STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335586	A. Building B. Wing	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alpine Rehabilitation and Nursing Center	755 E Monroe Street Little Falls, NY 13365

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to ensure a resident with pressure ulcers received the necessary treatment and services, consistent with professional standards of practice, to promote wound healing, prevent infection and prevent new ulcers from developing for two (2) of three (3) residents (Residents #24 and #64) reviewed. Specifically, Resident #64 was admitted to the facility with pressure ulcers and pressure relief measures were not implemented timely; Resident #24 was identified as high risk for the development of pressure ulcers and did not have adequate pressure relief measures in place and subsequently developed a pressure ulcer on their heel. Findings include: The facility policy Pressure Injury Prevention and Management/Wound Rounds, dated 12/2020, documented all residents were assessed for the risk of pressure injuries, would have an appropriate interdisciplinary preventive care plan implemented when indicated, and were evaluated for clinical condition and risk factors for pressure injury development. 1) Resident #64 had diagnosis including anemia, chronic kidney disease, and chronic pain. The 11/25/2025 admission Minimum Date Set assessment documented the resident's cognition was intact and was dependent for all activities of daily living including bed mobility. The resident was admitted with Stage 2 (partial thickness tissue loss) and Stage 3 (full thickness tissue loss) pressure ulcers, was at risk of developing pressure ulcers, had a pressure reducing device for bed and chair, was on a turning and repositioning schedule, and received application of ointments and medications. The 11/21/2025 Tissue Trauma Discovery Form completed by Registered Nurse Manager #21 documented the resident had a Stage 3 pressure ulcer on their sacrum (lower back) measuring 2.0 x 1.5 x 1.2 centimeters with undermining (separation of the wound edges from surrounding healthy tissue); and a Stage 2 pressure ulcer to the right lower buttock measuring 2.3 x 1.5 x 0.1 centimeters. Preventative treatment was initiated, the physician and family were notified, and the care plan was initiated and in place. Resident #64 was seen on weekly skin rounds on 12/03/2025, 12/10/2025, 12/17/2025 and 01/14/2026. There was no documented evidence the resident's comprehensive care plan included any pressure reducing devices or pressure relief interventions until the resident was readmitted to the facility from a hospital stay from 01/26/2026-01/28/2026. The 1/28/2026 Clinical admission readmission Evaluation Form completed by Registered Nurse #21 documented the resident had moisture associated skin damage on the left buttock measuring 3 x 2 centimeters and a Stage 3 pressure ulcer to the sacrum measuring 2.5 x 2 x 0.5 centimeters. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335586	A. Building B. Wing	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alpine Rehabilitation and Nursing Center	755 E Monroe Street Little Falls, NY 13365

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 1/28/2026 Comprehensive Care Plan documented the resident had a history of chronic pressure ulcers and was at risk of development of pressure ulcers. Interventions included chair cushion, air mattress, elevate heels on pillow, and turn and reposition every two hours. During a treatment observation on 04/01/2026 at 10:21 AM with Licensed Practical Nurse #15, the resident was assisted to their side by Certified Nurse Aide #23. The resident had a round pressure ulcer the size of a half dollar to the coccyx (end of spine) with no drainage. The area was cleansed and calcium alginate (absorbent dressing) dressing was applied. The sacral area had three (3) blister type areas, and the nurse cleansed the area and applied Balmex (protective cream). The gluteal fold (crease of buttock) had an open wound, and the wound bed contained yellowish and white tissue. The pressure ulcer was cleansed and the nurse applied a barrier cream and covered with a dry dressing. During an interview on 04/01/2026 at 11:19 AM, Certified Nurse Aide #23 stated the resident was transferred to the south unit from the rehabilitation unit a couple of months ago and the resident was admitted to the hospital with wounds on their bottom, and they were getting bigger. The certified nurse stated if they noticed any changes in the resident's skin, they would notify the licensed practical nurse or registered nurse. During an interview on 04/01/2026 at 1:16 PM, Licensed Practical Nurse #15 stated they thought one of the reasons the resident had problems with pressure ulcers was because of their bed. They thought the resident had a regular mattress when they first moved to the south unit and received their specialty air mattress soon after transfer. They stated the resident had an order for an alternating pressure mattress about three weeks ago, and they already had to replace it. They stated the resident refused to be repositioned back into their bed from their chair. During an interview on 04/03/2026 at 9:08 AM, Registered Nurse Unit Manager #6 stated they were the nurse that completed the admission on [DATE]. The resident was admitted with pressure wounds. They stated the resident was at risk for pressure ulcers and should have had a care plan with an air mattress, other pressure relieving devices, and pillows to assist. When residents were admitted they were assessed, and Resident #64 had wounds. The resident had a Stage 3 on their sacrum and another moisture associated wound on their left buttock. They