STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335657	A. Building B. Wing	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Campbell Hall Rehabilitation Center Inc	23 Kiernan Rd Campbell Hall, NY 10916

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 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 record review and interview conducted during the recertification from 7/29/25 to 8/5/25, the facility did not ensure there was sufficient nursing staff to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically, the staffing schedule from 6/27/25 through 8/4/25 documented the facility did not consistently provide adequate staffing on all units/shifts to meet the needs of the residents on 34 of the 39 days reviewed. The findings included: The Facility Wide Assessment updated 5/23/25 documented: Day shift and evening shifts one registered nurse weekdays and weekends, five licensed practical nurses weekdays and four weekends, twelve certified nurse aides weekdays and ten weekends. Night shift: one registered nurse weekdays and weekends, three licensed practical nurses weekdays and two weekends, six certified nurse aides weekdays and weekends. The facility staffing from June 27, 2025 through August 4, 2025 and the staffing plan based on Facility Wide Assessment, documented the facility was understaffed 34/39 days for Certified Nurse Aides. On 28 of the 39 days reviewed, the facility was short-staffed for certified nurse aide staff during various shifts and on 15 of the 39 days reviewed the facility was short-staffed for licensed practical nurses or registered nurses during various shifts. During an interview on 07/29/2025 at 11:27 AM, Resident #93 stated that the facility is understaffed and the staff they do have are overworked. During a Resident Council meeting on 7/30/2025 at 12:58PM residents were interviewed about facility staffing. Residents collectively stated that they do have to wait for extended periods of time when they ring call bells for assistance. They stated that the overnight shift is the worst. Resident #101 stated that some staff do not always do as thorough a job and work is rushed. Resident #125 stated that staff has been observed sleeping at night. They also complained that staff do not always return as they say they will. They say they will assist at a particular time and then don't follow through. They described this as a regular occurrence. During an interview on 08/04/2025 at 11:37 AM with Registered Nurse #5, they stated the facility could use more licensed practical and registered nurse to assist with treatments and medication administration. They stated that completion of these tasks does not leave time for tasks such as updating resident care plans. They stated that they believe the facility has sufficient certified nurse aide staff. They stated the facility has their own staffing agency which is mostly used for staffing. During an interview and observation on 08/05/2025 11:39 AM, the Director of Human Resources/ Staffing Coordinator stated staffing is planned daily as per the Facility Assessment (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
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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	recommendations. They stated staff callouts are problem some. When call outs occur, staff from previous shift are asked to stay or next shift asked to come in earlier. Staff not on schedule are also offered shift. Incentives and overtime are offered to meet staffing guidelines. They stated licensed practical nurse and registered nurse staffing goals are very difficult to meet. They stated recruitment is on-going and not many licensed practical nurses apply. On-going recruitment includes job fairs and hiring web sites. They stated the facility has their own staffing agency and outside staffing agencies are no longer used due to the expense. During an interview on 08/05/2025 at 12:14 PM, the Administrator stated there is frequently not enough staff available, especially with licensed practical nurses and registered nurses. They stated that the facility has been trying to hire Unit Managers and have not had many applicants. They stated that there are many nursing home facilities in area, and they are all competing for same pool of potential hires. Administrator stated that when staffing levels are low, support staff will assist with resident tray distribution and call bell response. Overtime is offered to staff willing to cover open shift. During an interview on 08/05/2025 at 1:12 PM Licensed Practical Nurse #8 stated staffing of certified nurse aides and licensed practical nurses had recently has improved but has been shorter again over past few weeks. They stated that the facility uses mostly agency staff. They stated not having a Unit Manager on second floor unit has had a big impact on cares such as care plans and physician orders not being entered. They stated certified nurse aides staffing is usually sufficient and a Unit Manager could assist in their supervision and ensuring tasks are completed. During an interview on 08/05/2025 at 1:26 PM, Certified Nurse Aide #9 stated that staffing during weekends can be low at times. During an interview on 08/05/2025 at 1:31 PM, the Director of Nursing stated the facility recently hired a full-time evening Nurse Supervisor and are currently working with local schools for new graduate licensed practical nurses. They stated that both facility units would benefit with a Unit Manager and the hiring search for these roles continues. NY CRR 415.13(a)(1)(i-iii)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on record review and interview conducted during the recertification survey from 7/29/25 to 8/5/25, the facility did not ensure certified nurse aides were provided the required 12 hours of training to ensure safe delivery of care. Specifically, the facility was unable to provide evidence that 5 of 5 Certified Nurse Aides (#15, #26, #27, #28 and #29) reviewed for nurse aide in-service training were provided 12 hours of mandatory annual in-service training, including dementia training. The findings included:The Corporate Facility Policy titled, Continuing Education In-Service and Competence Training, (revised 11/4/24) documented In-service training must be sufficient to ensure the continuing competence of nurse aides but be no less than 12 hours per year.During interviews and observations on 8/1/24 at 1:29 PM and 8/4/2025 at 1:31 PM, the Staff Educator Resident Nurse provided three hours of annual in-services for Certified Nurse Aide #15, one hour and 10 minutes for Certified Nurse Aide #26, one hour for Certified Nurse Aides #27 and #28 and two hours, forty-five minutes for Certified Nurse Aide #29. The Staff Educator Registered Nurse stated they were responsible for certified nurse aide annual in-services since April 2025 and were not aware of annual in-services completed prior to that time. They stated they were not able to provide twelve hours of annual certified nurse aide in-services for Certified Nurse Aides #15, #26, #27, #28 and #29 or evidence of an in-service on dementia. During an interview on 08/05/2025 at 1:31 PM, the Director of Nursing stated the requirement of twelve hours on annual in-services for certified nurse aide staff will improve with the recent hiring of a Staff Educator. 10NYCRR 415.26

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observations and interviews during the recertification survey from 7/29/2025-8/5/2025, the facility did not ensure a safe, clean, comfortable and homelike environment in multiple resident rooms during environmental observations. Specifically, air conditioner casings were not secured, loose, or detached in resident rooms 120, 124, 130, and 131, Rooms 2-206-D and 2-220-W had unfinished plaster patches behind beds, and room [ROOM NUMBER]-209-P had an approximate 5-inch x 3-inch hole in the wall behind the resident's bed. During an observation on 7/30/2025 at 10:06AM, the air conditioner casing in room [ROOM NUMBER] was off the wall and not secured. During an observation on 07/31/2025 12:50 PM, the air conditioner casing in room [ROOM NUMBER] was loose and not secured. Resident #93 was able to remove the panel. During observations on 08/04/2025 at 8:25 AM, the air conditioner casing in rooms [ROOM NUMBERS] were loose and not secured. During an interview on 08/05/2025 at 8:39 AM, the Director of Maintenance stated that the the air conditioner units should be enclosed in the casing. The casings should be secure and not off free standing in the room because they could fall off, or fall over if free standing, and that would be a safety concern. During an observation of room [ROOM NUMBER]-206-D on 07/29/2025 at 10:22 AM, five unfinished plaster areas were observed behind the resident's bed. During an observation of room [ROOM NUMBER]-220-W on 07/29/2025 3:06 PM, scuff marks were observed on the closet door and an approximate 2.5-foot area of unfinished plaster was observed on the right side of the resident's bed. During an observation and interview on 8/5/2 at 12:34 PM, the Director of Maintenance stated the walls in Rooms 2-206-D were plastered approximately ten days ago and should be painted. They stated room [ROOM NUMBER]-220-W needs to be painted, including the area with unfinished plaster behind the resident's bed and closet scuff marks. They stated the hole in the wall behind resident bed in Room should be plastered and repaired. During an observation on 07/29/2025 at 11:22 AM, an approximately 5 inch by 3 inch hole was observed near the baseboard in Resident 2-209-P room. During an observation and interview on 8/5/2 at 12:34 PM, the Director of Maintenance stated the hole in the wall behind the resident's bed in room [ROOM NUMBER]-209-P should be repaired and plastered. 10NYCRR 415.5 (h)(2)

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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 observation, record review, and interviews conducted during the recertification survey from July 29, 2025, to August 5, 2025, the facility did not develop and implement a comprehensive, person-centered care plan with measurable goals, time frames, and interventions to meet the needs of 3 out of 3 residents (Resident #2, Resident #13, and Resident #34) reviewed for care plans. Specifically, Resident #13 lacked a care plan addressing the use of anti-anxiety and antidepressant medications. Resident #2 and Resident #34 did not have comprehensive care plans developed for nutrition. The findings include: A facility policy titled Unintended Weight Loss, last reviewed 9/26/23, documented: It is the policy of facility to ensure residents with poor intake and/ or unintentional weight loss are assessed and have Care Plans developed addressing their clinical condition and risk factors. The Policy and Procedure titled Comprehensive Care Plan, last revised 5/19/25, documents that a Comprehensive Care Plan is developed for each resident by the 21st day of admission, updated quarterly, annually, upon readmission, and with any significant change of condition. 1) Resident #13 had diagnoses including Dementia, Generalized anxiety disorder, and Mood Disorder. The 7/15/2025 Quarterly Minimum Data Set, an assessment tool, documented that Resident #13 had severe cognitive impairment. The 1/15/25 physician's order documented Buspar 10 milligram tablet to be administered three times daily for anxiety, and Lexapro 10 milligram tablet to be administered once daily for depression. There was no documented evidence that a Care Plan was developed for anxiety or depression for Resident #13. During an interview on 08/05/2025 at 2:26 PM, the Director of Nursing stated that all the nurses are responsible for resident care plans. They stated that Registered Nurses initiate care plans, and Licensed Practical Nurses can update care plans. They stated Resident #13 should have a care plan in place for all medications. They stated that there was no unit manager assigned to the unit. During an interview on 08/05/2025 at 2:26 PM, Registered Nurse #5 stated that all the nurses are responsible for care plans. Registered Nurses initiate care plans, and Licensed Practical Nurses can update care plans. 