STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335565	A. Building B. Wing	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grand Rehabilitation and Nursing at Barnwell	3230 Church Street Valatie, NY 12184

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews conducted during the recertification and abbreviated survey (Case #'s NY00350241, NY00366370, NY00368315, NY00369256, and NY00374241), the facility did not ensure each resident was treated with respect and dignity and care in a manner and in an environment that promotes maintenance or enhancement of their quality of life for three (3) (Resident #s 11, 35, and 89) of 35 residents reviewed. Specifically, (a.) Resident #11 expressed in general that certified nurse aides were rude and or ignored them when asking for help; (b.) Resident #35 expressed they did not get out of bed because they were a two-person mechanical lift and there were not enough staff to assist, and or if they were to get out of bed, they would not be able to go back to bed until late night hours. In addition, they stated they did not take showers or tub baths due to not enough staff to assist; (c.) Resident #89 was observed eating in the common area in front of television with food smeared on face and clothing. Resident's hands also had food underneath nails and between fingers from eating without a utensil. Resident #89 was observed being wheeled from the 6th floor in the elevator, through the lobby and corridor to the therapy gym with food on face and clothing, and saliva and food drooling from resident's mouth. This is evidenced by: The facility Policy and Procedure titled Quality of Life - Dignity, reviewed on 1/2025, documented each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. 1. Residents shall be treated with dignity and respect at all times. 2. Treated with dignity means the resident would be assisted in maintaining and enhancing their self- esteem and self-worth. 3. Residents shall be groomed as they wish to be groomed (hair styles, nails, facial hair, etc.). 4. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Residents shall be encouraged and assisted to dress in their own clothes rather than in hospital gowns. 7. Staff shall speak respectfully to residents at all times, including addressing the resident by their name of choice and not labeling or referring to the resident by their room number, diagnosis, or care needs. 8. Staff shall keep the resident informed and oriented to their environment. Procedures shall be explained before they are performed, and residents will be told in advance if they are going to be taken out of their usual or familiar surroundings. Resident #11: Resident #11 was admitted to the facility with diagnoses of paroxysmal atrial fibrillation (fast, irregular heartbeat that lasts a few hours or days), old myocardial infarction (heart muscle tissue damage from past heart attack), and osteoarthritis (degenerative joint disease). The Minimum Data Set (an assessment tool) dated 4/20/2025, documented the resident was cognitively intact. The resident was able to make themselves understood and understood others. During an interview on 6/08/2025 at 4:31 PM, Resident #11 stated there were a few Certified Nurse Aides who were nasty and had 'sharp' tongues. They stated sometimes the aides ignored them and did not help them with their requests. They stated that about a month ago they made a complaint to the supervisor about a nurse who was nasty, and they were fired. They stated other nurses who still worked in the facility were just as nasty as the nurse who was fired. They stated they had never seen such lack of care for the patients. During an interview on 6/17/2025 at 10:31 AM, Licensed Practical Nurse #9 stated they were moved to the unit this week and were in the process of orienting one of the nurses. Resident #35: Resident #35 was admitted to the facility with a diagnoses of chronic obstructive pulmonary disease (a lung disease causing restricted airflow and breathing problems), congestive heart failure (a long-term condition that happens when your heart can't pump blood well enough to give your body a normal supply). and morbid obesity (Individuals are usually considered morbidly obese if their weight is more than 80 to 100 pounds above their ideal body weight). The Minimum Data Set, dated [DATE] documented the resident was able to be understood and was able to understand others with intact cognition. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/09/2025 at 12:04 PM, Resident #35 stated most of the time there were only two (2) Certified Nurse Aides working for 40 residents. They stated they needed a mechanical lift to get out of bed which was a two-person transfer. They only got out of bed on occasion because there were no staff to get them in and out of bed, and if they did get out of bed, they had to stay up late at night before someone could put them back to bed. They stated last time they got out of bed was about ten (10) days prior. Resident #35 stated staff did not ask any longer if they wanted to get out of bed because they did not have enough staff to help. Resident #35 also stated there was a lot of tension between aides and others. If they ask an aide for assistance, aide would give them an attitude and could not do it due to staffing. Resident #35 stated they did not get a shower or tub bath due to them being a two (2) person assist and no staff to accommodate them. They instead got a full bed bath, but that was not very often. During an interview on 6/13/2025 at 1:00 PM, Licensed Practical Nurse #2 stated on their unit there were two (2) to three (3) Certified Nurse Aides on day shift for 40 residents. They stated they were able to manage as several residents did not get out of bed on their unit. Resident #89: Resident #89 was admitted to the facility with a diagnoses of Parkinson's disease (a movement disorder of the nervous system that worsens over time), major depressive Disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and bipolar disorder (a mental health condition that causes extreme mood swings). The Minimum Data Set, dated [DATE] documented the resident could be understood and was able to understand others with mild cognitive impairment. During an observation on 6/12/2025 at 2:43 PM, Resident #89 was observed on unit common area extremely lethargic, drooling, spilling oatmeal in lap when attempting to feed themselves. Resident was unable to converse with writer due to lethargy; a decline from two days prior. Licensed Practical Nurse Unit Manager #2 went over and to help the resident eat the oatmeal, and did not clean the resident up. In an interview at this time, Licensed Practical Nurse Unit Manager #2 stated the resident was lethargic because they just returned from neurology, having received Botox injections for Parkinson's disease. Resident was then observed wheeled by staff member from unit onto elevator through main lobby through corridor to therapy gym. At that time resident was drooling saliva mixed with food from mouth, food was smeared on face, hands and clothing. During an interview on 6/12/2025 at 03:01 PM, Director of Nursing #1 stated Certified Nurse Aides access resident Kardex (resident care instructions for Certified Nurse Aide) using a tablet that was on the floor. The Care Kardex contained instructions on activities of daily living, level of care required. Resident #89's care Kardex list interventions for agitation and care was provided based on resident's behavior. They further stated all residents should be treated with dignity and respect. 10 New York Code of Rules and Regulations 415.3 (c)(1)(i)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews conducted during the recertification and abbreviated (Case #'s NY00350251, NY00357834, NY00359849, NY00360717) survey, the facility did not provide effective housekeeping and maintenance services on six (6) of six (6) resident units. Specifically, floors and resident units were not clean and maintained. This is evidenced by: During observations on 6/08/2025 between 1:30 PM and 5:30 PM: • The floors were sticky in the corridors on resident units One (1), Three (3), and Six (6). • The floors were sticky in resident Room #s 305, 605, and 606. • Trash was found in the corridor on Unit One (1). • The bathroom toilet and floor were soiled in resident room [ROOM NUMBER]. • The bathroom floor was littered wads of used toilet paper, and the wallpaper was improperly patched in resident room [ROOM NUMBER]. • The baseboard below sink was warped in resident room [ROOM NUMBER]. • The privacy curtain was stained in resident room [ROOM NUMBER]. During observations on 6/08/2025 at 3:03 PM, the soap dispenser in the resident room [ROOM NUMBER] bathroom was ripped off the wall and laying on the floor. During observations of Resident #23's room on 6/09/2025 at 3:29 PM: • (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The bed A top bed sheet had several dried blood stains. • The bottom sheet was visibly soiled with a large stain; the stain was partially covered with folded sheets and a protective cloth. • A soiled brief was draped over the side of the resident waste receptacle; the waste receptacle was placed close to the bedside. • The bed table and nightstand were cluttered with empty and unopened beverage bottles. • The resident room floor was sticky. During an interview on 6/13/2025 at 12:49 PM, Resident #23 stated that staff changed their top bed sheet but did not change the bottom sheet. The same bottom sheet was on their bed all week. The sheet was not useable and disgusting. Resident #23 stated staff covered the dirty stained sheet with a folded blanket. During observations on 6/16/2025 at 11:41 AM through 2:00 PM: • The floors soiled where door frame meets floor on resident units Two (2), Four (4), Five (5), and Six (6). • A moldy odor was detected on Unit Two (2). During an interview on 6/16/2025 at 11:51 AM, Director of Housekeeping #1 stated that they would clean where the door frame meets the floors and that they were not able to detect a moldy odor on Unit Two (2). During observations on 6/17/2025 at 11:38 AM, the surface of the wall around the west stairwell was crumbling and was soiled with a black mold-like substance. During an interview on 6/17/2025 at 11:40 AM, Director of Maintenance #1 that that they would repair the west stairwell wall. Director of Housekeeping #1 stated that they would clean the wall. 10 New York Codes, Rules, and Regulations 415.5(h)(4)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews conducted during the recertification and abbreviated survey (Case #'s NY00350852, NY00350999, NY00351150, NY00351346, NY00351455, NY00352656, NY00362053, NY00365247, NY00349022, NY00349553, NY003716080), the facility did not ensure the resident's right to be free from abuse and neglect for four (4) (Resident #s 52, 158, 192, and 208) of ten (10) residents reviewed for abuse and neglect. Specifically, (a.) on 10/16/2024, Resident #192 was injured by Resident #158 after the resident entered their room and hit them in the face causing a laceration to Resident #192's face above and below their left eye requiring an emergency room visit. Resident #158 was sent out for evaluation to the emergency room due to repeated aggressive behaviors; (b.) on 12/17/2024, Resident #158 punched Resident #52 in the face while attempting to take an item from their walker resulting in an injury to Resident #52's pinky; (c.) on 3/20/2025 Resident #158 punched Resident #475 in the face after the resident pushed Resident #158 three times to prevent them from entering their room. This resulted in Resident #475 suffering an injury to the lip; (d.) on 2/10/2025, Resident #208 was forcefully pushed by Resident #475, to prevent them from entering Resident #475's room, resulting in both residents falling to the floor on top of one another. This was the third incident of aggression to other residents with cognitive impairment by Resident #475 since their admission date. This is evidenced by: A Policy and Procedure titled, Abuse Prevention Protocol reviewed on 1/2025, documented it is the policy of the facility that every resident has the right to be free from abuse, mistreatment, neglect, misappropriation of property and to be free from abuse facilitated or caused by the facility's staff taking or using photographs or recordings in any manner that would demean or humiliate the residents. All personnel must attempt to immediately stop the abuse, then promptly report any incident or suspected incident of resident abuse. The facility has developed and operationalized policies and procedures for screening and training employees, protection of residents, and for the prevention, identification, investigation and reporting of abuse, neglect, mistreatment, misappropriation of property and exploitation. It is facility's policy to do all that is within their control to prevent such occurrences. Resident #158 Resident #158 was admitted to the facility with diagnoses of Schizophrenia (a mental health disorder with various symptoms that include hallucinations, delusions, disorganized thinking and behavior and flat or inappropriate affect, that causes difficulty with social interaction), traumatic brain injury (an acquired injury to the brain caused by an outside source, causing problems with brain functioning, behaviors and decision making), and epilepsy (a condition affecting the central nervous system or neurological disorder that causes abnormal brain behavior, that causes, triggering seizures, loss of consciousness, and unusual behavior). The Minimum Data Set, dated [DATE] documented the resident could be understood, understand others, and was cognitively intact. Record review of selected nursing progress notes from Resident #158's admission date to 10/17/2024 documented the following: • (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Note dated 6/20/2024 documented Resident #158 had horrible night with negative interactions with other residents. • Note dated 6/23/2024 documented Resident #158 in and out of other residents' rooms, Physician notified. • Note dated 7/07/2024 documented Resident #158 in and out of residents room. • Note dated 7/10/2024 documented Resident #158 was friendly with female resident in [nearby] room. The staff separating residents due to both residents being cognitively impaired, placed on 30-minute safety checks. • Note dated 9/25/2024 documented Resident #158 lost their balance, bumped head, was sent out to emergency room for evaluation. Resident was out of control running in halls in and out of residents rooms. Remains at the hospital readmitted [DATE]. • Note dated 10/08/2024 documented Resident #158 had begun exit seeking on hospital return 10/08/2024 and had been moved to another unit. • Nursing progress note dated 10/16/2024 documented Resident #158 was noted with blood on their hands carrying a plastic bag with blood on it. Nursing supervisor notified. Resident #192 noted with eye laceration, other residents reported Resident #158 had been seen fighting with another resident. Resident had hit and punched another resident. • Nursing Progress note dated 10/16/2024 at 4:20 PM, documented #158 Resident had belt incident with another resident. Physician called and Troopers called. Emergency service called and Resident #158 was transported to hospital for evaluation residents' family made aware. (a.) Resident #'s 158 and 192 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #192 was admitted to the facility with diagnoses of hemiplegia and hemiparesis following cerebral vascular accident (stroke, brain damage due to lack of blood supply from a blocked or ruptured blood vessel, affecting non-dominant side with (weakness and loss of function and strength on the affected side of the body), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and chronic obstructive pulmonary disease (a group of diseases that cause airflow blockages and breathing related problems). The Minimum Data Set, dated [DATE], documented the resident had severe cognitive impairment, could make themselves understood and usually understood others. An investigation dated 10/16/2024 started at 4:04 PM, documented Resident #192 was observed to have blood running down their face by another resident and called the nurse manager. Resident #192 was found with a laceration above and below the left eye. They reported a [person] in the yellow shirt entered their room and when they told them to get out the resident punched them in the face with a fist and a bag. Upon further investigation Resident #158 was observed holding a bag with a belt in it and blood spots on the outside of the bag but no blood on their hands. Resident #158 put the belt on and refused to allow anyone to look at or take the belt. Resident #158 had not recalled any part of the incident. Resident #192 identified Resident #158 as the person who hit them. Both residents were on 15-minute checks. Another resident stated they had witnessed Resident #158 hit Resident 192. A report dated 10/17/2024 prepared by the former Director of Nursing #2 documented the conclusion of the investigation. The findings determined Resident #158, who wandered, entered Resident #192's room and when they were told to get out, they assaulted resident #192 with their fist and a bag containing a belt. Resident #192 suffered a laceration to their upper and lower left eye, requiring medical care at the emergency room. Registered Nurse assessment was provided to both residents, family and physician notification was done. Resident #158 was sent out to the hospital for evaluation and upon return was moved to a private room and placed on 15-minute checks. Psychiatry and social work followed up with both residents. Conclusion on the investigation determined a resident-to-resident altercation occurred with injury and the Incident is reportable to New York State Nursing Home reporting division. A nursing progress note date 10/16/2024 at 3:45 PM, documented the following: Resident #192 notified this writer (Licensed Practical Nurse #1) and unit manager that they had been physically assaulted by another resident. Resident was noted to be actively bleeding from lacerations above and below the left eye. Area's cleansed with normal saline, steri strips applied and icepack applied for swelling. Unit manager asked resident what happened, they stated, 'that [person] who wanders into my room all the time, came into my room and when they were told to get out, punched me in the eye and then hit me with a white shopping bag that had something in it.' Administrative staff notified along with nursing supervisor who called the Physician. A nursing progress note dated 10/16/2024 at 8:42 PM, documented Licensed Practical Nurse #2 called supervisor to the unit to assess Resident #192 after the resident was hit by another resident. Laceration to upper and lower eye with steri strips continuing to bleed. Provider ordered resident to be sent to emergency room for stitches. Police notified and 911 dispatch called. Resident #192 sent to hospital. Resident #158 sent out for psychiatric evaluation. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Comprehensive Care Plan for behaviors dated 8/09/2024 documented Resident #192 exhibited behavior symptoms such as socially inappropriate /verbally aggressive/abusive; physically aggressive/abusive; Hallucinations; Delusions; Wandering Behavior. Goals: Resident #192 will exhibit fewer episodes of behavioral activity through the review date. Resident will verbalize understanding of the need to control inappropriate behavior through the review date. Resident will not harm self or others through the review date. Resident will seek out staff/caregivers when agitation occurs through the review date. Only revision documented from 8/09/2024 was dated 6/09/2025. Interventions dated 8/9/2024 as follows: Administer psychotropic meds as ordered, determine cause of behaviors and remove resident as needed, distract resident from wandering by offering pleasant diversions. Document all behaviors and identify triggers safety checks every 30 minutes. Modify the environment to reduce episodes of negative behavior. There was no documented evidence of Comprehensive Care Plan for at risk for abuse found in Resident #192's records before the incident on 10/16/2024 or after the resident returned to the facility from the hospital. During an interview on 6/16/2025 at 10:47 AM, Licensed Practical Nurse #2 stated Resident #158 had assaulted Resident #192 on 10/16/2024 around 4:00 PM. They stated they could not get the laceration to stop bleeding, so the Resident #192 was sent out by the physician to have it sutured. They further stated Resident #158 was sent out to the hospital for a psychiatric evaluation and was returned with no new orders and put in a private room. Licensed Practical Nurse #2 stated Resident #158 was move to a different unit. They further stated Resident #158 had been monitored the best they could. Staffing issues did not allow for the resident to always be placed on one to one (1:1) monitoring; Even with one to one (1:1) monitoring, Resident #158 was a problem because of their impulsive behavior; the facility had sent them out multiple times and they were returned without any solutions. A recent court order had prevented the facility from discharging the resident. During an interview on 6/12/2025 at 11:07 AM, Director of Social Work #1 stated they had made many attempts to discharge Resident #158 to a more appropriate setting. The resident came from a hospital that had not disclosed their aggressive and violent behavior. Medication had been changed, and it was determined when the resident was demonstrating behaviors, they needed to be placed on a one to one (1:1) monitoring. The resident was currently on a one to one (1:1) but had not been on one to one (1:1) monitoring when the incident occurred. They stated large population of behaviors made it difficult to manage and maintain care planning and adequate supervision to everyone who needed it. During an interview on 6/17/2025 at 11:07 AM, Director of Nursing #1 stated they had not been working at the facility at the time the incident occurred between Resident #192 and Resident #158 and did not do the investigation. (b.) Resident #'s 158 and 52 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #52 was admitted to the facility with diagnoses of dementia (the loss of cognitive functioning that affects thinking, remembering and reasoning to such an extent that it interfered with a person's daily life and activities), chronic obstructive pulmonary disease (a group of diseases that cause airflow blockages and breathing related problems), and bipolar disorder with anxiety and depression (a mental illness characterized by extreme shifts in mood, energy and activity levels, ranging from periods of intense happiness to deep sadness). The Minimum Data Set, dated [DATE] documented the resident was able to be understood, understand others, and had moderately impaired cognition for daily decision making. The comprehensive care plan for behavioral symptoms for Resident #52, documented resident exhibits behavioral symptoms such as verbally aggressive/abusive behavior towards staff and other residents. Goals stated to resident will exhibit fewer or no behavioral activity through the review date and will verbalize understanding of need to control inappropriate behavior. Interventions as follows: Administer psychotropic medication as ordered. Allow resident to express feelings. Determine cause of the behaviors. Distract resident with activities of interest. Document all behaviors. Evaluate the effectiveness of medication. Notify physician of inappropriate behaviors, negative behavior or activity. Through review date of 1/06/2024. The Nursing Home Investigative Report dated 12/20/2024, documented Resident #52 reported Resident #158 had punched them in the face and taken their peanut butter jar. Resident #52 had sustained a scratch to their left pinky. No facial injury was found. Resident #158 denied hitting the resident and the incident was unwitnessed by staff. Police was notified and Resident #158 was sent out to the emergency room for aggressive behavior to others to be evaluated. Resident #158 returned to the facility on [DATE] with no new orders. New interventions placed the resident on one to one (1:1) when out of the room for escalated behaviors. Referral to psychiatry for follow up. Resident #52 was monitored, offered a room change, and was seen by psychology. Conclusion of the investigation determined Resident #158 hit Resident #52. In a physician progress note dated 1/10/2025 at 10:15 AM, documented all medical records examined from inpatient hospital as well as skilled nursing care, noted the Resident #158 poses a risk to themselves and others despite interventions implemented in the facility. The resident has been involved in numerous verbal and physical confrontations with both residents and staff, leading to injuries. Since June 2023, the resident has experienced 11 hospital transfers due to aggressive behaviors and has spent several weeks in a psychiatric inpatient setting. The resident requires ongoing assistance with activities of daily living and instrumental activities of daily living, in addition to medication management. Given the residents diagnoses of psychoactive substance abuse, anxiety disorder, and traumatic brain injury, it is recommended that Resident #158 be placed in a long-term care psychiatric facility. I concur that the resident necessitates a higher level of care which is not suitable for a geriatric skilled nursing facility. After discussion with the Medical Director, they are agreeable with this plan. During an interview on 6/16/2025 at 2:19 PM, Director of Nursing #1 stated Resident #52 had no further resident to resident issues that they were aware of. Resident #192 had been put on another unit and often was 1 on 1 for monitoring. Resident #192 was prone to behaviors including aggression and abuse of residents and staff. Multiple discharge and readmissions for behaviors had occurred since the initial admission. They further stated that Resident #192 was not on one to one (1:1) monitoring at the time the resident-to-resident incident occurred between Resident #52 and Resident #158. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The comprehensive Care Plan titled, Behavioral Symptoms for Resident #158, documented resident exhibited behavior symptoms such as verbally aggressive/abusive; physically aggressive towards staff and residents, wandering behavior with difficult redirection at times wanders without purpose on unit, refuses meds, outbursts of physical aggression without provocation at times is unable to be redirected has been sent to hospital for psychiatric evaluations and follow up. Involvement in resident-to-resident physical altercations on 10/16/2024 and 12/17/2024, last updated 1/08/2025. Stated Goals: Resident #158 will not harm self, or others Initiated 10/24/2024 through 6/08/2025. Following interventions when the resident exhibits behavior symptoms such as socially inappropriate or verbally aggressive behavior are as follows: Administer psychotropic meds as ordered, Evaluate the effectiveness of medications. Initiate psychiatric evaluations as needed Close Observation by staff when out of room wandering and escalated behaviors. Initiated 1/08/2024. Distract resident with activities, determine cause of behavior and remove the resident. Be sure the resident had call bell in reach. Document all behaviors and evaluate effectiveness of medication. Notify physician of inappropriate behavior. Psychology follow up when resident returns from hospital after incident 12/17/2024. Redirect negative behavior as needed 11/29/2024. Social worker to follow up on 12/18/2024. Placed on one-to-one (1:1) on 4/02/2024. Record review of the Comprehensive Care Plan for Resident #158 revealed there were no further changes in interventions since 04/2025. During an interview on 6/17/2025 at 12:35 PM, Nurse Practitioner #1 stated they were continuing to try to manage Resident #158 by adjusting their medication and with behavioral interventions. The facility was still trying to find a more appropriate setting but as of, yet all referrals had been met with rejection for admission. Staff would need training on behavioral interventions because more of this type of difficult behavioral resident were being admitted . During an interview on 6/13/2025 at 4:00 PM, Administrator #1 stated the facility had a high population of residents with mental health diagnoses. They stated they were trying to screen residents who came from the hospital more carefully. They further stated hospitals were not always being honest about resident behaviors and that was what happened with Resident #158's admission. Administrator #1 stated they were doing the best they could. 