completed a tissue trauma sheet and gave it to the Director of Nursing. The wound information was added to a progress note, and depending on severity of wounds, the resident would be added to weekly wound rounds. The wound rounds were completed by a team including a nurse practitioner, the Director of Nursing, and the registered nurse. They stated the Director of Nursing kept copies of the tissue trauma forms. The resident's wound on their sacrum was nasty. They had it for years and it was now a Stage 3 pressure ulcer. They also had a left buttocks moisture wound without staging. During an interview on 04/03/2026 at 11:30 AM, Nurse Practitioner #10 stated their expectation of the registered nurses during wound rounds was to document stage, measurement, treatment, if it was an initial wound finding, and communication. The entire wound assessment should be documented by the registered nurse including what the wound looked like in their assessment. Nurse Practitioner #10 said that the resident came in with wounds and they knew the resident from home care. The resident's wounds fluctuated. It was getting better at first. The wound status declined recently. The gluteal fold wounds were acquired. The resident spent a lot of time in their chair and often refused to go to bed. 2)Resident #24 had diagnoses including right hip fracture, intellectual disabilities, and seizures. The 01/21/2026 Minimum Data Set assessment documented the resident's cognition was intact; required (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335586	A. Building B. Wing	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alpine Rehabilitation and Nursing Center	755 E Monroe Street Little Falls, NY 13365

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	supervision for most activities of daily living and was independent with bed mobility; was at risk of developing pressure ulcers; had an unhealed Stage 3 pressure ulcer; had pressure reducing device for chair; and received pressure ulcer care including application of ointments/medication. The 10/30/2025 comprehensive care plan documented the resident had potential for pressure ulcer development related to decreased mobility. Interventions included monitor and document any changes in skin. The 11/07/2025 at 10:21 AM, Licensed Practical Nurse #7 progress note documented Resident #24 had a large, deflated blister on the right heel. The area was cleaned and treatment to the area was applied. The information was reported to the Director of Nursing. A 11/07/2025 Director of Nursing progress note documented the resident had a ruptured blister on the right heel, and thinks it may be from the foot pedal on the wheelchair. The flap of skin over the blister was intact and the area measured 6 x 5 centimeters. Heel suspension boots were applied, to be on resident permits at all times when not in physical therapy or ambulating. A non-adhering dressing was applied. On 11/07/2025, the comprehensive care plan was updated to include heel suspension boots while in bed. Nurse Practitioner #10 documented the following wound observations during skin rounds: -11/11/2025 the deflated blister to the right heel was 7 x 7 centimeters and showed no signs or symptoms of infection. -11/24/2025 the wound as a deflated blister to the right heel, 7 x 7 centimeters with no signs or symptoms of infection. -12/07/2025 the outer aspect of right heel had a Stage 2 pressure ulcer which was two 2 x 4 x 0.1 centimeters with 100% granulation (a healthy red new tissue and scant drainage. -12/18/2025 right heel measured 1 x 1 centimeters and there were no signs or symptoms of infection. -01/07/2026 the right heel wound was 1 x 1 centimeters with no signs or symptoms of infection. -01/14/2026 the wound to outer aspect of the right heel was a Stage 3 pressure ulcer measuring 1 x 1 centimeter, superficial, with 100% granulation and minimal drainage. -01/30/2026 the right heel wound measured one 1 x 1 centimeters with no signs or symptoms of infection. -01/242026 the Stage 3 pressure ulcer to the right heel measured 2.5 x 2.5 centimeters with 100% slough (dead tissue) and noted foul smelling serosanguineous drainage (thin, pink, watery drainage). A new order was placed to cleanse the wound with normal saline, dry, apply medical-grade antibacterial honey (wound treatment) to the wound bed and cover with gauze dressing. -02/07/2026 the right heel wound was 1.5 x 1.5 centimeters with 100% granulation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335586	A. Building B. Wing	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alpine Rehabilitation and Nursing Center	755 E Monroe Street Little Falls, NY 13365

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-02/12/2026 the right heel Stage 3 pressure ulcer was 2 x 1 centimeters in diameter, with 100% granulation and no signs or symptoms of infection. -03/04/2026 the right heel wound measured 2 x 1 centimeters and was fully granulated with no signs or symptoms of infection. -03/18/2026 the right heel continued to improve and was 2 x 1 centimeters with 100% granulation. During an observation on 03/30/2026 at 1:48 PM, Resident #24 was sitting in their wheelchair with black surgical boots (used to protect and stabilize the foot and ankle while recovering from injuries or surgery, not designed to relieve heel pressure) with both feet on the floor. During an observation on 03/31/2026 at 3:44 PM Resident #24 was sitting in a wheelchair, had black surgical boots on each foot with both feet on the floor. Resident #24 was seated in their wheelchair on a yellow air cushion. There was no air mattress observed on the bed. During a skin and treatment observation on 04/01/2026 10:32AM, with Licensed Practical Nurse #11, Resident #24 was