2) Resident #2 had diagnoses including unspecified dementia, major depressive disorder recurrent, generalized anxiety disorder, and bipolar disorder unspecified. A five-day reentry Minimum Data Set, dated [DATE] documented Resident #2 had severe cognitive impairment, required set/up clean up assistance with eating and had a therapeutic diet. There was no active nutrition care plan in the electronic medical record. The 7/17/25 physician's order documented: no added salt, regular diet, thin liquids. Ensure Plus three (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	times a day. Resident #2's weights documented a weight loss of 5.7% from 05/02/2025 to 8/1/2025. During an interview and observation on 08/05/2025 at 1:05 PM, Licensed Practical Nurse #8 stated they were aware that Resident #2 had lost weight. During a review of the electronic medical record, Licensed Practical Nurse stated they were unable to locate an active nutrition care plan for Resident #2. They stated the facility has not had a Dietician for quite some time. Licensed Practical Nurse #8 stated they were not aware of care plan interventions in place for Resident #2. During an interview and observation on 08/05/2025 at 1:36 PM, the Director of Nursing stated they were aware of Resident #2's weight loss. During a review of the electronic medical record, the Director of Nursing stated Resident #2 did not have an active nutrition care plan in place. They stated Resident #2 had been hospitalized in July 2025 and a nutrition care plan had not been put in place / updated upon Resident #2's return to the facility. They stated the last dietary assessment for Resident #2 was in March 2025. They stated a new hire per-diem Dietician would be starting in facility on 8/5/25. They stated an interdisciplinary team member should have re-activated the nutritional care plan and updated the interventions if necessary. 3) Resident #34 had diagnoses including vascular dementia, unspecified severity with mood disturbance, type 2 diabetes mellitus and repeated falls. The 7/9/25 Quarterly Minimum Data Set (a resident assessment tool) documented Resident #34 had severe cognitive impairment, had weight loss of 5% or more in the last month or loss of 10% or more in the last six month and was on a therapeutic diet. There was no active nutrition care plan in the electronic medical record. The 7/28/25 physician's order documented: Dietary: No concentrated sweets, ground consistency. General swallow precautions, no by mouth intake if lethargic, ensure upright positioning. Resident #34's weights documented a 12.49% weight loss from 3/28/25 to 8/1/25. During an interview on 07/30/2025 at 10:38 AM, the resident's representative stated they were aware that Resident #34 had lost weight and were not aware of interventions in place to address the weight loss. During a brief interview on 07/31/2025 at 12:01 PM, the Administrator stated facility Dietician left employment about a month ago and a new part-time dietician has been hired who has not yet started. They stated that the nursing staff is monitoring resident nutritional status during the absence of a Dietician. During an interview and observation on 07/31/2025 at 12:02 PM, the Director of Nursing stated they were unable to observe an active nutrition care plan for Resident #34 in their electronic medical record. They stated that Resident #34's nutrition care plans were not re-activated and reviewed/updated in the electronic medical record after a recent hospitalization. They stated when Resident #34 returned to the facility, there was no Dietician employed at facility so an Interdisciplinary Team member should have re-activated the nutritional care plan and updated the interventions if necessary. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10NYCRR415.(c)(1)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observations, interviews, and record review during the recertification and abbreviated (NY00371600) surveys from 7/29/2025-8/5/2025, the facility did not ensure that the comprehensive care plans were reviewed and revised to reflect changes and updates in residents status for one of one resident reviewed for care planning (Resident #93), two of four residents reviewed for pressure ulcers (Resident #34 and #11). Specifically, 1) Resident #93 had no updates to their care plan for discharge planning, 2) Resident 34's care plan was not updated to include a physician's order to offload their heels, and 3), Resident #11's fall care plan was not updated to reflect a new order for neuro- checks. The facility policy Comprehensive Care Plans last reviewed 5/19/2025 documented that resident's comprehensive care plans will be individualized and remain up to date, reflecting the resident's current status and needs. Care plans must be updated within seven days of completing each comprehensive assessment and after any new event, order, condition change. 1) Resident #93 had diagnoses that included osteomyelitis, amputation, and peripheral vascular disease. The 3/29/2025 Five-Day Minimum Data Set assessment documented Resident #93 had intact cognition, required set up assistance for most activities of daily living, but required moderate assistance for lower body dressing and maximal assistance needed for putting on footwear. The resident was independent for bed mobility and touch assistance needed for transfers. Occupational and physical therapy received. No active discharge plan, resident was involved in goal setting. The 6/3/2025 Quarterly Minimum Data Set assessment documented the resident had intact cognition, required set up assistance needed for eating, hygiene, and upper body dressing, moderate assistance needed for showers and lower body dressing, and maximal assistance needed for footwear. The resident was independent for bed mobility and touch assist for transfers. Occupational and physical therapy received. No discharge planning to return to community, resident involved in goal setting. The Comprehensive Care Plan for Resident #93 had no documented evidence of any discharge planning or discussion. The care plan meeting record for Resident #93 documented the last care plan meeting was held on 3/6/2025. The social work progress notes had no documented evidence of discharge planning. During an interview on 07/29/2025 at 11:29 AM, Resident #93 stated that care plan meetings have not been happening routinely. They stated they are planning to go home but there has been no discussion or planning for their discharge. They stated the communication at the facility is very poor. During an interview on 08/04/2025 at 11:22 AM, the Director of Social Work stated that Resident #93's goal was to go home. They stated that discharge planning starts at the time of admission. They stated they had been working on Resident #93's discharge, however, the care plan and progress notes did not reflect this. They stated social work was responsible for discharge care plans and they will update the notes and care plan. 2) Resident #34's diagnoses included: vascular dementia, unspecified severity with mood disturbance, (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	type 2 diabetes mellitus and repeated falls. The 7/9/25 Quarterly Minimum Data Set (a resident assessment tool) documented Resident #34 had severe cognitive impairment and required substantial/maximal assistance for toileting and bathing and was dependent for transfers. The 7/22/25 physician's order documented to offload heels in bed. Resident #34's skin integrity care plan which was last updated on 7/23/25, did not documented to offload the resident's heels while in bed. During an interview and observation on 08/04/2025 at 11:25 AM, Registered Nurse #5 stated they did not find documented evidence of an intervention to offload Resident #34's heels in bed. During an interview on 08/05/2025 at 1:40 PM, the Director of Nursing stated that physician's orders should be added to care plan interventions by the unit nurse staff. 3) Resident #11 was diagnosed with Alzheimer's disease, schizoaffective disorder, and diabetes mellitus. The 7/17/25 Minimum Data Set (a resident assessment tool), documented that Resident #11 had severe cognitive impairment. The assessment indicated that the resident required assistance from staff to complete activities of daily living, including personal care. Additionally, the resident used a wheelchair for mobility. The 2/8/25 internal investigation documented the resident was found sitting on the floor in their assigned room. The 2/8/25 at 3:05 PM Progress Notes written by Licensed Practical Nurse #23 documented that a patient called the nursing station, stating, Please help me, I fell on the floor. The nurse responded and found the patient lying on the floor in their room. The supervisor was notified. The patient was observed to have a skin tear on their right lower leg and reported pain in their head, along with bruising to the head. The 2/8/2025 Fall at High-Risk care plan did not include an intervention for neuro-checks. The 2/9/25 at 9:22 AM Progress Note written by Registered Nurse Supervisor #4 documented that the resident returned at 11:39 PM from the hospital emergency room following a fall incident. The resident had bruising on both upper and lower extremities due to the fall, along with a laceration on the right lower leg, which had been sutured. Following the emergency department discharge summary, a physician's order was given for neurological checks for 24 hours. The 2/9/25 physician's order documented neurological checks every 2 hours for 48 hours. During an interview on 8/5/25, at 8:09 AM, Registered Nurse Supervisor #4 stated that the process for updating a care plan following a resident's fall included updating the care plan with relevant interventions and new orders each time residents experience a fall. 10 NYCRR 415.11(c)(2) (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 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. Based on observation, record review, and interviews during the recertification and abbreviated surveys (NY00374242) from 7/29/25-8/5/25, the facility did not ensure each resident received care, consistent with professional standards of practice, to prevent and treat pressure ulcers for 2 of 4 residents (Residents #34 and #114) reviewed for pressure ulcers. Specifically, 1) Resident #34 had a physician's order to offload their heels in bed. The resident was observed in bed with their heels resting directly on the mattress and there was no pillow on the mattress to offload the resident's feet. The physician's order, dated 7/22/25, to offload heels in bed was not added to the resident's care plan or certified nurse aide instructions. 