/2026 night shift (11:00 PM to 7:00 AM). During an interview with Registered Nurse #1, they stated from their view in the electronic medical record it appeared to be missed documentation. They stated if they had to guess, the Certified Nurse Aides did not have time to document. They further stated they often hound the Certified Nurse Aides to get their charting done and it was discussed at their monthly staffing meetings. During an interview on 4/14/2026 at 12:55 PM, Director of Nursing #1 was shown Resident #84 Certified Nurse Aide documentation for February 2026. They stated the care was done, it was just not documented. During an observation on 4/13/2026 at 10:15 AM, the south unit narcotic book shift count for 4/13/2026 7:00 AM to 3:00 PM shift was signed for change of shift 3:00 PM to 11:00 PM in advance by Licensed Practical Nurse #1. During an interview on 4/13/2026 at 10:15 AM, Licensed Practical Nurse #1 stated they signed it ahead of time, so they would not forget to sign it when they left. During an interview on 4/13/2026 at 3:09 PM, Director of Nursing #1 stated their narcotic log in-service was conducted on 1/08/2026 and 1/09/2026 and they reviewed the process for signing for narcotics. Director of Nursing #1 further stated they would audit narcotic books now and do one-to-one In-services on the floor. 10 New York Codes, Rules, and Regulations 415.22(a)(1-4)ˆ No Notes |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews conducted during the survey, the facility did not ensure an infection prevention and control program was established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for two (2) of two (2) residents reviewed for infection control practices (Resident #2 and Resident #7). Specifically, the facility did not ensure proper storage of perishable food items to prevent bacterial growth and potential foodborne illness and did not ensure staff adhered to infection control practices including hand hygiene, use of personal protective equipment, and appropriate handling of contaminated equipment. Findings include: The Facility's Policy and Procedure titled Infection Prevention and Control Program, revised 01/21/2026, documented the facility maintained an Infection Prevention and Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The policy documented the program included a system for surveillance, prevention, identification, reporting, investigation, and control of infections. The policy further documented staff were to follow infection prevention and control practices including hand hygiene, use of personal protective equipment, and cleaning and disinfection of equipment and surfaces. The policy documented procedures for transmission-based precautions for residents who were suspected of having communicable diseases or conditions. The Facility's Policy and Procedure titled Food Safety/Storage, undated, documented perishable food items must be refrigerated and maintained at safe temperatures to prevent bacterial growth and foodborne illness; staff were responsible to monitor food storage and ensure safe handling practices. The Facility's Policy and Procedure titled Tracheostomy Care, revised 12/02/2024, documented tracheostomy care was provided in accordance with standards of practice to maintain airway patency, prevent respiratory infections, and maintain skin integrity. The policy documented aseptic technique was to be maintained during care and sterile technique utilized during suctioning. The policy documented personal protective equipment (PPE) was to be worn during procedures to protect from exposure. The policy further documented tracheostomy care was to be provided at least daily and based on resident needs. The policy documented suction equipment, and related supplies were to always have been available, and staff were to perform hand hygiene before and after care, utilize appropriate PPE, and maintain clean and sanitary equipment to prevent the transmission of infection. 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, and 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 with goals to maintain adequate intake and maintain blood glucose levels within an acceptable range; interventions included providing counseling regarding nutritional needs and evaluating eating habits and food preferences. During an observation on 04/09/2026 at 2:45 PM, mayonnaise, milk, and lettuce were stored on the windowsill in Resident #2's room and were not refrigerated. During an observation on 04/10/2026 at 2:05 PM, re-observation revealed two milk cartons and lettuce remained on the windowsill. The outside temperature ranged between 67 degrees Fahrenheit and 70 degrees Fahrenheit. During an interview on 04/15/2026 at 12:26 PM, Infection Control Nurse # stated it was not acceptable for perishable food items to be stored unrefrigerated due to the risk of bacterial growth and foodborne illness; staff were not aware the food items were present in the room. During an interview on 04/09/2026 at 10:00 AM, the Director of Nursing stated there should not be any food in resident rooms that was not stored at the proper temperature. During an interview on 04/15/2026, (continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | the Medical Director stated all food in the facility should be stored at the proper temperature and under proper conditions; it was unacceptable for 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. Resident #7 Resident #7 was admitted to the facility on [DATE] with a diagnosis of malignant neoplasm of the larynx (throat cancer), tracheostomy (surgical opening in neck for breathing), and human immunodeficiency virus. The 01/28/2026 Minimum Data Set (an assessment tool) documented, the resident was understood and was able to understand, required substantial to maximal assistance with activities of daily living, and received suctioning and tracheostomy care. The comprehensive care plan dated 03/31/2026 documented Resident #7 had been diagnosed with extended-spectrum beta-lactamase (a multi-drug-resistant organism,) methicillin-resistant Staphylococcus aureus (a type of bacteria that is hard to treat and can cause infection; human immunodeficiency virus (a virus that weakens the immune system) The care plan documented the goal was for the resident to remain free from complications. Interventions included educating the resident, family, and visitors on precautions; monitoring for worsening signs and symptoms of infection; and implementing enhanced barrier precautions including use of personal protective equipment (gown and gloves) during high-contact care activities. During an observation on 04/08/2026 at 2:55 PM, a suction catheter was observed uncovered, cloudy liquid was present in the canaster, and tubing lacked date identification. During an observation of care and an interview on 04/13/2026 11:05 AM, Unit Manager #2 a Licensed Practical Nurse, had disconnected the residents unclean deep suction tubing without wearing personal protective equipment including gloves. Hand hygiene was not performed until they exited the room minutes later. They acknowledged they should have worn gloves and washed hands immediately to prevent the spread of infection. During an interview on 04/09/2026 at 10:00 AM, Director of Nursing #1 stated tracheostomy supplies should be maintained in a clean area and staff are trained in proper care techniques. 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 tubing should never have been handled without gloves. Hand hygiene needed to have been completed whenever there is any possible contamination as soon as possible. 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 have been provided by using the proper precautions and all staff should have known that. 10 New York Codes, Rules, and Regulations 415.19 |