sitting in a wheelchair with ortho shoes on both feet, holding right leg over left leg. There was no heel suspension boots in the room. Licensed Practical Nurse #11 stated the treatment for resident's right heel was wash with soapy water and apply skin prep (a skin protectant). Licensed Practical Nurse #11 removed the ortho shoe and lifted resident's compression sock to expose the wound site. Licensed Practical Nurse #11 stated that Resident #24 used to have a sore on the right heel that was open with a little bit of drainage. Resident #24 had a 2.0 centimeter round area of thick calloused skin surrounded by pale/pink skin to the back of the right heel. There was no dressing on the wound, no drainage and no discoloration to the surrounding skin. Licensed Practical Nurse #11 cleansed the lesion with soapy water, wiped with sterile gauze, and applied skin prep. Resident #24 denied having pain when Licensed Practical Nurse #11 asked about pain. Resident #24 remained sitting in wheelchair with both feet in ortho shoes and both feet on the floor after wound care. During an interview on 04/02/2026 at 9:51 AM, Certified Nurse Aide #12 stated an air mattress, repositioning every two hours, and other interventions in the resident's care plan were what they do to prevent pressure ulcers. They generally find information about the care plan or the care instructions in electronic health record. Certified Nurse Aide #12 remembered Resident #24 when they were admitted , and when the resident got a sore on the right heel. They stated it looked like a little red mark on the back of the heel. They used compression stockings (sock to promote circulation in the legs), and the nurses also put sterile dressings on the sore, then covered it with compression stockings and then an open toe slipper. They stated Resident #24's family member brought in surgical boots for Resident #24 to wear. They stated they saw heel suspension boots used in the past on other residents, but Resident #24 did not have them. During an interview 04/02/2026 at 10:09 AM, Licensed Practical Nurse #11 stated turning, positioning, skin checks, pushing fluids, and notifying the registered nurse in the care plan for interventions and the unit manager or the supervisor would initiate the interventions for the care plan. They stated Resident #24 had a sore on the right foot, it started out as a blister, then it just progressed. They stated Resident #24's family member wanted the resident to wear the surgical boots they brought from home as they used these when they had blisters before. Licensed Practical Nurse #11 stated after developing the sore to the heel, the staff used antibacterial honey, and some other treatments, and thought the staff were applying heel suspension boots, but could not remember. They were not sure if the resident had heel suspension boots in the room right now. They stated they (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335586	A. Building B. Wing	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alpine Rehabilitation and Nursing Center	755 E Monroe Street Little Falls, NY 13365

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	were no longer using a covered dressing anymore on the wound, but the resident was still at risk for pressure ulcers. Licensed Practical Nurse #11 stated the registered nurses usually print out sheets of the changes in care plans and give them to the Licensed Practical Nurses. They stated interventions in the care plan included heel suspension boots, and they recalled seeing the heel suspension boots but had not seen them today or at all recently. During an interview on 04/02/2026 at 10:30 AM, Registered Nurse Unit Manager #6 stated preventing pressure ulcers depended on the resident's mobility. The less mobile they were the more interventions staff used. They stated Resident #24 came in with a hip fracture and was at high risk for developing pressure ulcers. Resident #24's sore started with a non-blanchable area of redness to the back of the right heel. They thought the sore may have been caused by the resident scooching up with their right foot. The wound developed into a blister, then it opened and became worse. They stated the resident had heel suspension boots, and this information should have been in the care plan, and the staff are expected to follow it. They stated they go over care plans every week and do a full review of care plans every three months. Interventions included a bigger bed to help with mobility, and all interventions were in the care plan. Registered Nurse Manager #6 stated heel suspension boots were initiated on 11/7/2026. They stated there were no real preventative treatments for pressure ulcers documented in the care plan before 11/07/2025. During an interview on 04/02/2026 at 10:45 AM Licensed Practical Nurse #7 stated they went into Resident #24's room and found no heel suspension boots but later found them in the laundry. During an interview on 04/02/2026 at 11:40 AM the Director of Nursing stated that residents who are immobile, have poor nutrition, diabetes, a history of wounds, or tube feedings are at risk for developing pressure ulcers, and a hip fracture could put a resident at risk for developing pressure ulcers as well. They stated turning and positioning, off-loading pressure, skin prep for heels and other portions of the skin and adding calorie supplements to diets were common interventions to prevent pressure ulcers for residents at risk. They stated resident specific interventions were in the care instructions, registered nurses were responsible for care plans, and they expected staff to follow the care plans. The Director of Nursing accessed the electronic health record and located the care plan for Resident #24 and stated they personally initiated the care plan upon Resident #24's admission on [DATE], and someone else later updated it on 11/07/2025. They stated there were not any specific individualized care plans initiated for Resident #24 to prevent pressure ulcers upon admission. They stated the heel suspension boot order came later, and they should have had the heel suspension boots in the care plan earlier. They stated the interventions on the care plan were not 100% appropriate or effective, Resident #24 developed a pressure ulcer, and the facility did have the responsibility to prevent pressure ulcers. 10 NYCRR 415.12 (c)(1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335586	A. Building B. Wing	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alpine Rehabilitation and Nursing Center	755 E Monroe Street Little Falls, NY 13365