2) Resident #114 had pressure ulcers and wound care treatment was not provided consistently as ordered. The findings included:1) Resident #34 diagnoses included: vascular dementia, retention of urine and type 2 diabetes mellitus. The 7/9/25 Quarterly Minimum Data Set (a resident assessment tool) documented Resident #34 had severe cognitive impairment and required substantial/maximal assistance with bed mobility, toileting and bathing and was dependent on staff for transfers. The 7/22/25 physician's order documented to off load heels in bed. The 7/23/25 Skin Integrity care plan documented the Resident was at risk for skin breakdown related to decreased mobility, pain, incontinence. Interventions included Certified Nurse Aide evaluation of skin condition daily during care and report any skin abnormalities to nurse, encourage frequent position changes, prevent friction during transfers, resident care and bed mobility, and turn and repositioning schedule as recommended. There was no documented evidence that the care plan was updated to include the 7/22/25 physician's order to offload resident heels while in bed.The 7/22/25 hospital discharge summary note documented wound consult in hospital. Bilateral foot wounds. Scattered scabs to multiple toes with the most notable lateral on the bilateral bunion area, right foot. Recommendation: float heels with pillows. During observations on 07/30/2025 at 10:38 AM, 7/31/25 at 12:46 PM, and 8/1/2025 at 9:22 AM, Resident #34's bilateral heels were observed on their mattress, and not offloaded. Red scabs were observed on the resident's bilateral upper feet near and on their great toes. During an interview on 08/01/2025 at 9:22 AM, Certified Nurse Aide #15 stated they believe Resident #34's heels should be offloaded while they are in bed. They were not aware of an order or task for off-loading the resident's heels or if that was documented on the certified nurse aide instructions or tasks. They stated they will offload Resident #34's heels anyway as they probably should be. During an observation and interview on 08/04/2025 at 11:25 AM, Registered Nurse #5 stated Resident #34's bilateral heels should be offloaded. During a review of the electronic medical record, Registered Nurse #5 stated that a physician's order for Resident #34's heels to be offloaded was entered on 7/22/25 and that the skin integrity care plan for Resident #34 and the certified nurse aide instructions and tasks were not updated to reflect the physician order. They stated they are responsible for overseeing certified nurse aides on unit and for updating resident care plans. They stated that the staff member who entered the order could have updated the care plan and certified nurse aid instructions and tasks at that time. During an interview on 08/05/2025 at 1:40 PM, the Director of Nursing stated that when a physician's order is entered into the electronic medical record to offload a resident's heels, the expectation is that it be done. They stated that unit nurses should be assuring that physician's orders are added to resident care plans, interventions, and to the certified nurse aide instructions and tasks.2) Resident #114 had diagnoses that included end stage renal disease, diabetes mellitus, and heart failure. The facility Pressure Ulcer Treatment policy last reviewed 8/1/2025 documented general guidelines for the treatment of pressure ulcers and protocols based on the condition of the wound. Residents with congestive heart failure, renal disease, liver disease and diabetes, would be evaluated on a case-to-case basis. The 2/11/24 Quarterly Minimum Data Set documented moderately impaired cognition, no behaviors including refusal of care, dependent on assistance for most activities of daily living, incontinent bowel and bladder, unhealed pressure ulcers, two stage 4 ulcers (1 present on admission), interventions include pressure relief (continued on next page)

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	335657	A. Building B. Wing	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Campbell Hall Rehabilitation Center Inc	23 Kiernan Rd Campbell Hall, NY 10916

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bed, chair, turn and position, nutritional management, pressure ulcer care, and application of ointment. The 12/22/2023 Skin Integrity Presence of Pressure Ulcer Care Plan documented Resident #114 had pressure ulcers. The goals were documented as remaining free of infection and that the wound will show signs of healing. Interventions included wound rounds weekly, turn and position every two hours, apply treatments as ordered by the physician, and air mattress. The 12/21/2023 physician's order documented check integrity and verify settings of air mattress every shift.The 12/21/2023 physician's order documented Santyl 250 unit/gram topical ointment, apply 1 applicatorful by topical route once daily in the morning to the coccyx wound after cleaning with normal saline. The 12/29/23 Annual Minimum Data Set documented intact cognition and no behavioral symptoms or refusal of care. Resident required maximal assistance or dependent assistance with activities of daily living, catheter, incontinent of bowel, risk for pressure ulcer, has 2 stage 4 unhealed pressure ulcers (1 present on admission). Interventions included pressure relief bed, chair, turn and position, nutritional management, pressure ulcer care, application of ointment and dressing application. The 1/31/2024 wound care note documented a stage 4 to the coccyx (site 3) measuring 3.6 x 0.6 x 0.5 cm. Recommendations included offload wound, reposition per protocol, limit sitting. Factors complicating wound healing included end stage renal disease and heart failure. The 2/21/2024 wound care note documented the stage 4 to the coccyx (site 3) measured 3.9 cm x 0.9 cm x 0.6 cm. Recommendations for offloading and repositioning continued.The 4/3/2024 wound care note documented the stage 4 to the coccyx (site 3) measured 4.1 cm x 1.0 cm x 0.8 cm. New recommendations included Dakin's solution and mupirocin topical 2%. There was no documented evidence of Physician's orders for Dakin's solution or mupirocin topical 2%.The Treatment Administration Records dated 1/1/2024-4/5/2024 had twenty omissions for the daily wound care treatment to the coccyx.The Treatment Administration Record dated 1/1/2024-4/5/2024 had forty-two omissions for checking the air mattress integrity and settings. During an interview on 08/05/2025 at 2:55 PM, the Director of Nursing stated that Resident #114 was seen on wound rounds and did have treatments ordered. They stated there should be no omissions on the treatment or medication administration records, and if a medication or treatment was not documented there was no evidence that the treatment was done. 10NYCRR 415.12(c)(1)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. Based on observations, interviews, and record review during the recertification survey from 7/29-8/5/2025, the facility did not ensure that one of two residents (Resident #6) reviewed for hydration and one of four residents (#34) reviewed for nutrition were maintained within acceptable parameters of nutritional status. Specifically, 1) for Resident #6 who received oral and tube feedings, a nutritional assessment was not completed upon admission to the facility, or any time after admission, to assess for adequate intake, and 2) Resident #34 had a documented weight loss of 12.49% weight loss from 3/28/25 to 8/1/25 and there was no documented evidence of an active nutrition care plan in place with new interventions related to nutritional status. The findings included: 1) Resident #6 had diagnoses that included Down Syndrome, severe protein calorie malnutrition, and heart disease. The 6/20/2025 admission Minimum Data Set documented severely impaired cognition, dependent for all activities of daily living, feeding tube and mechanically altered diet, majority of calories through tube feeding and more than five hundred and one milliliters of fluid through tube feeding daily. The 7/2/25 Nutritional Status Care Plan documented Resident #6 was at risk for weight loss/gain and altered nutrition and hydration secondary to multiple diagnoses. Goals included, but not limited to, resident will adhere to therapeutic diet and maintain adequate fluid intake. Interventions included Bolus feed via gastrostomy tube between meals and labs monitored. The 6/25/2025 physician's order documented Jevity 1.2 Cal oral liquid. Give 250 milliliters by peg tube route five times per day. Free water flush 60 milliliters before and after each feeding The 7/23/2025 physician's order documented pureed diet, nectar thick liquids at mealtimes. Only feed as tolerated and perform oral care before and after oral intake. During an observation on 07/29/2025 at 2:46 PM, Resident #6 was observed with dry lips and dry flaky skin to their perimeter. During an observation on 07/31/2025 at 12:17 PM, Resident #6 was observed sitting in a gerichair in the common dining area. Their lips and tongue appeared very dry. Resident #6 was moving their tongue in and out of their mouth and licking the air. During an interview and observation on 07/31/2025 at 12:55 PM, Resident #6 was observed in the first-floor dining room eating lunch with the assistance of Certified Nurse Aide #24. Certified Nurse Aide #24 stated that Resident #6 ate one hundred percent of their food but only took about two ounces of fluids. During an observation on 08/01/2025 at 12:58 PM, a certified nurse aide was observed assisting Resident #6 with lunch. No fluids were offered, and fifty percent of their solid food was eaten. During an observation on 08/04/2025 at 8:22 AM, Resident #6 was observed sitting in the first-floor dining area in a geri chair. Their lips appeared dry with flaky skin around them, and the resident had a dry cough. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/05/2025 at 11:32 AM, Certified Nurse Aide #30 stated that Resident #6 was dependent for most cares. They assisted Resident #6 with eating this morning. At breakfast Resident #6 took approximately 60 milliliters of juice, but they also received their bolus feed. They stated it takes a lot of staff encouragement for the resident to take fluids orally. During an interview on 08/05/2025 at 12:48 PM, Licensed Practical Nurse #25 stated Resident #6 gets both oral intake and tube feedings. Water is administered with the feedings and with medications. They believed there was a dietician at the facility who was responsible for monitoring the resident's input, calories, and weight. During an interview on 08/05/2025 at 2:40 PM, the Director of Nursing stated that a Dietician was starting again that evening. They were without a dietician for a short time. Nursing was monitoring all nutritional issues or concerns while there was no dietician at the facility. A nutritional assessment was never completed for Resident #6. The orders for food and fluid were continued as ordered for Resident #6 at the hospital prior to coming to the facility. 2) Resident #34's diagnoses included vascular dementia, unspecified severity with mood disturbance, type 2 diabetes mellitus and repeated falls. The 7/9/25 Quarterly Minimum Data Set (a resident assessment tool) documented Resident #34 had severe cognitive impairment, had weight loss of 5% or more in the last month or loss of 10% or more in the last six months, and was on a therapeutic diet. Resident #34's weights documented a 12.49% weight loss from 3/28/25 to 8/1/25. There was no documented evidence of an active nutrition care plan in Resident #34's electronic medical record. The 7/28/25 physician's order documented no concentrated sweets diet, ground consistency, general swallow precautions, nothing by mouth if lethargic, and ensure upright positioning. There was no documented evidence of physician's orders for a supplement, assistance with meals, or weight monitoring. The 6/19/25 Dietary/Nutrition Assessment progress note documented diagnoses with nutritional implications, vascular dementia, cardiovascular disease, type II diabetes mellitus and depression. The clinical summary documented nutritional status was reviewed. Resident reports good appetite and intake by mouth without recent change. Per nursing report/documentation, resident has been consuming 75 to 100%. No supplementation. Lab results. No swallowing difficulties. Feeding ability/assisted devices for meals documented partial feed. Nutrition problem: at risk for malnutrition related to altered mental state. Nutritional risk factors: impaired cognition. Nutrition Plan of care: continue current diet as tolerated. Encourage intake of dietary protein and fiber, limit portions sizes of carbohydrates. Encourage meals/fluids, assist as needed. Honor resident food preferences, update as needed. Monitor and document weight trends, diet adequacy and tolerance, labs, skin and gastrointestinal patterns. During an interview on 07/30/2025 at 10:38 AM, the Resident's representative stated they were aware that Resident #34 had lost weight but they were not aware of interventions in place to address