STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335601	A. Building B. Wing	11/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Center for Nursing and Rehab at Hoosick Falls	21 Danforth Street Hoosick Falls, NY 12090

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 Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Based on record review and interviews during an abbreviated survey (Case # 2590765), the facility did not ensure residents received treatment and care in accordance with professional standards of practice that would meet each resident's physical, mental, and psychosocial needs for one (1) (Resident #1) of three (3) residents reviewed. Specifically, the facility did not ensure a physician order for treatment of a new wound on Resident #1's back, identified on 8/04/2025 during a wound care consult. This is evidenced by: Resident #1:Resident #1 was admitted to the facility with diagnoses of spina bifida (a condition that occurs when the spine and spinal cord do not form properly), constipation, and retention of urine with obstructive and reflux uropathy (retention due to a blockage that makes it difficult or impossible to pass urine). The Minimum Data Set (an assessment tool) dated 6/26/2025, documented the resident had severe cognitive impairment. The resident usually made themselves understood (difficulty communicating some words or finishing thoughts but was able if prompted or given time) and usually understand others (missed some part/intent of message but comprehended most conversation).Policy and Procedure titled, Consultants, revised 12/2024, documented the facility may use outside resources to furnish specific services to residents and to the facility. Such personnel were employed on a consultant basis. Consultant services included wound care. Consultants would provide the Administrator with written, dated, and signed reports of each consultation visit. Consultation reports contained recommendations; plans for implementation of their recommendations; findings; and plans for continued assessments. The facility retains the professional and administrative responsibility for all services provided by consultants.The Hospital wound care consult note for Resident #1 dated 8/04/2025, documented a new wound #6 located on the resident's back. Wound Treatment documented instructions for wound care of the back wound and included Triad 2.5 ounces, apply as directed three (3) times per week for fifteen (15) days; Alginate AG 4 x 4 inches, apply to wound bed three (3) times per week for fifteen (15) days. Diagnosis coding included spina bifida. There was no documented evidence of a physician order for treatment of the wound on the resident's back.Physician Order Report dated 7/01/2025 to 8/29/2025, documented an open-ended order dated 7/14/2025 for Wound Care Consult.The hospital wound care consult dated 7/28/2025, documented the resident had five (5) wounds as follows:o Wound #1 lower leg, right;o Wound #2 calcaneus (heel), righto Wound #3 coccyx (tail bone)o Wound #4 gluteus (buttock muscle), lefto Wound #5 upper leg, leftThe Hospital wound care consult note for Resident #1 dated 8/04/2025, documented wounds #1 through #5 and a new wound #6 located on the resident's back. Wound Treatment for the back wound included clean wound with saline, Triad 2.5 ounces (wound ointment), apply as directed three (3) times per week for fifteen (15) days; Alginate AG 4 x 4 inches (highly absorbent wound dressing), apply to wound bed three (3) times per week for fifteen (15) days. Diagnosis coding included spina bifida.There was no documented evidence of a physician order for treatment of the wound on the resident's back: Physician Order Report dated 7/01/2025 to 8/29/2025, did not document a treatment order for the wound on the resident's back. Treatment Administration Record dated 8/01/2025 to 8/20/2025, did not document an order for the wound on the resident's back. Review of the Medication Administration Record dated 8/01/2025 to 8/21/2025, did not document any wound treatment orders. Review of Nursing Progress Notes dated 8/04/2025 to 8/21/2025, did not document any notes about the new wound on the resident's back identified on 8/04/2025.Care Plan for Pressure Ulcer/Injury, revised 8/21/2025, documented the resident had actual skin impairment as evidenced by pressure ulcer to right heel and lateral foot, venous ulcers to right lower extremity, coccyx, and back. Approaches (interventions) included report any skin changes to provider as necessary; wound care treatment(s) as ordered.During an interview on 8/20/2025 at 1:53 PM, Assistant Director of Nursing #1 stated the facility's in-house wound care provider saw Resident #1 on 7/16/2025, and less than a week later, the resident's son wanted the resident to go to the hospital wound care center. Resident #1 usually returned with documentation from the hospital wound care center that was either given to them or Director of Nursing #1. Assistant Director of Nursing #1 reviewed the hospital wound care consult notes dated 8/04/2025, and stated there were six (6) wounds with treatments and there should be corresponding orders for all treatments in the computer system. They further stated, orders from the consult were entered in the computer system by them or Director of Nursing #1. The consult notes were then given to the Medical Records staff person to scan into the system. They stated the treatment orders would be documented on the Medication Administration Record, as they did not have a separate Treatment Administration Record.During an interview on 8/21/2025 at 2:05 PM, Director of Nursing #1 stated Resident