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, record review, and interviews during a survey, the facility failed to ensure resident menus were followed for one (1) of one (1) meal preparations observed. Specifically, the facility ran out of preplanned barbeque chicken thighs and did not follow the recipe of the preplanned cheddar broccoli bake. Findings include:On 04/01/2026 the facility's resident census was 75 residents. The facility's week one (1) Fall Winter 2024-2025 menu at a glance documented the Wednesday lunch was barbeque chicken, garden rice, cheddar broccoli bake, and rosy pears. The alternatives were fish on a bun, mashed potatoes, and spinach. The facility's 04/01/2026 menu item tally for Wednesday week one (1) Fall Winter 2024-2025 documented the following was prepared for the poultry entree:-56 barbeque chicken with a buffer of two (2) barbeque chickens for a total of 58 barbeque chickens.-10 ground barbeque chickens.-Three (3) pureed barbeque chickens. The undated facility's Cheddar Baked Broccoli Recipe documented three (3) quarts of cheddar baked broccoli were poured into each of three (3) greased twelve inch by twenty inch by two (2) inch pans. During a kitchen observation on 04/01/2026 from 10:18 AM through 1:16 PM the lunch meal was prepared:-At 10:41 AM, [NAME] #14 pulled one twelve inch by twenty inch by six (6) inch hotel pan containing the cheddar baked broccoli out of the oven and the temperature measured at 120 degrees Fahrenheit, so they put it back in the oven.-At 11:11 AM [NAME] #14 pulled one hotel pan out of the oven containing chicken thighs, and the temperature was measured at 200 degrees Fahrenheit. They pulled the two (2) additional hotel pans with chicken out of the oven, and the chicken was moved to the steam table.-At 11:17 AM, the oven timer was going off. [NAME] #14 pulled the twelve inch by twenty inch by six (6) inch hotel pan containing the cheddar baked broccoli out of the oven, measured the temperature at an unknown degree, stated it was not up to temperature and was still hard, then put the pan back in the oven. -At 11:30 AM and 11:37 AM, the oven timer was going off. [NAME] #14 pulled the twelve inch by twenty inch by six (6) inch hotel pan containing the cheddar baked broccoli out of the oven, measured the temperature at 140 degrees Fahrenheit, stated it needed a few more minutes and put the pan back in the oven. -At 11:44 AM, the Food Service Director pulled the twelve inch by twenty inch by six (6) inch hotel pan containing the cheddar baked broccoli out of the oven. They stated [NAME] #14 did not make it right. They moved some of the cheddar baked broccoli into a smaller pan, placed it on the stove and put hot water in the pan on the stove with a hot water hose.-At 11:47 AM, the Food Service Director stated it might work because it was steaming.-At 11:50 AM, the Food Service Director asked [NAME] #14 to take more of the broccoli from the large pan and move to a smaller pan. [NAME] #14 told the surveyor they had never made this recipe before. -At 11:54 AM, the Food Service Director measured the temperature of the first pan of broccoli they moved to the stove top and measured it at 165 degrees Fahrenheit and stated it was good and tender. -At 11:56 AM, [NAME] #14 started to plate items from the steam table while the Food Service Director continued to warm smaller portions of broccoli on the stove top while adding hot water from the hose. -At 12:53 PM, [NAME] #14 told the Food Service Director they did not have enough chicken thighs. At 12:55 PM, they determined they were short nine (9) servings of chicken thighs. -At 12:57 PM, the Food Service Director pulled frozen cooked chicken dated 03/31/2026 out of the freezer, cut it up, placed it on a plate and microwaved it. At 1:04 PM, they stated it was from yesterday and was boiled chicken that was prepared for ground and pureed chicken. -At 1:16 PM, the last tray with the microwaved, previously frozen boiled chicken breast left the kitchen. During an interview on 04/01/2026 at 1:17 PM, [NAME] #14 stated they were supposed to reference the tally sheet to determine how many whole, ground, and pureed chicken thighs they needed to prepare for the lunch meal. They showed the surveyor the tally sheet and said they followed it, so they were not sure what happened. They were supposed to count the chicken thighs, but it was hard because they were frozen and sometimes stuck together. They just cooked the whole box and were not sure how many chicken thighs were in a box. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335586	A. Building B. Wing	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alpine Rehabilitation and Nursing Center	755 E Monroe Street Little Falls, NY 13365