the weight loss. They stated they visit Resident #34 at lunch three times a week and that Resident (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#34 will complete 75% of meal when assisted with eating. During an observation on 07/31/2025 at 8:51 AM, Resident #34 was observed being assisted with eating breakfast by a certified nurse aide. Resident consumed 100% farina, 50% of egg/sausage and all fluids. During an interview on 07/31/2025 at 12:01 PM, the Administrator stated the facility dietician left employment about a month ago and a new part-time dietician has been hired who has not yet started. The Administrator stated nursing staff are monitoring resident's nutritional status during the time there is no dietician employed by facility. During an interview on 07/31/2025 at 12:02 PM, the Director of Nursing stated they could not provide evidence of an active nutrition care plan for Resident #34 on the electronic medical record. They stated Resident #34 had a nutrition consult on 6/19/25, although it did not document Resident 34's weight loss over last four months. They could not provide documented evidence of a physician's visit that addressed the resident's weight loss. They stated there were not aware why new interventions were not put in place related to the resident's significant weight loss. They stated they were not aware that certified nurse aides were assisting Resident #34 with eating. They stated that new interventions should be added to a care plan when a resident has a significant weight loss. They stated that Resident #34's nutritional/care plan had not been re-activated or reviewed or updated after a recent hospitalization. They stated that an Interdisciplinary Team member should have re-activated the nutritional care plan and updated interventions as necessary. During an observation and interview on 07/31/2025 at 12:46 PM, Resident #34's representative was assisting Resident #34 with lunch. Resident #34 completed 75% of their lunch. A vanilla magic cup container was observed on Resident #34's tray and the resident's representative was assisting them to eat it. The meal ticket on Resident #34's tray did not document a magic cup as part of the lunch meal. During an observation on 08/01/2025 at 9:22 AM, Certified Nurse Aide #15 observed assisting Resident #34 with breakfast. During a telephone interview on 08/05/2025 at 6:48 PM, Nurse Practitioner #1 stated they recently assessed Resident #34 after a hospitalization. They stated they did not assess weight loss due to not being aware of weight loss. They stated they are usually made aware of resident weight loss by the facility Dietician and the facility has not had a dietician for a few months. 10NYCRR 415.12(i)(1)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on observations, interviews, and record reviews during the recertification survey from 7/29/25-8/5/2025, the facility did not ensure that a licensed dietician was employed from 6/28/2025 until 8/4/2025. Specifically, there was no qualified dietician on staff full time, part time, or as a consultant during this period to oversee the dietary needs of residents.The findings included: During an interview on 07/31/2025 at 12:01 PM, the Administrator stated facility dietician left employment over a month ago and a new part-time dietician was hired and had not yet started. They stated that Nursing was monitoring resident nutritional status during the absence of a dietician. During an interview on 08/05/2025 at 2:40 PM, the Director of Nursing stated that a Dietician started again at the facility that day (08/05/2025). Nursing was monitoring all nutritional issues or concerns in the meantime while they had no dietician. There was no dietician for a brief period. During a telephone interview on 08/05/2025 at 6:48 PM, Nurse Practitioner #1 stated they were usually made aware of resident weight loss by the facility dietician and the facility had not had a dietician for a few months. 10 NYCRR 415.14(a)(1)(2)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review during the recertification survey from 7/29-8/6/2025, the facility did not ensure that the menus were followed for one of two residents reviewed for food (Resident #73), one resident observed during dining (Resident #37), and one of four residents reviewed for nutrition (#34). Specifically, 1) Resident #73 did not receive the items as specified on their meal ticket; 2) Resident #37 did not receive the type of milk as specified on their meal ticket; 3)Resident #34 received a magic cup that was not ordered or on their meal ticket.1) Resident #73 had diagnoses that included cerebrovascular accident, hypertension, and diabetes mellitus. The Annual Minimum Data Set, dated [DATE] documented the resident had intact cognition and required set up assistance for eating. During an interview on 7/30/2025 at 10:33AM, Resident #73 stated the food was terrible, the facility dietician was always changing, and the kitchen staff were not accommodating when requests were made. During an observation on 8/1/2025 at 12:31PM, Resident #73's lunch tray ticket and tray were observed. The contents of the tray did not match the meal ticket. The ticket documented a no concentrated sweets diet, no sandwiches, Italian sausage and peppers, alternate vegetable, white rice, saltine crackers, apple slices, whole milk 8 ounces, coffee, creamer, and assorted juice. There was a note documenting no pork or turkey (except bacon and sausage is okay), no cold cuts, extra portion non starch vegetable, and send Mrs. dash. The resident tray was observed with one pot pie, one yogurt, four ounces of juice, coffee, four ounces of milk, apple slices, two equal, two salt, and two creamers. 2) During an observation on 07/30/2025 at 8:50 AM in the first-floor dining room Resident #37's breakfast ticket listed whole milk and skim milk was on the tray. During an interview on 08/05/2025 at 1:54 PM, the Administrator stated residents had discussed inconsistencies with their tickets, but they did not believe it was a regular occurrence. The dietary aides were responsible for checking the tickets before loading the food trucks. The Food Service Director oversaw the aides. During an interview on 08/05/2025 at 5:28 PM, the Food Service Director stated that the tickets on the food trays were checked by the dietary aides on the food line. Two checks were performed and the nursing staff should be checking the tickets on the floors before distributing the trays. All details of the ticket should be examined, including condiments and preferences. The ticket should match what is on the tray. 3) Resident #34 had diagnoses that included vascular dementia, type 2 diabetes mellitus, and repeated falls. The Quarterly Minimum Data Set, dated [DATE] documented the resident had severely impaired cognition and required set up assistance for eating. There was no documented evidence of a physician order for a magic cup for Resident #34. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 07/31/2025 at 12:46 PM, a magic cup vanilla ice cream container was observed on Resident #34's tray which the resident representative was feeding to them. A review of the meal ticket on the tray did not have a magic cup documented as part of the lunch meal. During an interview on 07/31/2025 at 12:58 PM, Licensed Practical Nurse #25 observed the electronic medical record for Resident #34. They stated they were not able to locate a physician order or care plan intervention for a magic cup for Resident #34. They stated they were not aware why the magic cup was on their tray. During an observation on 08/01/2025 at 12:49 PM, the Food Service Director stated meal tickets were printed out from Meal Tracker software on the computer. Additional items should not be added on resident trays if not documented on the ticket. A magic cup would not be placed on a tray unless it was on ticket. They stated that the magic cup that was placed on Resident #34's tray was an error by an assembly line kitchen aide. 10NYCRR 415.14(c)(1-3)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interviews and record review during the recertification survey from 7/29/2025-8/5/2025, the facility did not ensure that resident grievances were acted on promptly, or responded to, for two of seven residents (Resident # 7 and Resident #34) investigated for missing property. Specifically, 1) Resident #7 reported a pair of missing shorts to staff, completed a form, and never received the results of the investigation or replacement of the item; 2) Resident #34's spouse reported a pair of missing sneakers, completed a grievance form, and never received the results of the investigation or replacement of the item.The Facility Grievance Policy last reviewed 5/26/2022 documented that it is the policy of the facility to assist residents, their representatives (sponsors), other interested family members, or advocates in filing grievances or complaints when such requests are made. The Social Services Department is responsible for investigating the grievances and submit their findings in a written report to the Administrator in five days. 1) The Quarterly Minimum Data Set submitted 7/9/2025 documented Resident #7 had moderately impaired cognition.During an interview at the Resident Council Meeting on 7/30/2025 at 12:58PM, Resident #7 stated that they lost a pair of their shorts that were labeled with their name. They stated they completed a form to report the missing item, but the shorts were never found, and they never received any follow up to the grievance. The Facility Grievance Log had no documented evidence of any missing items for Resident #7 . During a telephone interview on 08/01/2025 at 10:22 AM, the Director of Social Work stated that residents, family, and staff members can complete a grievance form for missing items. Once received, social work staff completes an investigation and would replace or reimburse the resident for the item if it is on their inventory log and not found. They stated that they were not aware that Resident #7 was missing shorts, or that Resident #34 was missing sneakers. They stated they never received a grievance for either resident. They stated that staff should know grievances and grievance forms are handled by the Social Work Department. During an interview on 08/04/2025 at 8:33 AM, Certified Nurse Aide #16 stated that when a resident reports a missing an item, they report the missing item to the floor nurse or nurse supervisor. They stated they have never filled out a grievance form. During an interview on 08/04/2025 at 11:36 AM, the Director of Social Work confirmed that Resident #7 was missing shorts and Resident #34 was missing sneakers, and they would be replacing those items. They stated staff needed re-education on the process of reporting grievances.2) Resident #34 diagnoses included: vascular dementia, retention of urine, unspecified and type 2 diabetes mellitus. The Quarterly Minimum Data Set (a resident assessment tool) dated 7/9/25 documented Resident #34 had severe cognitive impairment.During an interview on 07/30/2025 at 10:33 AM, Resident #34's representative stated that Resident #34 had a pair of sneakers that went missing from their room in April 2025. They stated the missing sneakers were reported to nursing staff and they believe to the social work staff. They stated they have not been provided with follow-up information regarding the missing sneakers and have not been reimbursed for the sneakers. During an interview on 08/01/2025 at 11:39 AM, Registered Nurse #5 stated when a resident reports missing items, the Social Work Department is informed. They stated if a missing item is reported Monday to Friday 9:00AM to 5:00pm, Grievance Reports are completed by Social Work Department who will provide resident or resident representative a Grievance Form to complete. If a report is made after hours, Grievance Reports can be obtained at front desk in Nurse Supervisor binder and Nurse Supervisor or Director of Nursing should be notified immediately. Registered Nurse #5 stated investigations are completed by members of the Interdisciplinary Team which includes unit staff. Social work staff will notify unit staff and resident/resident representative of outcome if investigation. During an interview of 08/04/2025 at 10:56 AM, Certified Nurse Aide #15 stated that if a resident reports missing items, they report to Nurse Supervisor on unit or Director of Nursing. They stated they do not fill out a form and are not aware of a form that needs to be completed. The facility Grievance Log had no documented evidence (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of any missing items for Resident #34.During an interview on 08/04/2025 at 12:56 PM, the Director of Social Work stated that Resident #34's representative reported the missing items to a staff member who is no longer at the facility and that the staff member did not inform Social Work Department. Therefore, an investigation was not completed. They stated social work staff has confirmed that Resident #34 had sneakers documented on their admission Items Form. They stated the investigation will be completed and Resident #34 will be reimbursed. The Director of Social Work stated they are unaware why the missing items were not reported immediately to the Social Work Department. 