10 New York Code, Rules, and Regulations 415.4(b)(1)(i)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and interviews conducted during a recertification and abbreviated (Case #'s NY00350852, NY00360717, NY00362053, NY00365247, NY00374739) survey, the facility did not ensure alleged violations involving abuse were reported immediately, but not later than two (2) hours after the allegation was made, if the events that cause the allegation involve abuse, to the administrator of the facility and to other officials (including to the State Survey Agency) in accordance with State law through established procedures for one (1) (Resident #148) of ten (10) residents reviewed. Specifically, an alleged sexual interaction between a physical therapist and Resident #148 on 10/29/2025 was not reported to the New York State Department of Health within two (2) hours of the allegation being made. This is evidenced by: The Policy and Procedure titled Abuse-Prohibition Protocol, Types of Abuse, Response/Reporting, last reviewed 1/2025, documented the following information should be reported to the supervisor/nurse: the names of the residents involved; the date and time that the incident occurred/discovery occurred; where the incident took place; the names of any of the witnesses to the incident; the type of abuse that was committed (i.e.: verbal, physical, sexual, neglect, etc.) and other information that may be requested by the nurse. Additionally, any alleged violations involving mistreatment, neglect or abuse, including serious injuries of an unknown source must be reported to the Administrator/Designee, Director of Nursing/Designee or department director immediately. An immediate investigation must be made and the findings of such investigation must be reported to the: Administrator/Designee within 24 hours of the occurrence/discovery of such incident, to the New York State Department of Health via the Electronic Incident Reporting form within 24 hours of occurrence/discovery, the facility must report any suspected resident abuse immediately, and no later than two hours after the allegation if the incident resulted in physical injury, all other reportable incidents are to be communicated to the New York State Department of Health within 24 hours, the facility is required to report the results of an investigation into an alleged abuse incident to the relevant authorities, such as the state Department of Health, within five business days of the incident occurring; essentially, they must provide a full report on their findings within that timeframe. Facility investigation dated 10/30/2024, documented on 10/29/2024 Resident #148 received physical therapy treatment from Physical Therapist #1 and Occupational Therapist #1. On 10/30/2024, Resident #148 reported to Occupational Therapist #1 that Physical Therapist #1 inappropriately touched them during the treatment given on 10/29/2024. Occupational Therapist #1 reported Resident #148's statement to Director of Physical Therapy #1 on 10/30/2024, who in turn reported to Director of Nursing #1. Director of Nursing #1 investigated the allegation, determined Resident #148 had made a false accusation and documented in the facility investigation that no abuse occurred within 2 hours of the reporting window. During an interview on 6/17/2025 at 8:41 AM, Director of Physical Therapy #1 stated that they had reported the abuse allegation to the Director of Nursing #1. When asked if they had reported it to the New York State Department of Health, Director of Physical Therapy #1 stated the allegation was investigated and unfounded. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/17/2025 at 9:58 AM, Director of Nursing #1 stated that they had gathered statements, determined there was no care plan violation, there were two (2) people in the room at the time and there was no witnessed abuse. Resident #148 had made conflicting statements when interviewed and refused to participate in follow up questioning. When asked if the allegation should have been reported, Director of Nursing #1 stated that because it was not true and they figured that out in the two (2)-hour window, it did not need to be reported. 10 New York Code of Rules and Regulations 415.4(b)(2)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on observation, record review, and interviews during the Recertification and abbreviated (Case #'s NY00350678, NY00350852, NY00362053,365247, NY00374739) survey, the facility did not ensure that all allegations of abuse and neglect were thoroughly investigated for one (1) (Resident #89) of ten (10) residents reviewed. Specifically, Resident #89 reported a staff member was rough with them in September of 2024. The investigation was closed without interviewing and or obtaining statement from resident, other residents, staff, family, visitors and or establishing timeline of event. This is evidenced by: The facility's Policy and Procedure titled, Abuse Investigation and Reporting, reviewed 01/2025, documented all reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) should be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations would also be reported. If an incident or suspected incident of resident abuse, mistreatment, neglect or injury of unknown source is reported, the Administrator will assign the investigation to an appropriate individual. The Administrator will provide any supporting documents relative to the alleged incident to the person in charge of the investigation. The Administrator will keep the resident, and his/her representative (sponsor) informed of the progress of the investigation. The Administrator will suspend immediately any employee who has been accused of resident abuse, pending the outcome of the investigation. The Administrator will ensure that any further potential abuse, neglect exploitation or mistreatment is prevented. The Administrator will inform the resident and his/her representative of the status of the investigation and measures taken to protect the safety and privacy of the resident. The individual conducting the investigation will, as a minimum: a. Review the completed documentation forms. b. Review the resident's medical record to determine events leading up to the incident. c. Interview the person(s) reporting the incident. d. Interview any witnesses to the incident. e. Interview the resident (as medically appropriate); f. Interview the resident's Attending Physician as needed to determine the resident's current level of cognitive function and medical condition. g. Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident. h. Interview the resident's roommate, family members, and visitors. i. Interview other residents to whom the accused employee provides care or services; and (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	j. Review all events leading up to the alleged incident. Resident #89 was admitted to the facility with a diagnosis of Parkinson's Disease (a movement disorder of the nervous system that worsens over time), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and bipolar disorder (a mental health condition that causes extreme mood swings). The Minimum Data Set (an assessment tool) dated 3/05/2025 documented the resident could be understood, understand others, and had mild cognitive impairment. During an interview on 6/10/2025 at 11:07 AM, Resident #89 stated Registered Nurse #3 hit them three (3) times in face about three (3) weeks ago while in the elevator. Resident #89 stated they reported the incident to Activities Director #1 who then notified the Director of Nursing #1. During an interview on 6/10/2025 at 11:10 AM, Licensed Practical Nurse #2 stated they were never made aware of an incident with Resident #89 and Registered Nurse #3. They however stated Resident #89 and Registered Nurse #3 have had personality conflicts. They stated Resident #89 did not like Registered Nurse #3 and was not sure why. During an interview on 6/10/2025 at 11:12 AM, Activities Director #1 stated they were never notified of any incident involving Resident #89. They stated if they were notified, they would have reported to the Director of Nursing #1. During an interview on 6/10/2025 at 11:15 AM, Director of Nursing #1 stated they were never notified any alleged abuse incident involving Resident #89. During an interview on 6/10/2025 at 11:21 AM, Administrator #1 stated they had no knowledge of incident with Resident #89 and Registered Nurse #3 happening a few weeks ago. However, Resident #89 had history of conflict with staff members. They stated Resident #89 went from person to person that they dislike and would make complaints against. Administrator #1 stated when they first started in August 2024, Resident #89 approached them and stated Registered Nurse #3 was rough with them. An investigation was initiated, and the allegation was unsubstantiated, because Registered Nurse #3 did not work that shift. Administrator #1 stated Registered Nurse was not to work with Resident #89 unless there was at least one witness present. The Investigative report dated 6/11/2025 consisted of staffing sheets from 9/17/2024 - 9/20/2024 and a statement written by the Administrator #1 outlining Registered Nurse #3 was not working at the time of the allegation. The exact date of the allegation was not provided. Administrator #1's original statement was Resident #89 approached them in August 2024. The statement was later amended and stated it was September 2024. However, the specific date was not determined by evidence. Record review revealed the following: There was no documentation in electronic medical records. There were no interviews or statements from any witnesses; resident's physician; staff who had contact with resident; resident's roommate; family and or visitors; other resident who had contact with Registered Nurse #3 and any events leading up to and validating the date and time of the alleged incident. In addition, the resident's care plan was not updated to reflect the alleged incident. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/11/2025 at 11:00 AM, Administrator #1 stated the incident from September 2024 was not reported because it was not considered abuse. Administrator #1 stated the investigation was not thorough in that there were no interviews and statements obtained as listed in the policy. They stated the incident should have been reported to New York state Department of Health. They also stated the alleged incident of three (3) weeks ago involving the same Registered Nurse #3 and Resident #89 was reported on 6/10/2025, and the investigation was underway. They also stated Resident Nurse #3 was suspended until the investigation was completed. 10 New York Codes, Rules, and Regulations 415.4 (b) (3)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews conducted during a recertification and abbreviated (Case #'s NY00349022, NY00349553, NY00350241, NY00350495, NY00351346, NY00357834, NY00368315, NY00369256) survey, the facility did not develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframe's to meet a resident's medical, nursing, mental, and psychosocial needs that were identified in the comprehensive assessment for seven (7) (Resident #s 59, 98, 104, 167, 171, 198, and 524) of 37 residents reviewed for care plans. Specifically (a.) Resident #104 was a risk for elopement, and their electronic monitoring device was not implemented and continued upon return from the hospital on 5/16/2025; (b.) Resident #171 was assessed to have a small open area to their coccyx area on 2/16/2025. There was no care plan developed that documented the discovery of this open area with interventions/tasks to be completed as a result of the open area to their coccyx; (c.) Resident #524, the comprehensive care plan for infection did not include any interventions; (d.) Resident #59 was assessed with a stage III pressure ulcer on the left heel on 5/06/2025. There was no documented evidence of care plan until 6/09/2025 and the stage III pressure ulcer was incorrectly documented as a stage II pressure ulcer; (e.) Resident #98 was ordered to have BiPAP (bilevel positive airway pressure - noninvasive ventilation) therapy on 11/27/2023. There was no care plan with goals and interventions for the therapy until 4/04/2025; (f.) Resident # 167, a comprehensive care plan was not developed for diagnosis and treatment of major depressive disorder; (g.) Resident #198 was admitted with concerns of substance abuse, predatory behaviors against others, and homelessness. There was no documented evidence of person-centered comprehensive care plan developed for adjusting to the facility that addressed these concerns. A generic care plan for discharge did not address those issues after an eight (8)-month admission with stated goals and interventions. This is evidenced by: Facility policy titled Care Plans, Comprehensive Person-Centered, effective 8/2017 reviewed 1/2025 documented a comprehensive, person-centered care plan that included measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs would be developed and implemented for each resident. The interdisciplinary team, in conjunction with the resident and their family or legal representative developed and implemented a comprehensive, person- centered care plan for each resident. The care plan interventions were derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The care plan described services furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Care plan interventions were chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and with relevant clinical decision making. Assessments of residents was ongoing, and care plans were revised as information about the resident and the resident's condition changed. The comprehensive, person-centered care plan was developed within seven (7) days of the completion of the required comprehensive assessment (Minimum Data Set). Resident # 104 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #104 was admitted to the facility with the diagnoses of Alzheimer's disease (a progressive brain disorder that gradually destroys memory, thinking skills, and eventually, the ability to carry out the simplest tasks), dementia (a decline in mental ability severe enough to interfere with daily life), and a high risk for elopement. The Minimum Data Set (an assessment tool) dated 5/16/2025 documented that the resident was usually understood, could understand others, and had moderate cognitive impairment. Resident #104 was admitted to the facility on [DATE] and sent to the hospital on 5/11/2025 for evaluation related to a fall with pain. Resident #104 was readmitted to the facility on [DATE] from the hospital. A review of Resident #104's Comprehensive Care Plan dated 4/17/2025 documented that they exhibit risk for elopement related to attempts or previous elopement, change in environment, cognitive impairment, desire to leave the facility, and mood disorder. Interventions and tasks implemented included checking the placement of the electronic monitoring device each shift. Record review revealed no goals, interventions, or revisions were done for Resident #104's care plan upon their return from the hospital. A review of Resident #104's Medication Administration Record for 05/2025 documented to check the placement of the electronic monitoring device on the resident's left ankle every shift, and if missing, to notify the supervisor. The documented start date of this record was on 4/17/2025 at 3:00 PM and discontinued on 5/11/2025 at 11:05 when Resident #104 was sent out to the hospital. There was no further documentation regarding the implementation of the resident's electronic monitoring device checks after the resident returned from the hospital on 5/16/2025. A review of Resident #104's Medication Administration Record for 06/2025 did not have documented evidence regarding the checking of the placement of the electronic monitoring device on the resident. An admission-readmission evaluation for elopement was completed on 5/16/2025 at 6:52 PM, documented Resident #104 scored a high risk level for elopement. During an interview on 6/16/2025 at 1:30 PM, Registered Nurse # 4 stated that the resident did have an electronic monitoring device in place, as they remembered it required to be taken off before they were recently sent to the hospital. The resident is currently out at the hospital because of a change in status. They stated that they were monitoring the device before resident was sent out on 5/11/2025, in the Medication Administration Record, but did not include the monitoring of the device when they returned on 5/16/2025. They stated that if there were changes, then the resident's care plan should