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	They pulled the chicken from the freezer the prior Sunday (03/29/2026) and thought the box would have enough. They followed the recipe for the cheddar baked broccoli, but it did not turn out. They looked for the recipe they used but could not find it in the recipe book. During an interview on 04/01/2026 at 1:27 PM, the Food Service Director stated [NAME] #14 was supposed to follow the production sheet and count the chicken thighs. [NAME] #14 told them they counted the thighs, so they were not sure what happened because they ran out. Menus needed to be followed, or the residents could get upset. The cheddar baked broccoli should have been cooked in three (3) pans not one (1). It was important the recipes were followed, or the food would not turn out right. 10 NYCRR 415.14(c)(1-3)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335586	A. Building B. Wing	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alpine Rehabilitation and Nursing Center	755 E Monroe Street Little Falls, NY 13365

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observations, record review, and interviews (iQIES intake 2809584), the facility failed to ensure residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices for two (2) of two (2) residents (Residents #13 and #48) reviewed. Specifically, Resident #13 did not have a significant bowel movement from 07/25/2025-08/08/2025 and there was no documented evidence bowel interventions were consistently provided, the resident's gastrointestinal status was assessed, or the physician was notified; and Resident #48 had position changing alarms initiated, impacting the resident's freedom of movement, without trialing other interventions first. Findings include: The facility policy Certified Nurse Aide Documentation & Usual Performance, revised 01/01/2026, documented the certified nurse aides must document care at the time it was provided and the specific care offered per the care plan must be objectively and completely documented.The facility policy Managing Falls and Fall Risk, revised 05/2025, documented if falling recurred despite initial interventions, staff would implement additional or different interventions, or indicate why the current approach remained relevant. Position-change alarms would not be used as the primary or sole intervention to prevent falls and would be monitored for efficacy. The facility policy Personal Care: Toileting, revised 10/12/2029, documented residents would be toileted according to the individualized plan of care to promote continence and maintain the resident's highest level of function and maintain dignity. Additionally, the date and time the resident was assisted to the bathroom would be recorded.The facility policy Restraints, revised 09/2025, documented the facility would only consider utilizing a restraint when all other reasonable options had been exhausted and the resident's medical condition warranted their use; position changing alarms were not considered a restraint unless it caused agitation, interfered with the resident's sleep pattern, or caused the resident to be afraid to move; any device that prevented a resident from freely and easily arising out of a chair or bed was considered a restraint; and any device that met the definition of a physical restraint must have a physician order, a care plan and a process in place for systematic and gradual restraint reduction and physician identification and record of the specific medical symptom that supported the use of the restraint.The facility policy Bowel Management, revised 11/2025, documented each resident would have at least one (1) bowel movement every three (3) days unless the practitioner documented a clinically appropriate alternative goal; every resident would have daily monitoring of their bowel movement documentation and days since their last bowel movement; and four (4) or more days without a bowel movement was a red flag and required immediate nurse assessment and practitioner notification. 1) Resident #13 had diagnoses including schizophrenia (a serious mental health condition), morbid obesity, and intestinal bypass. The 09/30/2025 Minimum Data Set assessment documented the resident had moderately impaired cognition, was incontinent of bowel, and required moderate assistance for most activities of daily living. There was no documented evidence the resident's Comprehensive Care Plan included reference to the resident's bowel function. The Bowel and Bladder Elimination Report documented from 07/25/2025 through 07/28/2025 the resident did not have a bowel movement (four days).The 07/27/2025 Nurse Practitioner #10 progress note documented the resident had multiple loose stools and was now constipated after Clostridium difficile (a bacteria causing diarrhea) culture was ordered. The resident had not had any bowel movements. There was no documented evidence the resident's gastrointestinal system was assessed by Nurse Practitioner #10.The 07/2025 Medication Administration Record documented the resident received Milk of Magnesia (laxative) on 07/28/2026 for no bowel movement for three (3) days. The Bowel and Bladder Elimination Report documented on 07/29/2026 the resident had a small bowel movement.The 07/2025 Medication Administration Record documented the resident received a Dulcolax suppository (laxative) one time only for no bowel movement for four (4) days on 07/29/2025.08/01/2025 Nurse Practitioner #10 progress note documented the resident's abdomen was soft, nontender, and without (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335586	A. Building B. Wing	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alpine Rehabilitation and Nursing Center	755 E Monroe Street Little Falls, NY 13365