10NYCRR 415.5(c)(6)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observation, interviews and record review conducted during the recertification and abbreviated surveys (NY00383678), it was determined for 1 (Resident #111) of 4 residents reviewed for abuse that the facility did not ensure that Resident #111 was free from mental abuse, including abuse facilitated or enabled through the use of technology. Specifically, Resident #111 was recorded on live stream video during cares revealing their naked upper and lower body which was posted to social media when Certified Nurse Aide #22 carried their cell phone in their pocket. This caused Resident #111 to verbalize they felt violated and humiliated by Certified Nurse Aide's #22 actions.Findings are:The facility policy titled Photo and Video policy dated 5/30/25 documented the facility is dedicated to protecting the privacy, dignity, and rights of residents. The unauthorized capture, recording or dissemination of photos of residents, their families or their surroundings is strictly prohibited unless prior written informed consent is obtained.The facility's undated policy and procedure titled: Cell Phone Usage, documented employees of the facility are not permitted to make or receive cell phone calls at any time while working in resident care areas or any area where resident services are being performed. Cell phones must not be carried in these work areas. The facility's policy and procedure titled and dated 05/30/22: Prevention, investigation and reporting of Resident Abuse, Mistreatment, Neglect and Misappropriation of Resident Property, documented that the facility did not permit verbal, mental, sexual or physical abuse including corporal punishment or involuntary seclusion of residents. The policy is to ensure all measures are taken to prevent abuse. Resident #111 had diagnoses which included atrial fibrillation, major depressive disorder and hemiplegia.The 4/19/25 Minimum Data Set assessment tool documented Resident #111 had intact cognitive skills for daily decision making.The Facility Incident Report form, dated 6/15/25 at 1:00 PM, documented Resident #111 was in bed receiving cares as Certified Nurse Aide #22 was live streaming on social media. The facility had received a call about a video being live streamed within the nursing home. Certified Nurse Aide #22 inadvertently pressed record on their phone activating live stream video and went about their routine, performing cares. They stopped the recording when they were approached by the facility Nursing Supervisor about the recording. Certified Nurse Aide #22 was terminated.During an interview on 7/30/25 at 10:38 AM, Resident #111 stated when they found out about the incident, they felt violated and terrible about it. They had trouble trying to understand how and why it happened and was humiliated when they were told about the video. They have since spoken to the facility Social Worker and Psychiatric Nurse Practitioner and their family member about it and finds comfort talking. During an interview on 08/01/2025 at 12:50 PM, Registered Nurse #14 stated they had many in-services about phones and photos and videos of residents, but it was hard to monitor staff when they were administering medications. They stated they did their best to intervene when they saw staff using their phone during cares. During an observation of the video with the Administrator on 8/1/25 at 3:40 PM, Certified Nurse Aide #22 was observed walking in and out of Resident #111's room. On entry to room Resident #111, the resident was easily identified and there was full exposure of their head, chest, and legs wearing only a brief. During an interview on 08/01/25 at 3:40 PM, the Administrator stated the staff was clearly in violation of using their cell phone in a resident area which was against their policy. A video was made of the resident without wearing clothing. They further stated that whether or not it was intentional, abuse occurred. They stated that staff had been made aware of the facility policy. During an interview on 08/04/2025 at 1:52 PM, Certified Nurse Aide #22 stated they were not aware they were live streaming to social media while delivering care. They did have an in- service during their employment orientation and was aware cell phones were not permitted but had it on their person anyway. 415.12(h)(2)]

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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 interview and record review conducted during the recertification and abbreviated (NY00368202) surveys from 7/29/2025 through 8/4/2025, the facility did not ensure that an alleged violation of abuse, was reported immediately, but not later than two hours after the allegation was made, for one (Resident #112) of 7 residents reviewed for accidents. Specifically, on 1/5/2025 Resident #112 and informed the staff that they had been raped. The facility did not report the rape allegation to the New York State Department of Health.The findings include: Resident #112 had diagnoses that included asthma, osteoarthritis, and anxiety. The Minimum Data Set (a resident assessment tool) dated 11/26/24 documented Resident #112 was cognitively intact and exhibited no behavioral symptoms. Resident #112 required assistance from staff to complete activities of daily living including personal care. The 1/5/25 at 10:23 AM progress note written by Registered Nurse Supervisor #17 documented a call from Resident #112's relative who reported that the resident was on the floor in their room and had been raped. Both floor nurses and Registered Nurse Supervisor #17 responded to the resident's room, where they found the resident sitting on the floor beside their bed. The resident was alert but disoriented, expressing confusion about their surroundings and repeatedly asking for clarification. The resident stated that someone had raped them and that they needed help. The resident stated that they had woken up and found their surroundings unfamiliar; the room looked different to the resident.The 1/6/25 at 1:43 PM Progress Note documented the Director of Social Services interviewed the resident, and the resident clarified that they had not been raped. During a telephone interview on 8/4/2025 at 9:59 AM, the resident's representative stated that the resident had called them to inform them that they were on the floor, naked, in their room on the morning of 1/5/25. The representative stated they then contacted the facility to request that someone check on the resident. A staff member later confirmed that they had seen the resident sitting on the floor in their room. During a telephone interview on 8/4/2025 at 1:39 PM, Registered Nurse Supervisor #17 stated they were working the overnight shift when the resident was observed sitting on the floor of their room and alleged rape. They stated they assessed the resident after their fall and found no injuries, and the resident later recanted their allegation of rape. They stated that the resident appeared disoriented to their surroundings and required staff to orient the resident to where they were. They stated that they informed both the Nurse Practitioner and the Director of Nursing and the physician about the incident.During an interview on 8/4/2025 at 12:54 PM, the Administrator stated Resident #112's allegation of rape had not been reported to the New York State Department of Health. They explained that the resident later retracted their claim of being raped. 10 NYCRR 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, interview, and record review conducted during the recertification and abbreviated surveys (NY00378577) from 7/29/25 to 8/5/25, the facility did not ensure that the staff involved in the incident was suspended during the entirety of the investigation to prevent further potential abuse for one of four residents (#71) reviewed for abuse. Specifically, during an incident on 4/20/25 at 9:30 PM, Certified Nurse Aide #11 caused bruising to Resident #71's left hand after physically removing Resident #71's left hand from Licensed Practical Nurse #10's arm during a fingerstick refusal. The facility documented on the Internal Investigation Report that both Certified Nurse Aide #11 and Licensed Practical Nurse #10 were suspended pending investigation, although the facility did not suspend Certified Nurse #11 while the abuse investigation was being conducted. The findings included:A facility policy titled Prevention, Investigation and Reporting of Resident Abuse, Mistreatment, Neglect and Misappropriation of Resident Property reviewed 5/25/25 included: If the staff are involved in the alleged abuse, this employee should be suspended immediately pending the outcome of the investigationResident #71 diagnoses included: heart failure, chronic pulmonary obstructive disease, and diabetes mellitus due to underlying condition with hyperglycemia. The 1/16/25 quarterly Minimum Data Set (a resident assessment tool) documented Resident #71 was cognitively intact, required set-up / clean up assistance with eating, and was independent in dressing and transfers.A resident care plan titled At Risk for Abuse, updated 4/21/25 documented: Resident is at risk for abuse secondary to: increased need for assistance with activities of daily living. Interventions included: monitor skin changes and report all to nursing supervisor every shift, Social Worker evaluation upon admission, quarterly, yearly and as needed and refer to Psychiatry as needed. The 4/20/25 Accident / Incident Report documentation included: Resident #71 consented to a finger stick, got stuck and got upset at licensed practical nurse. Resident #71 grabbed the licensed practical nurse. The certified nurse aide came and removed Resident #71's hands from the licensed practical nurse. The immediate action to prevent reoccurrence documented: Licensed practical nurse and certified nurse aide suspended. The root cause analysis documented: Resident #71 was disoriented and grabbed the licensed practical nurse. The certified nurse aide tried to deescalate by prying Resident #71's hands off the licensed practical nurse. Injury: ecchymosis on left hand. The Internal Investigation Report dated 4/25/25 documentation included root cause analysis: The certified nurse aide attempted to free the nurse from Resident #71's hold and put their hands on Resident #71's hands to free the licensed practical nurses' arms. They were unfamiliar with the scope of physical abuse which included any action to control a resident's behavior. The immediate action documented: the licensed practical nurse and certified nurse aide were suspended pending investigation. During interviews on 07/29/2025 at 3:16 PM and 08/04/2025 at 