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review and interviews during an abbreviated survey (Case # 2590765), the facility did not ensure that a resident with an indwelling catheter (a tube inserted into the bladder to drain urine) received appropriate care and services to prevent urinary tract infections for one (1) (Resident #1) of three (3) residents reviewed. Specifically, for Resident #1, the facility did not ensure daily catheter care for the resident's indwelling Foley catheter in May, June, July, and August 2025. There was no documented physician order for daily catheter care until 8/20/2025.This is evidenced by:Resident #1: Resident #1 was admitted to the facility with diagnoses of spina bifida (a condition that occurs when the spine and spinal cord do not form properly), constipation, and retention of urine with obstructive and reflux uropathy (retention due to a blockage that makes it difficult or impossible to pass urine). The Minimum Data Set (an assessment tool) dated 6/26/2025, documented the resident had sever cognitive impairment. The resident usually made themselves understood (difficulty communicating some words or finishing thoughts but was able if prompted or given time) and usually understand others (missed some pertinent of message but comprehended most conversation). Policy and Procedure titled, Catheter Care - Urinary, revised 9/2024, documented the purpose of the procedure was to prevent catheter-associated urinary tract infections. The Documentation section documented, the following information would be recorded in the resident's medical record: date/time catheter was given; name/title of individual giving the catheter care, all assessment data obtained when giving catheter care; characteristics of the urine; any problems noted during care; how the resident tolerated the procedure; if the resident refused the procedure, the reason(s) why and the intervention taken.Care Plan for Foley Catheter related to urinary retention, initiated 8/10/2024 and revised 7/09/2025. Approaches (interventions) included provide catheter care per facility policy. Review of Physician Order Reports documented:- Report dated 5/01/2025 to 5/30/2025, documented an order dated 10/08/2024 for Resident had a Foley Catheter related to urinary retention. There was no documented evidence of order for daily catheter care.- Report dated 5/30/2025 to 6/29/2025, documented an order dated 10/08/2024 for Resident had a Foley Catheter related to urinary retention. There was no documented evidence of order for daily catheter care.- Report dated 7/01/2025 to 8/29/2025, documented an order dated 10/08/2024 for Resident had a Foley Catheter related to urinary retention. An order dated 8/20/2025, documented provide Foley Catheter Care every shift: days, evening, nights.Review of Nursing Progress dated 5/01/2025 to 8/21/2025, did not have documented evidence for Foley catheter care was provided.During an interview on 8/20/2025 at 11:20 AM, Licensed Practical Nurse #1 stated the Certified Nurse Aide would ask them to come to the resident's room and do the Foley catheter care, since it was usually done with peri care. They stated there would be an order on the Medication Administration Record for the Foley catheter care and they would document on the record once it was completed. They stated they monitored the urine output, and the characteristics for signs and symptoms of infection. They stated if there was no order for Foley catheter care, they would not be prompted in the computer that it needed to be done.During an interview on 8/20/2025 at 11:41 AM, Director of Nursing #1 stated a general order was entered for Foley catheter care at the time of admission along with the admission orders. They stated there would also be orders for tubing changes and urinary drainage bag changes. They stated every resident with a Foley catheter had an order for catheter care to prevent urinary tract infections.During an interview on 8/22/2025 at 11:20 AM, Licensed Practical Nurse #2 stated they checked every resident and knew which residents had a Foley catheter and needed catheter care. There was an order for catheter care in the computer and they would document once the care was provided. If no order in the computer, they stated they would still do the care and document care was done in a progress notes. They stated there should be an order for daily catheter care for each resident who had a Foley catheter.During an interview on 8/22/2025 at 11:59 AM, Licensed Practical Nurse #3 stated residents with a Foley a catheter had orders in the computer for catheter care and flushing. If there were no catheter orders they would tell the supervisor, and the supervisor would call the physician to obtain an order. 10 New York Code of Rules and Regulations 415.12(d)(1)