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	masses. Bowel sounds were active. The Bowel and Bladder Elimination Report documented from 07/30/2025 through 08/08/2025 the resident did not have a bowel movement (10 days).The 08/05/2025 Physician #20 progress note documented the resident was seen for a 60 day follow up. Review of systems found the resident doing well without complaints of gastrointestinal symptomatology. Recent nursing notes were reviewed. The resident was examined with the nurse present. Their abdomen was soft, nontender, and without masses. Bowel sounds were active. There was no documented evidence the physician was made aware of the resident's lack of bowel movements since 07/30/2025. The 8/2025 Medication Administration Record documented:-on 08/05/2025 Enemeez Mini Rectal enema, insert one (1) suppository rectally one time only for no bowel movement x five (5) days. There was no documented evidence the suppository was administered as ordered. -on 08/06/2025 Enemeez Mini Rectal enema, insert one (1) suppository retally one time only for no bowel movement x six (6) days. The suppository was documented as administered at 10:34 PM. -on 08/07/2025 magnesium citrate give 148 milliliters by mouth one (1) time only for no bowel movement x seven (7) days. The magnesium citrate was administered at 11:30 AM. -on 08/08/2025 magnesium citrate give 148 milliliters by mouth one (1) time only for no bowel movement x eight (8) days. The magnesium citrate was administered at 11:48 AM with a 9 indicating other/see nurses note (the resident was sent to the hospital).The 08/08/2025 Nurse Practitioner #10 progress note documented the resident's presenting problem was constipation. Resident was noted to be multiple days without having a bowel movement and was complaining of abdominal pain. A KUB (an x-ray to assess abdominal area) was recommended. Due to the resident's size and weight, they were unable to have the KUB performed in-house. The resident was then noted to have some vomiting and extreme abdominal pain. The resident would be sent to the hospital to have imaging and rule out obstruction. The 07/27/2025- 08/07/2025 daily 24-Hour Report Sheets did not document the resident's bowel status had been monitored or assessed.Nursing progress notes did not document ongoing physician notification of the resident's bowel status or ongoing nursing abdominal assessments.During an interview on 04/02/2026 at 1:12 PM, Licensed Practical Nurse #15 stated a bowel movement report was ran daily that tracked how many days a resident went without a bowel movement. If two (2) or more days without a bowel movement the provider should be called for orders, and an abdominal assessment should be performed for anything beyond three (3) days. That assessment along with the physician notification should be documented. Resident #13 was not usually constipated. They stated during August of last year the resident had gone quite a few days without a bowel movement. There should be documentation of what intervention was provided for each day they were without a bowel movement. During an interview on 04/02/2026 at 3:57 PM, the Director of Nursing stated the nurse managers monitored the bowel list daily. If a resident had two (2) or more days without a bowel movement the provider was called for orders and should be called again if there were no results. That should go on the 24-hour report sheet and there should be a daily abdominal assessment that included bowel sounds, distension, gas, and appetite. Resident #13 should have had daily abdominal assessments and daily physician notification during the time they were not having any bowel movements but did not. The 08/05/2026 docusate sodium mini rectal enema order should be signed as administered but was not which indicated that medication was not administered. 2) Resident #48 had diagnoses including dementia, paralysis and weakness following a brain bleed, and seizures. The 02/18/2026 Minimum Data Set assessment documented the resident had moderately impaired cognition; required substantial assistance for most activities of daily living; was frequently incontinent of bowel and bladder; had one (1) fall with minor injury and two (2) falls without injury since admission; and used a bed and chair alarm daily. The Comprehensive Care Plan documented: -11/18/2025 at risk for falls. Interventions included a bed alarm, a chair alarm, low bed, and floor mats. The resident had actual falls on 11/22/2025, 01/31/206, 02/08/2026, 02/21/2026, 03/01/2026, 03/21/2026; and 03/25/2026. -11/20/2025 and revised 03/09/2026 activity of daily living and mobility deficit. Interventions included assistance of two (2) for toileting hygiene and toilet (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335586	A. Building B. Wing	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alpine Rehabilitation and Nursing Center	755 E Monroe Street Little Falls, NY 13365

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	transfer; moderate assistance of two (2) to move from lying on back to sitting on the edge of the bed without back support; moderate assistance of two (2) for toileting hygiene; and check and change and toilet every two (2) to three (3) hours and as needed. -11/26/2025 functional bladder incontinence related to impaired mobility. Interventions included ensure resident had an unobstructed path to the bathroom.The Comprehensive Care Plan did not document any fall prevention interventions used prior to the initiation of the position changing alarms or a process for the systematic and gradual reduction of their use.The Resident's Accident/Incident Reports documented the following: -On 11/22/2025 at 11:10 AM found sitting on the floor in their room.-On 01/03/2026 at 7:45 PM found on the floor next to their bed.-On 01/31/2026 at 6:30 PM fell when trying to get out of their wheelchair.