5:53 PM, Resident #71 stated they had an incident with a nurse and certified nurse assistant after they completed a fingerstick which they refused. Resident #71 stated they were trying to push the licensed practical nurse away and were yelling patient refuses treatment and nurse did not stop and continued with the fingerstick. Resident #71 stated the certified nurse aide presented to room and helped the licensed practical nurse instead of helping the resident. Resident stated their left hand and wrist area were bruised after the incident.During an interview on 08/04/2025 at 6:11 PM, Certified Nurse Aide #11 stated they recalled the incident with Resident #71. They stated they were walking in the unit hallway and heard Resident #71 yelling for help. They stated when they walked into Resident #71's room, they observed Resident #71 digging their nails into Licensed Practical Nurse #10's arm. They stated they put on gloves and tried to loosen Resident #71's finger grip on Licensed Practical Nurse #10's arm. They stated they may have had their hand over Resident #71's left wrist. Certified Nurse Aide #11 stated they were asking Resident #71 to remove their hand from Licensed Practical Nurse #10's arm which Resident #71 did.During an interview and observation on 08/05/2025 at 10:10 AM, the Director of Human Resources / Staffing Coordinator stated Certified Nurse Aide #11 had a written counseling dated (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/24/25 by employee and dated 4/22/25 by Administrator. A review of the Counseling Report documented the disciplinary action for the counseling was Verbal, Written 1 and Written 2. The Suspension x __ days line was left blank. The Director of Human Resources/Staffing Coordinator stated they are not aware if Certified Nurse Aide #11 was suspended. A review of the staffing sheets for Certified Nurse Aide #11 documented they returned to work 4/22/25 3:30 PM-6:04 AM. During an interview on 08/05/2025 at 12:18 PM, the Administrator stated the investigation of alleged abuse was completed and findings were not submitted to the Survey Agency until 4/25/25. The Administrator stated they were aware that Certified Nurse Aide #11 returned to work at the facility on 4/22/25 and that they should not have returned to work until after the investigation was completed. During an interview on 08/05/2025 at 1:51 PM, the Director of Nursing stated they were aware that Certified Nurse Aide #11 returned to work on 4/22/25, prior to the completion of the investigation of alleged abuse. They stated Certified Nurse Aide #11 should not have returned to employment until the investigation was completed. 10NYCRR 415.4(b)(3)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review during the recertification survey from 7/29/2025-8/5/2025, the facility did not ensure that the assessment accurately reflected the resident status for two of twenty-eight residents reviewed (Resident #101 and Resident #123). Specifically, 1) Resident #101 was observed with multiple decaying and broken teeth, however their comprehensive assessment dated [DATE] and their quarterly assessment dated [DATE] both documented no oral or dental issues; 2) Resident #123 has identified as a smoker since admission to the facility, however their annual assessment dated [DATE] did not document them as a smoker. 1) Resident #101 had diagnoses that included, but not limited to, heart failure, gastro-esophageal reflux, and fibromyalgia. The facility policy Minimum Data Set last reviewed 5/16/2025 documented that the Minimum Data Set provides an assessment system that is comprehensive, accurate, standardized, and reproducible for each resident's functional capabilities. The system helps staff identify health problems. The Minimum Data Set Coordinator is responsible for oversight of all sections. Section L, oral/dental status, and Section J, health conditions including tobacco use, are completed by nursing/Minimum Data Set Coordinator. The facility was not able to provide a dental policy. In house Dental Consult dated 12/29/2024 documented that Resident #101 needed #9 and #10 extracted. There was no documented evidence of any dental consultations after 12/29/2024. The Annual Minimum Data Set for Resident #101 dated 3/27/2025 documented intact cognition, no oral issues, as needed pain medication received. Physician orders dated 4/9/2025 documented Dental Consultation and Dental Consult Tooth Ache. The Quarterly Minimum Data Set for Resident #101 dated 6/27/2025 documented intact cognition, no broken teeth or mouth pain, received scheduled pain medication. The physician order dated 7/18/2025 documented Orajel 3X Mouth Sores 20%-0.1%-0.15% mucosal gel, apply to affected area 3 times per day for disorders of teeth and supporting structures. During an observation and interview on 7/30/25 at 12:58PM at Resident Council, Resident #101 expressed concerns about their need for dental services and the delay in receiving them. Resident #101 was observed with multiple decaying and broken teeth. During an interview on 08/04/2025 at 12:13 PM, the MDS Coordinator stated if a resident has decaying or broken teeth that should be marked on the assessment. 2) Resident #123 diagnoses included: paraplegia, incomplete, schizoaffective disorder, and nicotine dependence, (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Annual Comprehensive Care Plan dated 1/17/25 documented Resident #123 was cognitively intact, ambulated with a wheelchair, and was independent in bed mobility, transfers, eating, and dressing. Resident #123 was not documented as a tobacco user. A resident care plan titled Smoking, dated 12/21/24, documented: Resident was a resident of facility prior to facility becoming smoke free. If compliant, Resident shall continue to smoke tobacco or chew tobacco and no others substances (cocaine, cannabis, heroin) on facility-grounds. The smoking activity can only take place outside of the physical facility. A physician order dated 8/3/25 documented: Resident is care-planned to smoke in facility designated smoking area only. During an interview on 08/04/2025 at 10:32 AM, the Director of Nursing stated the facility has had a remote Minimum Data Set Coordinator for over four years. A per diem in-house Minimum Data Set Coordinator was hired in July 2025 and is currently on vacation. During an interview on 08/04/2025 at 12:10 PM, the Minimum Data Set Coordinator stated they missed documenting Resident #123 as a smoker. They stated that Resident #123 was a grandfathered smoker in the facility and should have been documented as a tobacco user in the annual Minimum Data Set, dated [DATE] and they will correct. 10 NYCRR 415.11(b)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on record reviews and interviews during the recertification survey from 7/29/2025-8/5/2025, the facility did not ensure the accuracy of the preadmission screening for one of twenty-eight residents reviewed for preadmission screening. Specifically, the preadmission screening for Resident #6 did not follow the screen instructions and contained errors. The facility Screen/PASSAR policy, last reviewed 1/9/25, documented that Admissions and Social Work review the preadmission screens to ensure their accuracy, they may not admit if components are not completed properly. Resident #6 had diagnoses that included, but not limited to Down Syndrome, severe protein calorie malnutrition, and heart disease.The preadmission screen dated 6/16/2025 for Resident #6 was not completed as per the screen instructions and there were inaccuracies in the answers. During a telephone interview on 08/01/2025 at 11:33 AM, the Director of Social Work stated that the preadmission screening is completed prior to the resident being admitted . The screen is reviewed by admissions and should be checked for accuracy. They stated they will review Resident #6's screen for accuracy. During an interview on 08/04/2025 at 8:44 AM, the Director of Admissions stated they receive the preadmission screen for a resident with their patient review instrument. They stated that they do check the screen for accuracy. They then distribute the screen to other applicable facility staff including social work and nursing. The social worker checks the screen for accuracy as well. They were not certain if the screen for Resident #6 was completed correctly. During an interview on 08/04/2025 at 11:00 AM, the Director of Social Work stated that they will be completing education on reviewing the screens because the screen for Resident #6 does have an error. 10NYCRR 415.11 (e)

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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. Based on record review and interview during the recertification and abbreviated surveys (NY00032854) conducted from 7/29/25 to 8/4/25, the facility did not ensure that 1 of 7 residents (Resident #112) reviewed for accidents received adequate supervision and/or an environment free of hazards to prevent accidents. Specifically, Resident #112 was found on the floor of their room on 1/5/2025, and there was no documented evidence that a facility incident/accident report or investigation had been completed to determine a possible cause of the accident and to determine interventions to prevent further accidents.The findings include:The 5/22/2025 facility policy and procedure on resident accident/incident report policy documented the facility will promote and maintain a safe environment and maintain reports and surveillance of all resident's accidents and incidents. In addition, the facility will investigate and document all accidents and incidents and develop corrective measures to prevent reoccurrences.Resident #112 had diagnoses that included asthma, osteoarthritis, and anxiety. The 11/26/24 Minimum Data Set (a resident assessment tool) documented Resident #112 was cognitively intact. Resident required assistance from staff to completes their activities of daily living including personal care. The 1/5/25 at 10:23 AM progress note written by Registered Nurse Supervisor #17 documented a call from Resident #112's relative who reported that the resident was on the floor in their room and had been raped. Both floor nurses and Registered Nurse Supervisor #17 responded to the resident's room, where they found the resident sitting on the floor beside their bed. The resident was alert but disoriented, expressing confusion about their surroundings and repeatedly asking for clarification. The resident stated that someone had raped them and that they needed help. The resident stated that they had woken up and found their surroundings unfamiliar; the room looked different to the resident.The 1/5/25 at 6:55 PM progress note written by Nurse Practitioner #2 documented the reason for the residents' visit was related to the resident's fall. The resident was awake and alert in bed. According to nursing staff, the resident had been found on the floor that morning. Nurse Practitioner #2 observed no bruising or swelling and observed that the resident's range of motion was at baseline.During a telephone interview on 8/4/2025 at 9:59 AM, the resident's representative stated that the resident had called them to inform them that they were on the floor, naked, in their room on the morning of 1/5/25. The representative stated they then contacted the facility to request that someone check on the resident. A staff member later confirmed that they had seen the resident sitting on the floor in their room. When requested, the facility could not provide documented evidence of an incident/accident report for Resident #112's fall on 1/5/2025.During a telephone interview on 8/4/2025 at 1:39 PM, Registered Nurse Supervisor #17 stated they were working the overnight shift when the resident was observed sitting on the floor of their room and alleged rape. They stated they assessed the resident after their fall and found no injuries. They stated that the resident appeared disoriented to their surroundings and required staff to orient the resident to where they were. They stated that they informed both the Nurse Practitioner and the Director of Nursing and the physician about the incident. They stated an incident/accident report was initiated and was passed on to the next supervisor.During an interview on 8/4/2025 at 12:54 PM, the Administrator stated that a facility incident/accident report was not completed for the resident's fall on 1/5/25, because the allegation of rape made by the resident took precedence over the fall incident. During an interview on 8/5/2025 at 2:05 PM, the Director of Nursing stated that they would attempt to locate the incident/accident report for the fall on 1/5/25. In a follow-up interview on 8/5/2025 at 3:25 PM, the Director of Nursing stated that they could not locate the incident/accident report for Resident #112's fall on 1/5/25. 10 NYCRR 415.12 (h) (2)