have been updated. They also stated that since the Comprehensive Care Plan documented that interventions and tasks included checking the placement of the wander guard each shift, it should have been continued in the Medication Administration Record when they returned. Resident # 171 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #171 was admitted to the facility with a diagnoses of hemiplegia and hemiparesis (weakness or paralysis on one side of the body) following cerebral infarction (a condition where brain tissue dies due to lack of blood supply) affecting non-dominant side, pressure ulcer of right buttock, stage 3 (injury to skin and underlying tissue resulting from prolonged pressure on the skin), and muscle wasting and atrophy (decrease in size and strength of muscle tissue). The Minimum Data Set, dated [DATE] documented the resident had moderate cognitive impairment, could be understood and understand others. A review of nursing progress notes dated 2/16/2025 written by Licensed Practical Nurse #12 documented the following: On 2/16/2025, a small open area was noted on Resident #171's coccyx (tailbone) area. Calmoseptine (a topical substance commonly used to treat and prevent minor skin irritations) was applied by a Certified Nursing Aide. Will have Registered Nurse look at it tomorrow. A review of Care Plan with focus Resident #171 has bowel incontinence related to hemorrhagic stroke with bilateral lower extremity weakness, left upper extremity weakness, initiated 1/25/2024. Goal included Resident #171 will not have skin breakdown due to incontinence through review date, initiated 2/01/2024. There was no documented evidence of an open area on coccyx on 2/16/2025 nor did it document interventions/tasks specific to treatment of this open area. A review of Care Plan with focus Resident #171 is at risk for pressure ulcer development related to incontinence, bilateral lower extremity weakness, left upper extremity weakness due to stroke, initiated 2/02/2024. Goal included Resident #171 will have no voidable skin breakdown through the review date, initiated 2/02/2024. There was no documentation of an open area on coccyx on 2/16/2025 nor did it list interventions/tasks specific to treatment of this open area. A review of Care Plan with focus Resident #171 is at risk for impaired skin integrity related to bilateral lower extremity weakness, left upper extremity weakness, incontinence, initiated 1/25/2024. Goal included Resident #171 skin will remain intact throughout the review period, initiated 1/25/2024. There was no documentation of an open area on coccyx on 2/16/2025 nor did it document interventions/tasks specific to treatment of this open area. A review of care plan with focus Resident #171 has bladder incontinence related to urinary retention, initiated 1/25/2024. Goal included Resident #171 will remain free from skin breakdown due to incontinence and brief use through the review date, initiated 2/02/2024. There was no documentation of an open area on coccyx on 2/16/2025 nor did it list interventions/tasks specific to treatment of this open area. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/13/2025 at 11:41 AM, Licensed Practical Nurse #8 stated Resident #171 had an open area on their coccyx but now they had moisture associated skin damage. Resident #171 was turned and positioned every two to three (2-3) hours, the staff provided incontinence care, and the moisture associated skin damage was currently being treated with the application of triad paste and application of a bandage once a day and every day shift as needed. Licensed Practical Nurse #8 looked at Resident #171's care plan and stated there were no updates made to the care plan after the open area on the coccyx was discovered on 2/16/2025 and a care plan that addressed this open area should have been implemented. During an interview on 6/16/2025 at 12:50 PM, Assistant Director of Nursing #1 stated each care plan had a focus that was related to a resident's medical problems which were personalized for the care they required. Interventions to help the residents reach their goals were included on the care plan. Care plans were updated quarterly and as needed. If a new wound was discovered, they would initiate a skin care plan or a pressure ulcer care plan. Assistant Director of Nursing #1 stated a new care plan should have been initiated after the open area to Resident #171's coccyx was discovered, but it was not. They stated they would have expected to see information about the open area and how to care for the area, but this information was not captured on Resident #171's care plan. Resident #524 Resident #524 was admitted to the facility with the diagnoses of major depressive disorder, hypertension, and pressure ulcer of the sacral regions. The Minimum Data Set, dated [DATE] documented the resident was understood, could understand others, and was cognitively intact. The Minimum Data Set documented the resident had one stage three (3) pressure ulcer (full thickness tissue loss but tendons and muscle are not exposed) and one stage four (4) pressure ulcer (full thickness tissue loss with exposed bone, tendon, or muscle). The Comprehensive Care Plan titled, Resident has infection on antibiotics intravenously, initiated 4/08/2025 did not include any interventions. 10 New York Code of Rules and Regulations 415.11(c)(1)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on observation, record review and staff interviews conducted during the Recertification and Abbreviated survey (Case #'s NY00349553, NY00351346, NY00357492, NY00365247, NY00365338, NY00371134, NY00366370), the facility did not provide the necessary care and services to ensure that a resident's abilities in activities of daily living (ADLs) do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable for one (1) (Resident #35) of ten (10) residents reviewed for activities of daily living. Specifically, Resident #35 was not assisted out of bed during observed dates of 6/09/2025, 6/10/2025, 6/11/2025, 6/12/2025, 6/13/2025, 6/16/2026, and 6/17/2025. Resident #35 stated they did not get out of bed because they were a two - person mechanical lift transfer and there were not enough staff to assist. In addition, Resident #35 was no longer offered showers only bed baths due to need for mechanical lift and two-person transfer. This is evidenced by: The facility Policy and Procedure titled, Quality of Life - Dignity, reviewed 1/2025, documented each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. Residents shall be treated with dignity and respect at all times. Treated with dignity means the resident will be assisted in maintaining and enhancing their self- esteem and self-worth. Residents shall be groomed as they wish to be groomed (hair styles, nails, facial hair, etc.). Demeaning practices and standards of care that compromise dignity is prohibited. Staff shall promote dignity and assist residents as needed by: Promptly responding to the resident's request for toileting assistance; and Allowing residents unrestricted access to common areas open to the public, unless this poses a safety risk for the resident. Resident #35 was admitted to the facility with a diagnoses of chronic obstructive pulmonary disease (a lung disease causing restricted airflow and breathing problems), congestive heart failure (a long-term condition that happens when your heart can't pump blood well enough to give your body a normal supply), and morbid obesity (Individuals are usually considered morbidly obese if their weight is more than 80 to 100 pounds above their ideal body weight). The Minimum Data Set (an assessment tool) dated 3/05/2025 documented the resident was able to be understood and was able to understand others with intact cognition. The Comprehensive Care Plan titled, Activity of Daily Living dated 5/18/2025 documented, resident is at risk for functional decline in mobility and self-care related to primary diagnosis of lack of coordination, and rehab treatment diagnosis of muscle weakness, need for assistance with personal care. Interventions: Encourage resident to participate to the fullest extent possible with each interaction. Encourage resident to use bell to call for assistance. Engage, encourage, educate and regularly assess resident's ability to use call bell and appropriate assistive/adaptive devices to improve, maintain, and reduce risk of decline in function, injury and falls. Monitor for changes in status, notify interdisciplinary team as needed. Wheelchair / Scooter Use: Broda chair. Shower/Bathing; substantial/maximal. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grand Rehabilitation and Nursing at Barnwell	3230 Church Street Valatie, NY 12184

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/09/2025 at 12:04 PM, Resident #35 stated most of the time there were only two (2) Certified Nurse Aides working for 40 residents. They stated they needed a mechanical lift to get out of bed which was a two-person transfer. They only got out of bed on occasion because there were no staff to get them in and out of bed, and if they did get out of bed, they had to stay up until late at night before someone would put them back to bed. The last time they got out of bed was about ten (10) days prior. Resident #35 stated staff did not ask anymore if they wanted to get out of bed because they did not have enough staff to help. Resident #35 stated they do not get a shower or tub bath due to them being a two (2) person assist and no staff to accommodate them. They instead get a full bed bath, but that was not very often. During an interview on 6/13/2025 at 1:00 PM, Licensed Practical Nurse #2 stated on their unit there were two (2) to three (3) Certified Nurse Aides on day shift for 40 residents. They stated they were able to manage as several residents did not get out of bed on their unit. During an interview on 6/16/2025 at 12:17 PM, Director of Rehabilitation #1 stated Resident #35 on occasion got out of bed. They were a mechanical lift from bed to chair. Resident #35 previously sat in a Broda chair (a Broda Chair is a chair or wheelchair that provides comfort, support, and mobility throughout the day), but was transitioned to sitting into a wide wheelchair. Resident related to rehabilitation director #1 that they preferred to sit in the Broda reclining chair. The Broda chair was no longer available and was in use by another resident. Rehabilitation Director #1 stated they were in process of reviewing what other types of chairs could be offered to Resident #35. Resident #35 was to attend physical therapy five times per week. They stated since resident did not get out of bed, therapy provides services at bedside for upper and lower body strengthening. 10 New York Codes, Rules, and Regulations 415.12(a)(2)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews conducted during the recertification and abbreviated survey (Case #s NY00350771 and NY00350999), the facility did not ensure that residents were as free from accidents and hazards as possible for three (3) (Resident #s 143, 158, and 192) of nine (9) residents reviewed for accident hazards. Specifically, (a.) for Resident #143, the corridor door to the resident's room was ajar and was unable to be freely closed or opened; (b.) for Resident #158 there was no adequate supervision to prevent an elopement on two different occasions 8/10/2024 and 8/19/2024 when the resident had been identified as an elopement risk from admission; (c.) Resident # 192 was not provided adequate supervision on 8/08/2024, when the resident eloped (left the facility without staff's knowledge). Resident #192 who was on 30-minute safety checks due to cognitive impairment, was last seen at 1:30 PM. At 1:42 PM, Resident #192 was found outside by staff and stated they exited the facility through a side exit door after holding the door release for fifteen (15) seconds. Unit staff did not respond to the door alarm and were unaware the resident was missing. This is evidenced by: The Facility's Policy and Procedure titled, Wandering and Elopement revised 1/2024, documented staff shall promptly report any resident who tried to leave the premises or is suspected of being missing to the Charge Nurse of Director of Nursing. If an employee observed a resident leaving the premises they should: a. attempt to prevent the departure in a courteous manner; (b). get help from other staff members in the immediate vicinity, if necessary; and (c.) Instruct another staff member to inform the Charge Nurse or Director of Nursing Services that a resident has left the premises. When the resident returns to the facility the Director of Nursing Services or Charge Nurse shall: (a.) Examine the resident for injuries; (b.) Notify the Attending Physician; (c.) Notify the resident's legal representative of the incident; (d.) Complete and file a report of an Incident and Accident; and (e.) Document the event in the resident's medical record. The Policy and Procedure titled, Elopements, renewal date 1/25, documented staff would investigate and report all cases of missing residents. A situation in which a resident leaves the premises or safe area without the facility's knowledge and supervision, if necessary, would be considered an elopement. Staff were to promptly report any resident who tried to leave the premises or was suspected of being missing to the Charge Nurse or Director of Nursing. If an employee observed a resident leaving the premises they should attempt to prevent the departure in a courteous manner, get help from other staff members in the immediate vicinity if necessary, and instruct another staff member to inform the Charge Nurse or Director of Nursing Services that a resident had left the premises. If an employee discovered a resident was missing from the facility they should initiate an extensive search of the surrounding area. Resident #143 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #143 was admitted to the facility with the diagnoses of peripheral vascular disease (a circulatory issue where blood vessels outside the heart and brain narrow, blocking or restricting blood flow, often to the limbs), hypertension, and glaucoma (a group of disorders that damage the optic nerve of the eye, which carries visual signals from the retina to the brain, allowing us to see). The Minimum Data Set (an assessment tool) dated 5/23/2025 documented the resident could be understood, usually understand others, and was moderately cognitively impaired. During an observation on 6/08/2025 at 3:33 PM, the corridor door to the resident's room was ajar and was unable to be freely closed or opened. The resident was in the room during this observation. During an observation on 6/08/2025 at 4:09 PM, the corridor door to the resident's room was stuck half-way open and would not freely fully close; a resident was in the room during observations. During an observation on 6/08/2025 at 4:52 PM, the corridor door to the resident's room was ajar and was unable to be freely closed or opened. During an observation on 6/08/2025 at 5:30 PM, the corridor door to the resident's room was fixed and able to open and close freely. During an interview on 6/08/2025 at 5:15 PM, Certified Nurse Aide #3 stated the door had not been like that when they came on shift at 3:00 PM. During an interview on 6/09/2025 at 10:38 AM, Licensed Practical Nurse #2 stated they had not noticed an issue with the door the previous day. During an interview on 6/09/2025 at 12:46 PM, Administrator #1 stated that the door to room [ROOM NUMBER] now opens and closes freely without obstruction, and a full house audit of all doors found no other obstructions Resident #158: Resident #158 was admitted to the facility with diagnoses of Schizophrenia (a mental health disorder with various symptoms that include hallucinations, delusions, disorganized thinking and behavior and flat or inappropriate affect, that causes difficulty with social interaction), traumatic brain injury (an acquired injury to the brain caused by an outside source, causing problems with brain functioning, behaviors and decision making), and epilepsy (a condition affecting the central nervous system or neurological disorder that causes abnormal brain behavior, that causes, triggering seizures, loss of consciousness, and unusual behavior). The Minimum Data Set, dated [DATE] documented the resident could be understood, understand others, and had severely impaired cognition. Comprehensive Care Plan for risk for Elopement related to change in environment, cognitive Impairment related to recent (TBI) traumatic brain injury with desire to leave the facility. Resident will remove and will refuse placement of wander guard, effective 6/19/2024, last updated 6/5/2025 documented, Stated Goals: Resident will not leave facility unattended through the review date, initiated 6/19/2024. Interventions included: Check Placement of wander guard each shift. encourage placement of wander guard. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Elopement on 8/10/2024 and 8/19/2024 with interventions not documented and not updated as documented in both incident and accident reports. During an observation on 6/8/2025 at 5:45 PM, Resident #158 was observed sitting in a chair over by the elevator on Unit #3. The resident was seen without a wanderguard on and had a one-to-one staff member assigned and monitoring them. Facility Incident Report dated 8/10/2024 documented Resident #158 reached the lobby and quickly exited the building when a Receptionist in training let the resident exit the front door and staff redirected the resident back into the facility. Resident #158 was returned to Unit #4 assessed for injury and no injury found, family and physician were notified. Receptionist was immediately reeducated on safety precautions regarding wandering residents. Facility investigation dated 8/10/2024, documented the residents elopement occurred when the resident got past the receptionist and got out of the building from the first-floor unit. Witness stated the resident was gone approximately 10 minutes. A staff member observed them outside and returned them to the unit. It was determined the resident eloped and had no injury had occurred. Resident #158 was placed on one-to-one observation until further interventions could be put in place for the residents safety. The Facility Investigative Report dated 8/19/2024, documented on 8/19/2024 at 6:00 PM, the receptionist paged the supervisor to call them, after being informed by a Certified Nurse Aide #17 that Resident #158 was outside the building. Registered Nurse Supervisor #2 responded to the lobby and stated that the resident was found by an aide outside the building. Certified Nurse Aide #17 had notified them that Resident #158 was found walking down the sidewalk across the street from the building. Certified Nurse Aide #17 stated they had approached Resident #158 and were able to direct them back into the building where the Supervisor now was waiting. They had determined Resident #158 was last seen on 8/19/2024 on the 4th floor by the elevator at 5:40 PM by Certified Nurse Aide # 18. Registered Nurse Supervisor #2 stated there were no noticeable injuries to Resident #158. The resident was not wearing any wanderguard. Resident #158 was then closely monitored with nursing staff by the nurses station to check if the resident attempted to go down the elevator. The incident was considered an elopement and was noted to be missing at 6:00 PM only when the Certified Nursing Aide #17 found the resident outside when they went outside the building and called the receptionist. Care plan updated. It had been determined that staff did not follow the elopement policy. A nursing progress note dated 8/10/2024 at 6:00 PM, documented Resident #158 walked quickly out the main door from the lobby and was redirected. No injuries occurred. Administration team and Director of Nursing made aware. Health Care Proxy notified. Care Plan updated. One-on-One ordered for resident until further changes completed. A Nursing Practitioner #1 progress note dated 8/10/2024 at 7:29 PM, documented they were notified by staff that the resident was found outside of the building across the street and was assisted back into the building. No injuries occurred. Appropriate people notified by nursing. Discussed temporary plan of care over the weekend that currently nursing has the resident on a one-to-one. Further intervention for safety will be discussed with administration. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note dated 8/19/2024 at 10:47 PM written by Registered Nurse Supervisor #2 documented an incident/elopement had occurred on 8/19/2024 at 6:00 PM. Receptionist paged this writer (Registered Nurse Supervisor #2) to call her. Supervisor went down to the lobby and the receptionist stated that Resident #158 was found by an aide outside the building. Aide safely redirected Resident #158 back to the facility where the supervisor was waiting. No injury noted. Resident is confused at his baseline. Observed the resident was not wearing any wanderguard. Resident was closely monitoring at this time and make sure nursing staff will be in the nursing station to check resident going down to elevator. A written statement dated 8/19/2024 written by Certified Nurse Aide #17 documented at 5:58 PM they observed Resident #158 walking on Church Street across from the Daycare Center. They reported they stopped their car and asked the resident where they were going. The resident stated, I'm going to a different program. Certified Nurse Aide documented they then notified the facility immediately by phone and safely redirected the resident back to the facility where the supervisor was waiting. During an interview on 6/08/2025 at 6:00 PM, Certified Nurse Aide #6 stated Resident #158 was an elopement risk and had eloped in the past. Not sure how that happened but the resident will not leave a wanderguard on. Resident #158 needed to be monitored for behaviors and elopement, but staffing did not always allow for the resident to have a one on one, it left the floor short and difficult to monitor other residents who had behaviors as well. Administration was aware. They stated resident was aggressive and could get physical with staff and other residents. During an interview on 6/12/2025 at 9:16 AM, Licensed Practical Nurse #3 stated Resident #158's was currently on a one to one and did not have a wander guard on. The resident had eloped in the past but now when the resident leaves the unit a staff member was with them. The resident would not wear a wander guard and resident was very skilled on how to remove one if they do manage to get one on the resident. It only alarms the front door, and the receptionists have those monitored During an interview on 6/13/2025 at 11:38 AM, Licensed Practical Nursing Unit Manager #2 stated they had worked at the facility when the elopement occurred. Resident #158 was on a different unit when they eloped twice. The resident was then transferred to unit 6 and the facility was having difficulty managing them. Resident #158 had no further elopements, that they were aware of, but had many resident to resident and abuse to staff concerns. They stated they had sent the resident out and had looked for more appropriate placement. Resident #158 was transferred off this unit after a February 2025 incident. The resident would not keep a wanderguard on. When Resident #158 was on the unit staff had to check the wanderguard and was frequently one on one monitoring or close supervision with 15-minute checks as allowed. During an interview on 6/17/2025 at 11:47 AM, Director of Nursing #1 stated they had not been working at the facility when the resident was first admitted and when the elopement took place. Facility had a different Director of Nursing and Administrator. The investigative report they had provide to the surveyors was everything they had found in the file. Many of the staff that had been at the facility in the summer of 2024 were no longer at the facility. Reviewing the records it was clear Resident #158 had eloped on two occasions in August of 2024. Both were reported to the New York State Department of Health reporting division by the previous administration. Multiple changes to Residents #158 Comprehensive Care Plan for elopement and behaviors had been implemented and updated with needed changes and attempts to place the resident in a more appropriate setting after many crises and failed changes in interventions, that included being sent out to psychiatric facilitates, had been done. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Attempted interviews with staff that were present working on 8/10/2024 and 8/19/2024 were unsuccessful. The administrator and Director of Nursing #2 were no longer at the facility to clarify aspects of the elopement and the investigation that was provided to the surveyor. Interviews conducted onsite during the Recertification and complaint investigation determined conclusively that Resident #158 had eloped from the facility on 8/10/2024 and 8/19/2024 and interventions were not revised, and the care plan was not updated nor documented both elopements. During an interview on 6/13/2025 at 1:01 PM, Director of Nursing #1 stated they did not know how the resident left the unit unattended on the 2 occasions they left the facility. Resident #192: Resident #192 was admitted to the facility with diagnoses of hemiplegia and hemiparesis (muscle weakness and partial paralysis) following cerebral infarction (stroke) affecting left non-dominant side, major depressive disorder (serious mental illness characterized by persistent feelings of sadness, loss of interest, and difficulty functioning in daily life), and chronic obstructive pulmonary disease (ongoing lung condition caused by damage to the lungs). The Minimum Data Set, dated [DATE], documented the resident had severe cognitive impairment. The resident could be understood and usually understand others. Nursing Progress Note dated 8/08/2024 at 3:06 PM written by Registered Nurse #4, documented the resident was observed outside the facility and was redirected back into the facility. The resident had an observed fall resulting in a head strike and received a one (1) inch laceration above the left eye. Resident was able to perform assisted range of motion of upper and lower extremities and able to come to a standing position independently. Resident's vitals were taken, and blood pressure was documented as 180/107 (normal is 120/80). Resident #192 refused all medications and refused a full body assessment. The physician was made aware, and the resident was sent to the hospital for further evaluation related to hypertension (high blood pressure) and head strike. Incident Report for Resident #192 dated 8/08/2024 at 4:00 PM by Registered Nurse #4, documented a fall outside. Resident #192 was observed outside. Upon redirecting, the resident tripped and fell and caught themselves with their hands and hit their head. Injury observed documented abrasion on the face. Nursing Home Facility Incident Report dated 8/8/2024 at 3:13 PM by Director of Nursing #2, documented elopement on 8/8/2024 at 1:30 PM. Date/time noted missing was 8/08/2024 at 1:42 PM. Incident overview documented Resident #192 was on 30-minute checks due to cognitive impairment and was last seen at 1:30 PM. Resident #192 was found walking down the sidewalk by Registered Nurse #4. Resident #192 stated they exited through a side exit door after holding the door release for fifteen (15) seconds. Resident #192 walked down the road and Registered Nurse #4 identified them. Resident #192 returned to the facility with staff and sustained a laceration to left eyebrow due to falling while transferring into the vehicle when returning to the facility. Resident #192 was seen by the Nurse Practitioner for medical evaluation and was sent to the emergency room for further evaluation. It documented the resident was at risk for future elopement and a wander guard would be placed on the resident upon their return. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A General Statement dated 8/08/2024 by Registered Nurse #4, documented the resident was observed outside the facility and was redirected back into the facility by them (Registered Nurse #4). The resident had an observed fall resulting in a laceration above the left eye. The resident refused a full body assessment. The physician was made aware with orders to send to hospital for further evaluation. Nursing Progress Note dated 8/09/2024 at 4:52 AM, documented Resident #192 returned from the hospital and had no signs and symptoms of pain or discomfort. A General Statement dated 8/08/2024 by Public Relations #1, documented the resident stated they went out a side door at the facility. The facility tried to redirect the resident back into the building. A staff member who was in their car stopped and they got the resident in the car. At that time, the resident fell and had a cut over their left eye. The resident was brought back into the building, was treated, and was sent to the hospital. There were no documented statements by unit staff and no documented evidence that the facility investigated the resident's elopement. During an interview on 6/12/2025 at 11:30 AM, Registered Nurse #4 stated they were driving back to the facility and noticed someone sitting on a rock and it was raining. They stated they realized it was Resident #192 and they were able to redirect the resident into the car. They stated the resident was usually unsteady on the feet and tripped and fell. They did not recall what time of day it was and said it was during the dayshift. They were unsure of how the resident was able to exit the building. They stated the resident explained how they were able to push the door open after the alarm sounded and then exited the building. Surveyor asked if staff were interviewed. They stated everyone had to write a statement. When asked about staffing, they stated they did not recall what staffing was like that day. They stated staffing was generally not good. During an observation of Unit 3 on 6/12/2025 11:38 AM, Nurse Manager #4 showed the surveyor the room Resident #192 used to reside in. The room was located next to a door that exits into a stairwell. A sign on the door read: Emergency Exit Only, push until alarm sounds. Door can be opened in 15 seconds. Surveyor asked Registered Nurse #4 to open the door. The alarm sounded and was opened after fifteen (15) seconds. Surveyor and Registered Nurse #4 traveled down three (3) flights of stairs to a door that Registered Nurse #4 said exited to the outside. Door sign: Fire Door Keep Closed. Surveyor and Registered Nurse #4 tried to open the door but it would not open. Registered Nurse #4 stated they had never used the stairwell. During an observation on 6/12/2025 1:58 PM, Registered Nurse #4 showed the surveyor where they found Resident #192 outside the building on 8/8/2024. They pointed to a small tree located on the same side of the facility about 23 feet from the edge of the facility's visitor parking lot. They stated the resident was sitting on a brick that was on the ground. Surveyor asked if there was an investigation about how the resident was able to exit unnoticed by unit staff through a door that was alarmed. They stated they wrote a statement, and the resident was able to report that they exited through the door. They did not question unit staff about the door alarm and/or that the resident was missing. They stated that the questioning by the surveyor was an eye opener. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 6/12/2025 at 2:12 PM, Housekeeper #2 was observed exiting the building from a stairwell exit door. Surveyor asked if they could show them the other stairwell exit that the resident could have used to exit the building from unit 3. Housekeeper #2 brought the surveyor to unit 3 and both went down the stairwell next to the resident's room. The surveyor was not able to open the door to exit the building. Housekeeper #2 stated that maybe the door was locked because of the incident with the resident. They then brought the surveyor back up the stairs and then outside the building. They showed the surveyor where the door was located from the outside of the building and the surveyor was unable to open the door. Housekeeper #2 stated the door stays permanently locked. Surveyor used an application on their cell phone to measure the walking distance via the sidewalk from the door to the tree where the resident was found, and it was 0.11 miles. During an interview on 6/12/2025 at 4:19 PM, Administrator #1 stated Public Relations #1 was involved in the investigation of Resident #192's elopement. They stated the receptionist heard the alarm on the panel box and then notified Public Relations #1. They stated the former Director of Nursing #2 reported the incident to the New York State Department of Health. During an interview on 6/17/2025 at 12:02 PM, Public Relations #1 stated the unit 3 door alarm sounded at the reception desk. They stated Receptionist #1 usually contacted them when they were not sure of something, and Receptionist #1 told them they thought someone got out of the building. Public Relations #1 went outside the front door and then walked up the hill to the sidewalk and saw Registered Nurse #4 trying to get Resident #192 into the car. The resident fell and was attended to once they were back in the building. Surveyor asked how the resident was able to get out of the facility. They stated the resident exited through one of the doors and an alarm sounded. When activated, door alarms sound on the unit and then at the reception desk. They stated it was important to do an investigation following an elopement to find out how the resident got out of the building to prevent it from happening again. During an interview on 6/17/2025 at 12:14 PM, Receptionist #1 stated a side door was alarming at the reception desk. They stated they called Public Relations #1 because there was no supervisor until 4:00 PM. They stated somebody was coming into work and saw the resident outside. They stated the resident fell when the staff member was trying to get the resident back in the building. 10 New York Code, Rules, and Regulations 483.25 (d)(1)(2)

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The Grand Rehabilitation and Nursing at Barnwell	3230 Church Street Valatie, NY 12184

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews conducted during the recertification survey, the facility did not ensure that each resident received the necessary respiratory care and services that followed professional standards of practice, for six (6) (Residents #s 8, 35, 78, 98, 147, and 190) of seven (7) residents reviewed for oxygen administration. Specifically, (a.) for Residents #s 8, 78, 98, and 190, supplemental oxygen tubing was not dated and labeled to reflect when the tubing was changed; (b.) for Resident #147 supplemental oxygen was not provided as ordered by the physician; and (c.) Residents # 35 and 98 oxygen delivery devices (BiPAP (bilevel positive airway pressure - noninvasive ventilation) machine were not appropriately cleaned to prevent respiratory infections. This is evidenced by: A review of the facility policy titled, Oxygen Administration, dated 01/2025, documented that the facility was to provide oxygen by way of an oxygen mask, nasal cannula, and/or nasal catheter. oxygen mask/cannula to residents with deficiencies or abnormalities of pulmonary function, to prevent or reverse hypoxia, and improve tissue oxygenation. The procedure is documented to verify that there is a physician's order for this procedure and review the physician's orders or facility protocol for oxygen administration; review the resident's care plan to assess for any special needs of the resident; and assemble the equipment and supplies as needed. Resident #8: Resident #8 was admitted to the facility with diagnoses of Muscular Dystrophy (a group of genetic diseases that cause progressive weakness and breakdown of the body's muscles), chronic respiratory failure with hypoxia(a condition where the lungs cannot adequately exchange oxygen and carbon dioxide), and a stage 4 pressure ulcer of sacral region (a severe type of pressure injury, characterized by full-thickness tissue loss with exposed bone, tendon, or muscle). The Minimum Data Set (an assessment tool) dated 4/21/2025, documented that the resident could be understood and could understand others, and had a severe impact on cognition. During an observation on 6/08/2025 at 4:18 PM, the resident was in bed receiving oxygen at three (3) liters via a nasal cannula that was connected to an oxygen concentrator (a device that provides a continuous supply of oxygen). There was no dated label on the oxygen tubing when it was changed. During an observation on 6/10/2025 at 9:45 AM, the resident was in bed receiving oxygen at three (3) liters via a nasal cannula that was connected to an oxygen concentrator (a device that provides a continuous supply of oxygen). There was no dated label on the oxygen tubing when it was changed. During an observation on 6/11/2025 at 11:01 AM, the resident was in bed receiving oxygen at three (3) liters via a nasal cannula that was connected to an oxygen concentrator (a device that provides a continuous supply of oxygen). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no dated label on the oxygen tubing when it was changed. During an observation on 6/13/2025 at 1:22 PM, the resident was in bed receiving oxygen at three (3) liters via a nasal cannula that was connected to an oxygen concentrator (a device that provides a continuous supply of oxygen). There was no dated label on the oxygen tubing when it was changed. A review of medical orders with a start date of 1/13/2025 documented that the resident was to receive oxygen at three (3) liters per minute via nasal cannula (a device that gives additional oxygen through the nose) continuously every shift for shortness of breath. A review of the Medication Administration Record dated June 2025, documented that the oxygen tubing (nasal cannula) was to be changed one time weekly on Sundays, during the 11-7 shift, and was documented as being changed on 6/08/2025. During an interview on 6/13/2025 at 12:23 PM, Registered Nurse #2 stated the oxygen tubing change was usually done weekly during the 11:00 PM - 7:00 AM shift on Sundays and should have a label on it when it was changed. Licensed Practical Nurse #2 was asked what the potential problems were of oxygen tubing that was dirty or not changed, and they stated a multitude of issues for the resident, including but not limited to respiratory infections. During an interview on 6/16/2025 at 12:17 AM, Director of Nursing #1 stated that staff should change the oxygen tubing once a week. They stated that staff should be labeling the oxygen tubing when they are finished with the process of changing it. Mentioned the labeling observations with the Director of Nursing #1, and they stated that the tubing should not be unlabeled. Resident #98: Resident #98 was admitted to the facility with diagnoses of chronic respiratory failure (a condition where there is not enough oxygen or too much carbon dioxide in the body) with hypoxia (low levels of oxygen in body tissues), chronic obstructive pulmonary disease (ongoing lung condition caused by damage to the lungs), and dependence on supplemental oxygen. The Minimum Data Set (an assessment tool) dated 3/23/2025, documented that the resident was cognitively intact. The resident was able to make themselves understood and understood others. Care Plan for Alteration in Respiratory System related to chronic obstructive pulmonary disease, revised 5/27/2025. Interventions documented to provide oxygen per physician orders and maintain/change tubing per protocol. Physician order dated 11/22/2024, documented oxygen three (3) liters/minute via nasal cannula (thin flexible tube that provides supplemental oxygen therapy) or mask; continuously or PRN (as needed) for shortness of breath every shift. Treatment Administration Record dated June 2025, documented an order dated 12/5/2024 to change the oxygen tubing weekly, every night shift, and every Thursday. On 6/5/2025, it was documented that the tubing was changed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 6/09/2025 at 11:18 AM, Resident #98 had oxygen in use via an oxygen concentrator (a medical device that gives you extra oxygen) at three (3) liters. Resident #3 stated they used three (3) liters of oxygen continually. There was no label/date on the oxygen tubing that was in use by the resident. Physician order dated 11/27/2023 documented BiPAP (bilevel positive airway pressure - noninvasive ventilation) nightly; settings 18/6 with 30% FiO2 at bedtime for Sleep Apnea (a potentially serious sleep disorder in which breathing repeatedly stops and starts). Care Plan for Alteration in Respiratory System related to OSA (obstructive sleep apnea) syndrome, revised 5/27/2025, documented BiPAP ((bilevel positive airway pressure - noninvasive ventilation) treatment was started during recent hospitalization, and documented that the resident, at times, would refuse BiPAP despite education and encouragement. There were no documented interventions for the BiPAP treatment refusals. Additionally, there were no documented interventions for the cleaning/maintenance of the BiPAP equipment until 5/28/2025. Review of the Treatment Administration Record dated May 2025, documented: Use BiPAP nightly at bedtime for sleep apnea. The start date was 11/7/2023, and it was scheduled to be done at 9:00 PM. Review of the record documented that the resident refused BiPAP treatment on 17 of 31 days. For instance, 5/23/2025 through 5/26/2025 documented 2 (drug refused). Review of Nursing Progress Notes dated May 2025 did not document the refusals and/or that the physician was notified. There were no orders dated for the cleaning/maintenance of the BiPAP (bilevel positive airway pressure - noninvasive ventilation) equipment until June 2025. Review of the Treatment Administration Record dated June 2025, documented: BiPAP headgear wash with warm water and soap as needed every day shift, every Wednesday for BiPAP use. The start date was 6/4/2025 and was documented as done on 6/4/2025. Clean BiPAP mask and tubing with warm soapy water and allow to soak, then rinse with warm water and air dry every day shift for BiPAP use. The start was 6/9/2025 and was documented as done on 6/9/2025. During an interview on 6/17/2025 at 11:39 AM, Assistant Director of Nursing #1 stated that the nurses should be notifying the provider to obtain further instruction when Resident #98 refused the BiPAP therapy. There should be documentation of the refusal and the notification to the physician. They stated there should have been an order for the cleaning/maintenance of the BiPAP when the physician first ordered it. Resident #147: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #147 was admitted to the facility with diagnoses of Non-Alzheimer's dementia (a range of conditions that cause cognitive decline that impact memory, thinking and behavior), anemia (a condition where red blood cells and hemoglobin (a protein) are diminished and effect the amount of oxygen throughout the body) and acute respiratory failure with hypoxia (condition where the lungs cannot adequately oxygenate the blood resulting in low levels of oxygen in the blood stream). The Minimum Data Set, dated [DATE], documented that the resident could understand and was understood by others with moderately impaired cognition for daily decision making. A physician's order dated 1/14/2024 documented Oxygen 2 liters via nasal cannula continuously for shortness of breath. A physician's order dated 6/8/2025 documented changing the tubing every week, 11 to 7 shift every Sunday. Record review of Residents comprehensive care plan for respiratory system related to acute respiratory failure with hypoxia dated 1/01/2025 documented stated goal for the resident to be adequately oxygenated with interventions as follows: Observed signs and symptoms of poor airway clearance and gas exchange, report abnormalities, provide oxygen per physician's orders and maintain tubing per protocol. Review of the electronic treatment administration record dated 6/2025, the following was documented: (1) Oxygen 2 liters via nasal cannula continuously for shortness of breath every shift, dated 1/14/2025, there was no documented evidence that this was done on 6/9/2025 for the day shift (2). Resident to have foam ear protectors in place when the oxygen nasal cannula is in use. Every shift. Dated 5/22/2025 During an observation on 6/8/2025 at 4:35 PM, Resident #147 was sitting in their wheelchair in the dining room, the oxygen was being delivered by a portable oxygen tank and was set at 2.5 Liters, and did not have labeling indicating the date the tubing was changed. During an observation on 6/9/2025 at 9:35 AM, Resident #147 did not have labeling indicating the date the oxygen tubing was changed. The resident was still in bed and was lying flat with the oxygen concentrator delivering oxygen via the nasal cannula; the concentrator was set at 2 Liters. During an observation on 6/10/2025 at 1:30 PM, Resident #147 was sitting in the dining room with their family. The portable oxygen was being used and was being delivered at 2.5 Liters via nasal cannula. During an interview on 6/10/2025 at 1:45 PM, Registered Nurse Manager #3 stated the correct amount of oxygen for Resident #147 was 2 liters. Tubing is due to be changed once a week on Sunday, and tubing should be dated when changed. The documentation on the electronic treatment record for 6/9/2025 was not done for the day shift, and they would review why. If it's not recorded, it may have been missed. The delivery of the oxygen needs to match the physicians' orders. Education on checking the oxygen would need to be given. Any nebulizers and BIPAP machines should be labeled, and nebulizer equipment needs to be cleaned and placed in a plastic bag labeled with the resident's name and their room number. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/17/2025 at 10:22 AM, Infection Control Specialist #1 stated that oxygen tubing is changed weekly on Sunday. Nurses sign the electronic treatment administration record and are supposed to place a tag on the tubing documenting the date the tubing was changed. Staff are educated on this, and it is in the facility's infection control policy. The nebulizers and BIPAP machines are to be cleaned after use, and staff are required to put them in a clean plastic bag that identifies the resident and room number. This is also in the infection control policy. 10 New York Code of Rules and Regulations 415.12(k)(6)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observation, record review, and interviews during a recertification and abbreviated (Case #s NY00350251, NY00350678, NY00350852, NY00359849, NY00366370, NY00380238, and NY00381177, NY00360717) survey, the facility did not ensure the provision of sufficient nursing staff to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident throughout the facility. Specifically, (a.) staff reported a lack of sufficient staffing, and (b.) residents reported during interviews that the facility was short-staffed at times, and this resulted in call bells not being answered promptly and long wait times for care to be provided. This is evidenced by: Upon entrance to the facility on 6/08/2025, there were 222 residents residing in six (6) units. The Facility Assessment, last reviewed on 6/02/2025, documented that the facility's bed capacity was 226, with an average daily census of 222 - 225 residents. Section 3.2, titled Staffing Plan, documented the following: - Day shift required 6-11 Licensed Nurses providing direct care, and 12 -23 Certified Nurse Aides. - Evening shift required 6-10 Licensed Nurses providing direct care, and 12 -23 Certified Nurse Aides. - Night shift required 5-7 Licensed Nurses providing direct care, and 6 - 12 Certified Nurse Aides. During an interview on 6/09/2025 at 10:59 AM, Resident #59 stated that staff took long time to answer the call light. They stated it took about an hour for staff to come in, and sometimes staff would just come in and turn the call light off and leave, and they must put it on again. They stated that the second shift also took a long time to come in and assess their needs. During an interview on 6/09/2025 at 11:39 AM, Resident #171 stated that the second shift took a long time to come in. They stated that there was no supervision on the floor at shift change, and staff would not come in tight away or provide an excuse that they just arrived, and they wee unable to provide the care at that time. During an interview on 6/09/2025 at 12:04 PM, Resident #35 stated that only two aides working most of the time and that it was impossible to take care of 40 residents on the unit. They stated that to get out of bed, they required 2 aides and mechanical lift. They stated most of the time, they did not get out of bed because there were not enough staff to assist them. They stated they did not receive full showers or baths due to staffing. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 6/09/2025 at 3:45 PM, Resident #107 stated that they were always short-staffed and there were not enough staff to take care of all the residents. During an interview on 6/10/2025 at 11:39 AM, Resident #8's family stated that they believed there were not enough staff, and the residents' did not get the care that they required. During a surveyor-led group resident meeting on 6/10/2025 at 11:07 AM, the eight (8) residents in attendance all reported insufficient staffing to meet their needs. They stated that they had often had to wait up to an hour at times for staff to answer their call light. They stated that the staff would turn off their call light and tell them they would be back to provide requested care and never returned. They stated that on the weekends and the 3:00 PM-11:00 PM and 11:00 PM-7:00 AM shifts were the most difficult times. They stated that there had been times when there was one aide by themselves, along with a single nurse. They stated residents' were not getting the care they deserved because they were short-staffed. During an interview on 6/11/2025 at 11:53 AM, Certified Nurse Aide #2 stated they were often short-staffed, and residents would have to wait for care. They stated that there were usually only two aides on the unit, and if they had three, it would be a rare occasion. They stated that there were a lot of individuals on the unit who required added attention, and sometimes they were not able to give them the extra attention that was needed. They stated that there were 6 - 7 residents on the unit that required 2 persons to move, and they had to wait an additional amount of time to provide the care due to the number of staff on the unit at a time. They were able to provide all the needed care, but no time for anything extra. During an interview on 6/11/2025 at 11:53 AM, Certified Nurse Aide #3 stated that there were usually only two aides on the unit most of the time. They further stated that there were a lot of individuals on the unit who required a lot of care, and there was only so much that they could do with the number of staff who were on the unit. They stated that they were able to provide all the needed care, and no resident has gone without care, but there was no time for anything extra, and they would need to wait a little bit longer. During an interview on 6/18/2025 12:09 PM, Licensed Practical Nurse #10 stated that there have been times when they have been short-staffed. Being short-staffed was very stressful and made it difficult completing job functions tasks on time. They stated that there have been times when their medication administrations have been late due to having to assist in the care of residents. During an interview on 6/13/2025 12:32 PM, Registered Nurse #2 stated they often helped by giving medications, toileting residents, and doing dressing changes when the staffing was low, and then stayed late to get their job done. They stated that everyone attempted to pitch in and assist when staffing was low. Many times, other nursing staff came to their unit and assist, as it was one of the larger units in the facility. During an interview on 6/16/2025 at 12:20 PM, Director of Nursing #1 stated they were aware of consistent staffing issues. They stated that staffing was looked at daily and adjusted as needed. They stated that units 2 and 3 were the most demanding units due to the number of residents and their required needs. They stated that they were using multiple incentives to attempt to get additional staffing into the facility. They stated they were not aware of any care not being provided; however, insufficient staffing resulted in residents waiting for care that they should not have to wait for. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	10 New York Code Rules and Regulations 415.13(a)(1)(i-iii)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview conducted during the recertification and abbreviated survey (Case #'s NY00349022 and NY00368315), the facility did not ensure licensed nurses and Certified Nurse Aides had the specific competencies and skills necessary to care for residents' needs. Specifically, nursing staff did not possess the knowledge needed to complete the tasks assigned to their position regarding the mentally disabled and intellectually disabled residential population. This is evidenced by: The facility assessment dated [DATE] documented the following: - Section 1.1 resident profile numbers documented that they are licensed to care for 236 residents with six nursing units. Units 3,4,5, & 6 are each 40-bed units that are for long-term care. Unit 1 is a 30-bed secured unit for those with Dementia/Alzheimer's. Unit 2 is a 47-bed unit that provides long-term care and short-term rehab. There are no designated beds secured for residents with mental health or behavioral disorders. - Section 1.3 that the resident population had Disease/Conditions, Physical and Cognitive Disabilities which included Psychiatric/Mood Disorders such as Anxiety Disorder, Bipolar Disorder, Depression, Impaired Cognition, Mood Disorders, Borderline Personality Disorder, Schizophrenia, Schizoaffective Disorder, Traumatic Brain Injury, Psychosis (Hallucinations, Delusions, etc.). - Section 1.4 for decisions regarding care for those not listed in documents, assessment of resident referrals includes identifying additional needs of residents, such as physical space, equipment, assisted technology, individual communication devices, or other material resources that are needed to provide the required care and services to residents. If Nursing Administration believes the facility can manage a referral, a referral will be made to the Nursing Educator to provide education to the nursing staff. Competency of staff will be assessed to ensure understanding of the education provided. - Section 1.5 documented the resident acuity of mental health and behavioral health needs with an average range of 42 residents in the facility. - (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Section 2.1 residents care and services the facility offers documents under mental health and behavior they offer services to manage medical conditions & medication related issues causing psychiatric symptoms & behavior, identify & implement interventions to help support residents with issues related to dealing with anxiety, care of someone with cognitive impairment, care of person with depression, other psychiatric diagnoses and developmental disabilities. During a review of annual competencies for nursing staff, there were no documented evidence of annual educational competencies to address residents with mental health or behavioral needs. During an interview on 6/8/2025 at 5:13 PM, Certified Nurse Aide #6 stated there were only three (3) aides and one (1) Licensed Practical Nurse on the unit. They stated that they do have residents with difficult behaviors, and there was not enough time to monitor and provide all the residents' care. During an interview on 6/12/2025 at 11:15 AM, Director of Social Work #1 stated that they have a large population of residents with behavioral needs and mental health issues, which makes it challenging to manage and maintain care planning and adequate supervision for everyone who needs it. During an interview on 6/13/2025 at 4:00 PM, Administrator #1 stated the facility had a high population of residents with mental health diagnoses. They stated they were trying to screen residents who came from the hospital more carefully. Hospitals were not always honest about Residents' behaviors. They stated that staff education was going to have to include training in de-escalating and managing behaviors, but with unpredictable residents, that did not always work. During an interview on 6/16/2025 at 11:15 AM, Nurse Educator #1 stated that they did not have any education during orientation or annually for mental health or behavioral health needs. 10 New York Code of Rules and Regulations 415.26(c)(1)(iv)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews conducted during a recertification survey, the facility did not ensure that its medication error rate did not exceed 5% for three (3) (Resident #s 46, 206, and 67) of four (4) residents observed during a medication pass for a total of 27 observations. This resulted in an error rate of 59.26%. This is evidenced by: The Policy and Procedure titled, Administering Medications, reviewed 01/25, documented medications would be administered in a safe and timely manner, and as prescribed. Medications would be administered in accordance with the orders, including any required time frame. Medications would be administered within one (1) hour of the prescribed time, unless otherwise specified (for example, before and after meal orders). Resident #46: Resident #46 was admitted to the facility with diagnoses of epilepsy (a brain condition that causes recurring seizures), chronic obstructive pulmonary disease (ongoing lung condition caused by damage to the lungs), and hypertension (high blood pressure). The Minimum Data Set (an assessment tool) dated 6/03/2025, documented the resident had moderate cognitive impairment. The resident was able to make themselves understood and understood others. The Medication Administration Record dated June 2025 for Resident #46 documented the following medications were to be administered at 9:00 AM: Lyrica (pregabalin) oral capsule 150 milligrams, give 1 capsule 2 times a day for 14 days for pain. Acetaminophen Extra Strength tablet 500 milligrams, give 2 tablets by mouth 2 times a day for pain. Cholecalciferol tablet 1000 unit, give 1 tablet by mouth 1 time a day for vitamin D deficiency. Aspercreme Lidocaine Patch 4%, apply to lower back topically for pain relief, apply in AM and remove at bedtime During the medication administration observation on 6/11/2025, Licensed Practical Nurse #10 administered the above medications at 10:23 AM. Resident #206: (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #206 was admitted to the facility with diagnoses of orthopedic aftercare following surgical amputation, anemia (low levels of healthy red blood cells to carry oxygen throughout the body), and atherosclerosis (buildup of fats, cholesterol, and other substances on artery walls) of native arteries of extremities with gangrene (death of body tissue due to a lack of blood flow or serious infection) of bilateral legs. The Minimum Data Set, dated [DATE], documented the resident was cognitively intact. The resident was able to make themselves understood and understood others. The Medication Administration Record dated June 2025 for Resident #206 documented the following medications were to be administered at 9:00 AM: Atorvastatin Calcium oral tablet 20 milligrams, give 1 tablet by mouth 1 time a day for high triglyceride level. Gabapentin capsule 300 milligrams, give 1 capsule by mouth 3 times a day for neuropathy (nerve damage outside the brain and spinal cord). Metoprolol Succinate Extended Release 24-hour oral tablet, give 1 tablet by mouth 1 time a day for hypertension. Ferrous Sulfate tablet 325 milligrams, give 1 tablet by mouth 1 time a day for supplementation. During the medication administration observation on 6/11/2025, Licensed Practical Nurse #10 administered the above medications at 10:50 AM. Resident #67: Resident #67 was admitted to the facility with diagnoses of wedge compression fracture of unspecified vertebra (fracture usually occurs in front of the vertebra (bone of spine) and