-On 02/08/2026 at 9:20 PM found lying prone on the floor in the common area. They sustained a raised purple area to their left face.-On 02/21/2026 at 11:00 AM fell in the bathroom-On 03/01/2026 at 6:40 AM found on the floor in their room. Their bed alarm was turned off, and they said they needed to use the bathroom.-On 03/25/2026 at 2:00 AM they got out of bed, urinated on the floor, slipped in the urine, fell, and sustained a nasal fracture. The resident was toileted at 1:45 AM.Nursing progress notes documented the following:-On 02/272026 at 10:14 PM the resident frequently attempted to self-transfer and alarms alerted the staff.-On 03/08/2026 at 10:46 PM the resident was non-compliant with alarms and transfers. -On 03/09/2026 at 10:01 PM the resident was non-compliant with staying in the chair or bed, was setting off alarms multiple times during the shift, and stripped off their clothing and brief and was incontinent. -On 03/12/2026 at 8:18 PM the resident was consistently undressing and walking around getting off their chair alarm.-On 03/15/2026 at 10:07 PM the resident was up and out of bed multiple times that shift and was non-compliant with the alarms.-On 03/16/2026 at 9:47 PM the resident was non-compliant with staying seated and often tried to walk to the bathroom.-On 03/19/2026 at 10:13 PM the resident was very anxious, was up and down out of bed and in and out of the bathroom multiple times.-On 03/25/2026 at 10:12 PM the resident persistently tried to ambulate themselves.-On 03/26/2026 at 3:08 PM the resident was constantly reminded to ask for assistance when needing to use the restroom so they would not fall again.-On 03/29/2026 at10:41 PM the resident was found self-transferring multiple times and was non-compliant with alarms.-On 03/30/2026 at 10:59 PM the resident was awake all night. They got up to walk to the bathroom, but they were incontinent along the way making the floor wet and increasing risk of falling. They moved quicker than the alarm alerted staff.-On 03/30/2026 at 5:09 PM the resident was non-compliant and was getting out of their chair, walked around, activated alarms and pushed staff so they could take a walk.-On 03/30/2026 the resident was non-compliant with staying seated. There was no documented evidence an attempt was made to determine the root cause of why the resident was attempting to rise or was not compliant with the alarms and alternative interventions attempted. The following observations were made of Resident #48:-On 03/31/2026 at 1:51 PM the resident attempted to stand from their wheelchair and a high-pitched alarm sounded. The resident said oh and immediately sat back down.-On 03/31/2026 at 2:18 PM, the resident stood from their chair and began pulling at a straight back chair as though they were going to sit in it. Their chair alarm immediately sounded, and several staff ran down the hall saying no, no, no and directed the resident to sit back down.-On 04/01/2026 at 12:02 PM the resident was lying in bed, the bed was in lowest position, and the bed alarm began playing the song It's a Small World.-On 04/02/2026 at 10:24 AM the resident's bed alarm went off, and they were sitting at the edge of the bed. An unidentified staff member went into the room, talked briefly to the resident who then laid back down.-On 04/02/2026 at 10:34 AM the resident was in bed, the bed was in lowest position, and they started to move towards the edge of the bed and the alarm started playing It's a Small World.During interviews on 03/30/2026 at 12:01 PM, 03/31/2026 at 1:51 PM and 04/03/2026 at 12:41 PM, the resident stated they did not like the alarms, and no one asked them how they felt about them. The chair alarm went off if they stood up or if they leaned too far forward. When it went off everyone and their brother came running to tell them to sit down. The alarm made them jump and feel like they were doing something wrong. They knew when they had to (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335586	A. Building B. Wing	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alpine Rehabilitation and Nursing Center	755 E Monroe Street Little Falls, NY 13365

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	go to the bathroom, but would not get up because of the alarm, which resulted in bladder accidents. They had accidents two (2) to three (3) times a day and the smell of urine killed them. Not being able to get up to use the bathroom and having accidents made them feel like they were losing their liberty. If staff were not going to let them get up to use the bathroom, then staff needed to take them to the bathroom in time. They did not like the bed alarm. It alarmed when they were just changing position and startled them when they were trying to sleep. Sometimes they turned it off. They hated the bed alarm tune and asked the surveyor how they would like to be awoken at 4:00 AM by a children's song. During an interview on 04/02/2026 at 12:13 PM, Certified Nurse Aide #16 stated a resident's toileting plan could be found on their care instructions. If a resident was incontinent, they were checked and changed every two (2) hours. If a resident was incontinent but sometimes continent, they asked the resident if they needed to be changed. Position change alarms were loud and alarmed a lot. Some residents became upset when staff responded to them. Usually, residents just wanted to get up and move. Resident #48 was checked and changed every two (2) hours and was not on a set toileting schedule. The resident asked to go to the bathroom all the time, tried to take themself and they witnessed the resident urinate while on the toilet. The resident had a bed and chair alarm that sounded a lot and were activated even if