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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. Based on observations, interviews, and record reviews during the recertification survey from 7/29/2025-8/5/2025, it was determined for one of two residents (Resident #19) reviewed for urinary catheter, the facility did not ensure that residents with indwelling catheters received appropriate treatment and services to prevent urinary tract infections. Specifically, Resident #19 had an indwelling catheter in place and the catheter was observed positioned above their waist band and the catheter collection bag was observed on the floor on multiple occasions. Resident #19 had diagnoses that included urinary tract infection, bacteriuria, and dementia.The 1/15/25 facility policy, Catheter Care, documented that a non-obstructed downhill flow of urine must be maintained at all times. The 6/19/2025 5-Day Minimum Data Set documented Resident #19 had severely impaired cognition, was dependent on staff assistance with toileting, frequently incontinent of bowel, and had an indwelling catheter.The 6/13/25 Foley Catheter care plan documented resident is incontinent of bladder function and currently has an indwelling catheter. The goal was that incontinence care would be rendered. The interventions documented to monitor for signs and symptoms of infection and report to physician.The 6/12/25 physician's order documented Urology Consult.The 6/13/25 physician's orders documented a 16 French foley catheter in place, catheter care every shift, foley catheter bag change as needed, may change foley catheter if plugged, leaking or displaced as needed.During observations on 07/29/2025 at 3:16PM and 4:17PM, Resident #19 was observed sitting in a wheelchair with their catheter tubing coming up and over the waist band of their pants.During an observation on 07/30/2025 at 3:20 PM, Resident #19 was observed lying in bed. Their catheter was draining cloudy yellow urine, and the collection bag was lying on the floor.During an observation on 08/01/2025 at 1:06 PM, Resident #19 was observed lying in bed. Their foley catheter bag was lying on the floor.During an observation on 08/04/2025 at 8:06 AM, Resident #19 was observed sitting in a wheelchair with their catheter tubing coming up over the waist band of their pants.During an observation on 08/04/2025 at 3:56 PM, Resident #19 was observed lying in bed. Their catheter bag was hanging on the bed rail with the bottom of the bag touching floor. The 6/12/2025 to 7/31/2025 Certified Nurse Aide documentation for catheter care documented thirty-five omissions.During an interview on 08/05/2025 at 11:40 AM, Certified Nurse Aide #24 stated that catheter care and output documentation should be completed every shift. The catheter bag should be lower than the bladder and not be on the floor, to prevent infection. The tubing and bag should be fed down through the pants down the leg. The catheter should not be coming up over the waist band because it may affect the flow of urine. During an interview on 08/05/2025 at 12:37 PM, Licensed Practical Nurse #25 stated catheter bags should not be on the floor for infection control reasons. The catheter tubing should not be placed up over the waist band of the pants because it may cause urine backflow. During an interview on 08/05/2025 at 2:25 PM, the Director of Nursing stated both nurses and certified nurse aides document catheter care. The certified nurse aides should be documenting catheter care every shift. Foley catheter bags should not be on the floor. The catheter tubing should not be up over the waist band because that may impede the flow of urine. 10NYCRR 415.12(d)(1)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observations, record review and interviews conducted during the recertification survey from 7/29/2025 to 8/5/25, the facility did not ensure that 1 of 2 Residents (Resident #66) reviewed for Respiratory Care was provided with such care, consistent with the professional standards of practice. Specifically, Resident #66, had a physician's order for oxygen to be administered via nasal cannula at 2 liters per minute. Resident #66 was observed multiple times with oxygen running at 4 liters per minute. Additionally, there was no signage outside door indicating oxygen usage. The findings included:The 5/26/22 facility policy titled Oxygen Therapy (Administration Of) documented: A physician's order is required to institute oxygen therapy. Nursing will obtain/check Physician Orders for oxygen therapy-concentrators. Post No Smoking sign on room door.Resident #66 diagnoses included Parkinson's disease without dyskinesia, chronic respiratory failure with hypoxia, and type 2 diabetes mellitus without complications.The 5/2/25 quarterly Minimum Data Set (a resident assessment tool) documented Resident #66 was cognitively intact and received oxygen therapy.The 6/7/25 physician's order documented oxygen via nasal cannula at 2 liters / minute.The 3/14/25 care plan documented Resident #66 required use of 2 liters/minute oxygen due to episodes of shortness of breath. Interventions included to provide oxygen as ordered by the Physician.During observations on 07/29/25 at 11:06 AM, 7/30/25 at 11:00 AM, and 8/1/25 at 9:10AM, Resident #66 was observed in bed, nasal cannula in place, and oxygen concentrator running at 4 liters/minute. There was no signage indicating oxygen use on the Resident's door. During an observation and interview on 08/01/25 at 9:10 AM, Registered Nurse #14 observed Resident #66's oxygen delivery rate running at 4 liters/minute. They stated they were not aware of the rate of oxygen documented in the physician's order. During a review of the electronic medical record, Registered Nurse #14 stated the physician's order is for 2 liters/minute, and they were not aware why Resident #66's oxygen was running at 4 liters/minute. They stated they would reduce the flow rate to 2 liters/min. During an interview on 08/01/25 at 9:41 AM, Certified Nurse Aide #21 the correct oxygen level was provided by the nurse on unit. They stated if they observed an oxygen concentrator not on the right level, or if they were unsure of the level, they would report to the nurse. During an interview on 08/04/25 at 11:13 AM, Registered Nurse #5 stated they were not aware of a reason why there was no signage indicating oxygen in use on the resident's door. During an interview on 08/05/2025 at 1:44 PM, the Director of Nursing stated the oxygen concentrator should be set as ordered by physician. They stated oxygen use signage should be placed on resident room doors.10 NYCRR 415.12

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	335657	A. Building B. Wing	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review conducted during the recertification survey from 7/29/2025 to 8/4/2025 revealed that the facility did not ensure that drugs and biologicals were stored according to current professional standards for 1 out of 29 residents (Resident #79) reviewed for medication storage and labeling. Specifically, three medication cups containing red capsules were observed on Resident #79's bedside table from 7/29/25 to 7/31/25. The resident stated that the capsules were stool softeners. A registered nurse counted 31 capsules, which were identified as Colace 100 mg capsules, observed on Resident #79 bedside table. The findings include: Resident #79 was admitted with diagnoses of hypertension, constipation, and anxiety. The Minimum Data Set (an assessment tool), documented in the quarterly review dated 7/18/ 2025, that the resident is cognitively intact and has no behavioral issues. Resident #79 requires assistance with activities of daily living, including personal care and medication administration. During observations on 7/29/2025, at 10:57 AM, 7/30/2025, at 8:51 AM, and 7/31/2025, at 10:41 AM revealed three medication cups containing red capsules on the resident's bedside table. The physician's orders dated 7/3/2025, documented to administer Colace 100 mg capsules, giving two capsules (200 mg) by oral route once daily. The Medication Administration Records for June 2025 documented the administration of Colace 100 mg capsules as prescribed, with two capsules (200 mg) given by oral route at 6 PM every day from 6/1/2025 to 6/30/2025. The Medication Administration Records for July 2025 documented Colace 100 mg capsules were given by oral route, two capsules (200 mg) at 6 PM. During an interview on 7/31/25, at 10:41 AM, Resident #79 stated that the red capsules on the bedside table were stool softeners. The resident stated the nurse leaves 2 stool softeners but they only took one because they did not want to experience diarrhea. During an interview on 7/31/25, at 12:47 PM, Registered Nurse # 5 stated they administered the resident's morning medications but did not observe any medication left at the resident's bedside. Stated they counted 31 red capsules and identified them as Colace, were left in three cups on the over-bed table. Additionally, they stated that no medications should be left at the bedside. During an interview on 8/1/25, at 1:03 PM, the Director of Nursing stated their expectation that the nurses remain with residents during medication administration to ensure proper intake of medications. The Director of Nursing also stated that they were made aware by nursing staff the findings of 31 Colace capsules on the over-bed table of Resident #79. In addition, they stated the nurse practitioner was informed, and the resident's prescription was adjusted to one Colace capsule daily. During an interview on 8/1/25 at 3:20 PM, Licensed Practical Nurse # 13 stated that they stay with the residents until all medications are taken. They stated that they did not observe the resident hoarding any medications at the bedside. 