collapses), schizoaffective disorder depressive type (chronic mental health condition characterized by symptoms of schizophrenia such as hallucinations and delusions and mood disorder such as depression), and chronic pain syndrome (chronic pain that lasts over three months). The Minimum Data Set, dated [DATE], documented the resident had severe cognitive impairment. The resident was able to make themselves understood and sometimes understood others (responded adequately to simple, direct communication only). The Medication Administration Record dated June 2025 for Resident #67 documented the following medications were to be administered at 9:00 AM: Amlodipine Besylate oral tablet 10 milligrams, give 1 tablet by mouth 1 time a day for hypertension. Ascorbic Acid tablet 500 milligrams, give 1 tablet by mouth 2 times a day to promote wound healing. Fluoxetine HCl oral capsule 40 milligrams, give one 1 capsule by mouth 1 time a day for depression. Folic Acid oral tablet 1 milligram, give one 1 tablet by mouth 1 time a day for hematopoietic (the process of blood cel formation). (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Benztropine Mesylate oral tablet 1 milligram, give one 1 tablet by mouth 2 times a day for anticonvulsive. Venlafaxine HCl Extended Release 24-hour 150 milligrams, give one 1 tablet by mouth 1 time a day for depression. LPS Protein 30 milliliters, two times a day to promote wound healing. Pyridoxine (vitamin B6) HCl tablet 100 milligrams, give 1 tablet by mouth 1 time a day for vitamin supplement - was scheduled to be given at 9:00 AM and was not available. During the medication administration observation on 6/11/2025, Licensed Practical Nurse #10 administered the above medications at 10:55 AM. During an interview on 6/11/2025 at 11:12 AM, Licensed Practical Nurse #10 stated they knew medications were late, but they could not pass all medications on time while they were alone on the unit. Surveyor asked Licensed Practical Nurse #10 if they asked for help, and they stated management staff knew they needed help. New York Code Rules and Regulations 415.12(m)(1)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations and interviews during the recertification survey and abbreviated survey (Case #'s NY00366370, NY00349022, NY00365338), the facility did not ensure each resident received and the facility provided, food and drink that was palatable, attractive, and at a safe and appetizing temperature of greater than 135 degrees Fahrenheit (F) for warm food and less than 41 degrees Fahrenheit for cold food for four (4) (Resident #s 23,35, 109, and 198) of four (4) residents reviewed. Specifically, (a.) residents complained that the food was cold, appeared uncooked, and was generally unpalatable during the resident council meeting; (b.) Resident #23 complained about cold, undercooked, and unappetizing food; (c) Resident #35's meal was not palatable and not served at a safe and appetizing temperature during lunch service on 6/13/2025; (d.) Resident #109 and their family member complained about cold and unappetizing food; and (e.) Resident #198 complained about cold, undercooked food. This is evidenced by: The Policy and Procedure titled, Food and Nutrition Services, revised 01/2025, documented each resident was provided with a nourishing palatable, well-balanced diet that met their daily nutritional and special dietary needs, taking into consideration the preferences of each resident. Food and nutrition services staff would inspect food trays to ensure that the correct meal was provided to each resident, the food appears palatable and attractive and was served at a safe and appetizing temperature. During the resident council meeting on 6/10/2025 at 11:07 AM, residents reported food was cold, hard and uncooked. If the food was cold, they would ask staff to reheat it, but staff would not always do it. They stated there were concerns about frequent inconsistencies with the meal ticket and what they received on the meal tray. Resident #35: Resident #35 was admitted to the facility with a diagnoses of chronic obstructive pulmonary disease (a lung disease causing restricted airflow and breathing problems), congestive heart failure (a long-term condition that happens when your heart can't pump blood well enough to give your body a normal supply), and morbid obesity (usually considered morbidly obese if their weight is more than 80 to 100 pounds above their ideal body weight). The Minimum Data Set (an assessment tool) dated 3/05/2025, documented the resident was able to be understood and was able to understand others with intact cognition. Unit 6: On 6/13/25 at 11:50 AM, Resident #35's lunch tray arrived and was tested. The lunch tray temperatures were taken, and items served were tasted. The results were as follows: Beef taco: 114.1 Fahrenheit, meat did not appear appetizing; did not resemble meat (meat was in crumbs, dry) and did not taste like meat. The taco shell was hard and unable to chew. Carrots and green beans: 108 Fahrenheit (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Chocolate ice cream: 21.2 Fahrenheit and was liquidly. Jello: 56.5 Fahrenheit Coffee was on the meal ticket but was not on tray. Resident 109: Resident #109 was admitted to the facility with diagnoses of type 2 diabetes mellitus (a chronic condition that happens when a person has persistently high blood sugar levels), end stage renal disease (a condition in which the kidneys lose the ability to remove waste and balance fluids), and chronic obstructive pulmonary disease (narrowing of the airways of the lungs making it difficult to breathe). The Minimum Data Set, dated [DATE] documented the resident had moderate cognitive impairment, could make themselves understood, and understand others. During an interview on 6/10/2025 at 12:44 PM, Family Member #1 of Resident #109 stated prison inmates received better food than Resident #109. They stated they brought food from outside of the facility for Resident #109 to eat. During an interview on 6/17/2025 at 10:09 AM, Resident #109 stated they did not like anything about the food the facility provided. They stated the food had no flavor; the vegetables were bland. The facility did not provide seasoning such as salt and pepper or they did not provide butter to add to the food. They stated by the time they received the food it was cold. Staff did not heat up the food or offer to get a replacement when they complained of being served cold food. They stated the only time they received hot food was when Family Member #1 came to visit and brought them food from outside of the facility. They stated overall the food looked unappetizing; like it was just thrown on the plate. Unit 5: On 6/13/2025 at 12:12 PM, a test tray was provided. The test tray temperatures were taken, and items served were tasted. The results were as follows: Beef taco (2): 112.6 Fahrenheit and 113.5 Fahrenheit. When the beef tacos were picked up, grease was pooled on the plate underneath them. The tacos tasted greasy, and they were not hot. Peas and carrots: 103.1 Fahrenheit and were not hot. Tossed Salad: 55.6 Fahrenheit Canned Fruit (peaches): 55.4 Fahrenheit Coffee: 126 Fahrenheit, was warm. Creamers (2): 60.1 Fahrenheit and 62.2 F Diet cola: 68.5 Fahrenheit, was tepid, not cold. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Yogurt: 47.7 Fahrenheit Cottage cheese: 61 F, was not cold. Italian dressing: 75.2 F Fahrenheit Side container of cheddar cheese: 68.4 F, was not cold. Side container of salsa: 68.4 Fahrenheit, was not cold. Side container of lettuce: 59.7 Fahrenheit, was not cold. Sour cream: 66.6 Fahrenheit was not cold. Resident #23: Resident #23 was admitted to the facility with diagnoses of excoriation (skin-picking) disorder, lymphedema (tissue swelling caused by an accumulation of protein-rich fluid that is usually drained through the lymphatic system, often affecting arms and legs), and chronic peripheral venous insufficiency (leg veins become damaged and struggle to send blood back up to the heart). The Minimum Data Set, dated [DATE], documented the resident was cognitively intact. The resident was able to make themselves understood and understand others. During an interview on 6/10/2025 at 9:24 AM, Resident #23 stated they just finished their breakfast. They stated the food they received was either overcooked or undercooked and cold. They lifted the cover from their food plate and pointed to the hashbrown patty on the plate and stated it was dry and was not warm when it arrived. They stated the bagel was hard, cold and was not toasted. They stated they have received meat that was pink and did not look done and would not eat it. They stated they have complained about the food, but nothing was done about it. Unit 4: On 6/13/2025 at 1:41 PM, Resident #23's lunch tray arrived and was tested. The lunch tray temperatures were taken, and items served were tasted. The results were as follows: Beef taco (2): one 126.7 Fahrenheit and tasted bland. The other taco was not tested. Peas and carrots: 124.5 Fahrenheit. There was a double portion of peas and carrots on the plate that did not look appetizing. Several peas were shriveled and overcooked, while other peas appeared undercooked. The carrots appeared to be overcooked and were mushy. The vegetables were not palatable. Jello: 53.2 Fahrenheit and was not cold. Cottage cheese: 55.6 Fahrenheit and was not cold. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 6/11/2025 at 9:38 AM, Regional Manager Food Service #1 stated they had complaints of food being cold. They currently had open carts and there were 6 units. They had requested closed carts but have received nothing yet. Distributing trays to the residents was often a problem because the elevators were slow. Unit 3: On 6/13/2025 at 1:20 PM, a test tray was provided. The test tray temperatures were taken, and items served were tasted. The results were as follows: Beef taco: 110 Fahrenheit and the soft taco shell was soggy from the juice of the peas and carrots that were separated from the taco. Peas and carrots: 100.4 Fahrenheit were cool not hot. The carrots were overcooked, and the peas were undercooked and mixed in together with excess juice. Butter would not melt on the peas and carrots. The carrots and peas were bland and unappetizing. Milk: 60 F and was warm. Cola was unopened and the can of soda was warm. No ice was provided on the tray. During an interview on 6/13/2025 at 1:50 PM, Licensed Practical Nurse #3 stated the residents without cognitive concerns always complained about the food being cold. The trays come up and because they are not always on time, staff might be giving care and there would be delays passing them especially if staffing was low. They stated the carts did not keep the trays hot even with the covers on the plate. If a resident complains, staff call down and ask for a new tray but that was not always a solution because of the time frame involved, especially if someone was hungry. This has been discussed with administration and the food service people, but nothing has been changed. During an interview on 6/13/2025 at 1:58 PM, Certified Nurse Aide #6 stated the trays come up late and because they were not always on time staff might be giving care and there were delays passing them. They have a resident who needed 1 on 1 supervision on the unit and that made it harder to get trays passed. The carts do not keep the trays hot even with the covers on the plates. They stated food was always cold, and most residents just ate it cold rather than wait to get another tray, or they ordered a sandwich. Administration was aware of the problem with the food, but nothing was done. During an interview on 6/16/2025 at 12:16 PM, Certified Nurse Aide #14 stated if a resident did not like their meal, they could call the kitchen for an alternative meal. Items such as salads, sandwiches, and cheeseburgers were always available. They stated if a resident complained they received cold food, they would call the kitchen to bring up a new tray or warm the food in a microwave on the floor. Certified Nurse Aide #14 stated some complaints they received from residents regarding the food were due to the food not being hot, but there more complaints were about the taste of the food and that it was bland. During an interview on 6/16/2025 at 12:19 PM, Licensed Practical Nurse #8 stated if a resident complained about the food, they would call down to the kitchen to see if they could get a replacement. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 6/17/2025 at 8:42 AM, Director of Kitchen Services #1 stated they were trying to resolve the complaints regarding the food being cold. They stated trays sometimes get held up when being delivered from the kitchen to the floors due to kitchen staff needing to wait for an elevator as the kitchen does not have a separate elevator to use for deliveries. They stated they were trying to get closed carts or carts that have a plastic covering that go over them to help insulate the carts. They were also considering a system that would enable them to serve food on the floors like a buffet style. They stated this would reduce the waiting time for the food to be delivered, and it would help with having the food served at the appropriate temperature. Director of Kitchen Services #1 stated they wanted the residents to be happy and they tried to make accommodations for food items they liked. If the resident did not like their meal, an alternative hot meal was available along with sandwiches, hamburgers, and grilled cheese. During an interview on 6/17/2025 at 11:19 AM, Director of Nursing #1 stated the temperature of the food was checked before it left the kitchen. Once the food arrived on the unit, it was the responsibility of the nursing staff to distribute the food. If residents complained of the food being cold, the nursing staff should warm it up in a microwave on the unit or contact the kitchen for a replacement tray. They stated they were not aware of food getting to the units late and being served cold because it took a long time for the elevators to arrive, causing the food to not be distributed in timely manner from the kitchen. 10 New York Code Rules and Regulations 415.14(d)(1)(2)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and interviews conducted during the recertification survey, the facility did not provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. Specifically, the exterior of the facility building, and the grounds were not clean and maintained. This is evidenced by: During observations on 6/08/2025 at 4:18 PM, the blocks in the retaining wall on the west end of the property were crumbling, the propane tank area was overgrown with vegetation and the wooden fence in disrepair, brickwork in the loading dock wall was crumbling, the east exterior wall stucco had black water staining, and grounds along the west exterior wall was littered and had a build-up of leaves and overgrown vegetation. During an interview on 6/10/2025 at 11:11 AM, Director of Plant Operations #1 stated that they would repair the walls and fencing and cut the overgrown vegetation. New York Codes Rules and Regulations Title 10 §415.5(h)(4)