the resident was only repositioning themselves. Their bed alarm played a song, so the staff were better able to determine whose alarm was sounding. The resident got frustrated with the alarms and had turned them off in the past. During an interview on 04/03/2026 at 9:28 AM, Licensed Practical Nurse #15 stated toileting frequency was on the care instructions and should be followed. The facility used position changing alarms for residents who had a lot of falls. Alarms allowed staff to know when a resident was getting up and sounded even if the resident was readjusting their position. Resident #48 tried to get up a lot saying they had to urinate. They believed their care plan stated they should be toileted every two (2) to three (3) hours. They had a chair alarm, a bed alarm and a low bed. During an interview on 04/03/2026 at 10:32 AM, Registered Nurse Unit Manager #6 stated the least restrictive fall prevention interventions should be tried first. On admission if a resident was at high risk for falls, alarms might be initiated immediately. Alarms were not considered a restraint, did not require an order, did not need a documented medical condition, and were used primarily to alert staff that the resident was moving. Alarms did not decrease the risk of falls but sometimes they startled the resident enough to make them sit back down. Residents should be asked, when appropriate, how they feel about the alarms. Fall intervention effectiveness was evaluated quarterly and as needed and was based on how many times that resident fell. Residents who were both continent and incontinent of urine were checked and changed every two (2) to three (3) hours. When Resident #48 was admitted they were incontinent, not able to move their left side and unable to speak. Alarms were initiated without trying other fall interventions first. Now they were up and down all the time trying to get to the bathroom. The resident might be a good candidate for bladder training. If the alarms agitated them, they should be asked about how they felt about the alarms. It could be upsetting to them if the alarm attracted everyone. During an interview on 04/03/2026 at 11:30 AM, Registered Nurse Unit Manager #4 stated alarms were not considered a restraint. Resident #48 had fallen numerous times and had alarms that alerted staff the resident was already up. Their bed alarm played It's a Small World so staff could differentiate their alarm from others. They thought the resident did not like the alarm because they tried to turn it off. During an interview on 04/03/2026 at 12:05PM, the Director of Nursing stated the effectiveness of fall prevention interventions was based on the number of falls. Position changing alarms and low beds were not considered a restraint, did not require an order or a related physician documented medical condition. Their use should be discussed with the family and resident and documented as such. The resident's feeling about the alarms should trump everything else. For residents at high risk for falls, alarms were used without trying other interventions first. If a resident was turning off their alarms and still falling, then those alarms were not effective and would likely be discontinued. They expected residents to be toileted in accordance with the comprehensive care plan and staff documented each time the resident was toileted. 10 New York Code Rules and Regulation 415.12 (k)(1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335586	A. Building B. Wing	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alpine Rehabilitation and Nursing Center	755 E Monroe Street Little Falls, NY 13365

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, record review, and interviews the facility failed to ensure the correct medication was administered in the correct dose in accordance with manufacturer's specifications and with standards of practice for of one (1) of six (6) residents (Resident #2) reviewed. Specifically, Resident #2's insulin pen was not primed (removal of air bubbles to ensure the precise dosage of insulin) prior to administration. Findings include: The facility policy Blood Glucose Management documented when using an insulin pen the needle would be screwed onto the end of the pen, the cap removed, and the flow of the delivery device checked by priming with two (2) units of insulin and pressing the button on the non-needle end of the pen all the way down. Next, the dose prescribed by the physician for administration would be selected by dialing the number of units on the pen.Resident #2 had diagnoses including diabetes. The 12/16/2025 Minimum Data Set assessment documented the resident had moderately impaired cognition and received daily insulin injections.The 01/07/2025 Comprehensive Care Plan, revised 04/27/2025, documented the resident had diabetes. Interventions included diabetes medications as ordered by the physician.The 01/19/2026 physician order documented aspart (a fast-acting insulin) five (5) units daily with meals via a pen injector. During an observation and interview on 04/01/2026 at 12:50 PM, Licensed Practical Nurse #5 attached the needle to the aspart insulin pen, dialed it to five (5) units, then administered it to the resident. They did not prime the pen first. They stated priming was not needed because when the button on the end of the pen was pushed during administration it was priming. During an interview on 04/01/2026 at 1:05 PM, Registered Nurse Unit Manager #4 stated when preparing an insulin pen, after attaching the needle the needle should be primed by performing a waste dose of one (1) or two (2) units. If that was not done there might be air in the needle and then the correct dose of insulin would not be given. 10 NYCRR 415.12(m)(2)