10 NYCRR 415.18 (d)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review during the recertification survey from [DATE]-[DATE], the facility did not ensure each resident received routine dental services for one of one resident (Resident #101) reviewed for dental services. Specifically, Resident #101 was referred by the in house dentist for extractions after four different consultations over a two year period, but was still waiting to see an outside dentist for follow up at the time of the survey. The findings included:Resident #101 had diagnoses that included heart failure, anxiety, and depression.The facility was unable to provide a dental policy.The [DATE] Annual Minimum Data Set documented resident had intact cognition, supervision required for oral hygiene, no oral issues documented, as needed pain medication received.The [DATE] Quarterly Minimum Data Set documented intact cognition, supervision required for oral hygiene, no broken teeth or mouth pain, received scheduled pain medication. The in-house Dental Consultations for Resident #101 dated [DATE], [DATE], and [DATE] all documented that resident needed extractions and follow up with an outside dentist. The [DATE] consultation also documented bleeding and teeth that have died. The [DATE] consultation also documented pain and badly broken-down dentition beyond the scope of what can be done at the facility. The [DATE] consultation documented pain and need for x-rays and outside treatment. There was no documented evidence of any outside dental consultations, except for verbal statements from the Director of Nursing and the Resident Transport/Appointment Coordinator stating the resident went to a local oral surgeon for a dental consult on [DATE] but the resident's wheelchair could not fit into the dentist's office.The Dental Care Plan updated [DATE] documented resident with actual impairment. The goal was documented as resident will be free of dental infection and pain. Interventions included to assess chewing, assess risk factors, assist with oral hygiene, monitor dentition and oral mucosa with cares, and refer to dietician as needed to adjust diet.Physician orders dated [DATE] documented Dental Consultation and Dental Consultation for tooth ache.Physician order dated [DATE] documented Tramadol 50 milligram tablet, give one by oral route two times per day for general pain.Physician order dated [DATE] documented acetaminophen 325 milligrams, two tablets once daily for general pain 1-3.Physician order dated [DATE] documented Orajel for Mouth Sores 20%-0.1%-0.15% mucosal gel, apply to affected area 3 times per day.During an interview and observation at the Resident Council Meeting on [DATE] at 12:58PM, Resident #101 stated that they had dental issues. They stated they had a dental assessment in the facility, but they need to go out for follow up and a procedure. They had been waiting a long time and their mouth was sore. They were uncertain why there was such a delay. They stated they had to take medicine for the oral pain in the meantime. Resident #101 was observed with multiple decaying and broken teethDuring an interview on [DATE] at 10:08 AM Resident Transport/Appointment Coordinator stated that Resident #101 has a dental appointment in September to see an oral surgeon for a consultation and possible extractions. They stated that Resident #101 did go to an oral surgeon locally on [DATE] but the office could not accommodate the wheelchair, so they were not seen. They stated the only appointment they could get had an eleven month wait time. The office did offer urgent/emergency visits daily but it was difficult to coordinate the transportation for same day appointments. During an interview on [DATE] at 2:31 PM, the Director of Nursing stated that Resident #101 did have a dental consultation previously scheduled, but that office could not accommodate the wheelchair. They have not received any reports that the resident has had any pain or difficulty eating. If they did, they would have tried to get an emergency visit. During an interview on [DATE] at 6:50 PM, Nurse Practitioner #1 stated that wait times were long for the oral surgeon. Resident #101 had not had signs of infection and they could not do anything about the wait and were not concerned about the delay. 10NYCRR 415.17

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on record review and interview conducted during the recertification survey from 7/29/2025 -8/5/2025, the facility did not ensure that the Quality Assurance & Performance Improvement and Quality Assessment & Assurance committees consisted, at a minimum, of the Medical Director or their designee, who attended quarterly meetings. Specifically, the Medical Director or designee had not participated in Quality Assurance & Performance Improvement meetings for six sessions. The findings are:The facility's Quality Assurance and Performance Improvement Policy, last revised on December 27, 2024, documented. Aspects of care and services that should be evaluated during the Quality Assurance and Performance Improvement include, but are not limited to, Medical Director and Physician Services, Nursing Services, Dietary Services, Recreation Services, Environmental Services, Human Resources, Rehabilitative Services, Social Services, Maintenance Services, Resident Care, and Care TransitionsA review of the Monthly Meeting Attendance Sheets entitled Quality Assurance and Performance Improvement Meeting for February 25, 2025; March 13, 2025; March 26, 2025; April 24, 2025; May 29, 2025; and June 26, 2025, revealed that the Medical Director or designee did not sign the attendance sheets.During an interview on 8/5/2025 at 4:00 PM, the Administrator stated they held Quality Assurance Performance Improvement meetings every month, and the Medical Director did not attend in person, by phone, or via Zoom. They further stated the Medical Director should be part of the team.During an interview with the Medical Director on 8/5/2025 at 4:30 PM, they stated they sometimes attended the meeting, and if the facility needed them, they could be reached by phone.10 NYCRR 415.15(a)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview conducted during the recertification survey from 7/29/25 to 8/5/25, the facility did not ensure infection control prevention practices were maintained to prevent the development and transmission of infection for 2 of 2 residents (Residents #34 and #66) reviewed for infection control. Specifically, Registered Nurse #14 was observed without the use of a gown when they provided wound care to Resident #66 who was on enhanced barrier precautions and 2) Certified Nurse Aide #15 was observed providing morning cares without the use of a gown to Resident #34 who was on enhanced barrier precautions.The findings included:The facility policy titled Infection Control Policy, last reviewed 1/17/25, documented: The implementation of stringent infection control measures is essential to minimize the spread of communicable disease and maintain a healthy environment for all. Appropriate personal protective equipment must be used during certain patient interactions and during any procedures likely to generate splashes of blood, body fluids, secretions, excretions, and aerosols.1) Resident #34 diagnoses included vascular dementia, retention of urine, and type 2 diabetes mellitus. The Quarterly Minimum Data Set (a resident assessment tool) dated 7/9/25 documented Resident #34 had severe cognitive impairment and required substantial/maximal assistance for toileting and bathing and was dependent for transfers. A resident care plan titled Enhanced Barrier Precaution, dated 7/23/25, documented Resident #34 will be maintained on Enhanced [NAME] Precautions. Interventions included staff would don appropriate personal protective equipment when providing direct patient care.A physician order dated 7/22/25 documented an indwelling catheter French #16 (size) for retention of urine. A physician order dated 7/22/25 documented enhanced barrier precautions. During an observation on 07/29/2025 at 12:18 PM, Certified Nurse Aide #15 was providing dressing and toileting cares to Resident #34 without wearing a gown. During a brief interview with Certified Nurse Aide #15, they stated they were made aware that Resident #34 was on enhanced barrier precautions a few days prior and that they should have donned a gown prior to providing cares and that they had forgot to do so. They were not aware why there was no personal protective equipment located outside Resident #34's room. 2) Resident #66 diagnoses included Parkinson's disease without dyskinesia, chronic respiratory failure with hypoxia, and type 2 diabetes mellitus without complications. A Quarterly Minimum Data Set (a resident assessment tool) dated 5/2/25 documented Resident #66 was cognitively intact and was dependent for toileting, bathing and transfers. A resident care plan titled Enhanced Barrier Precautions, dated 7/24/25 documented: enhanced barrier precautions. Interventions included: staff will don appropriate personal protective equipment when providing direct patient care. A physician order renewed 6/7/25 documented enhanced barrier precautions. During an observation and interview on 07/29/2025 at 11:26 AM, Registered Nurse #14 was providing wound care to Resident #66 without donning a gown. During an interview with Registered Nurse #14 they stated they were aware Resident #66 was on enhanced barrier precautions, and they should have donned a gown prior to providing wound care. Personal protective equipment cart was observed outside Resident #66's room. During an interview on 08/05/2025 at 4:51 PM, the Director of Nursing stated that staff should be donning gown and gloves for all resident on enhanced barrier precautions while providing hands on care which included wound care and toileting/bathing cares. Staff were in-serviced on enhanced barrier precautions upon hire and during mandatory and infection control during in-services. 10 NYCRR415.19

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observations and interviews during the Recertification Survey initiated on 7/29/25 to 8/5/25, the facility did not maintain all mechanical, electrical, and patient care equipment in a safe operating condition. Specifically, Resident #71's stated during an interview that their electrical bed had not been repaired in over a year, and they had to use pillows to elevate their head while in bed. The findings included:A facility policy titled, Resident Equipment, documented the facility will ensure that all resident-use equipment is safe, functional, and maintained according to manufacturer instructions and facility protocols. This applies to both facility-owned and resident-owned equipment, and includes medical devices, mobility aids, and other items used for resident care.Resident #71 diagnoses included heart failure, chronic obstructive pulmonary disease and morbid obesity. A quarterly Minimum Data Set (a resident assessment tool) dated 7/18/25 documented Resident #71 was cognitively intact and was independent in dressing, bed mobility and transfers.A resident care plan titled Congestive Heart Failure dated 9/12/23 documented Resident #71 has potential and at risk for malformations of the heart that involve the septum, valves, and large arteries. Interventions included to encourage the head of bed elevated at 30-45 degree when in bed.A physician order dated 3/19/25 documented encourage the head of bed elevated at 30-45 degree when in bed. During an interview on 07/29/2025 at 3:06 PM, Resident #71 stated their bed's electrical component had not worked in over a year. They stated they had to rely on pillows to elevate their head while in bed. Resident #71 stated that they had informed staff of the broken bed, and nothing had been done to repair the bed. During an interview and observation on 08/01/2025 at 11:55 AM, Maintenance Assistant #20 stated it was the first observation and report of Resident #71's bed malfunctioning. During the observation, Maintenance Assistant #20 observed the bed was not plugged in to an electrical outlet and that there was no remote control for the bed. Maintenance Assistant #20 obtained a remote control and plugged bed and remote into electrical outlet and stated the bed was still not functioning. Maintenance Assistant #20 returned with a new motor for bed and stated that the motor originally on bed was not functioning, therefore the bed had been electrically inoperable. During an interview and observation on 08/04/2025 at 11:45 AM, Registered Nurse #5 stated there was a logbook on unit where maintenance requests were entered. Maintenance checked the books daily for services needed and when completed they place a check mark in the book. They stated they were not aware of Resident #71's bed being broken. They stated Resident #71 elevated their head with pillows and that Resident #71 went to bed independently, so they never noticed the electrical component of bed was not working. A review of maintenance book documented that bed in Resident #71's room was fixed on 10/2/24, the electrical plug came out and was placed back in. An entry dated 11/11/25, documented Resident #71's bed would not move up and down. This entry was not checked as completed. 10 NYCRR 415.5(e)(1)(2)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, record review, and interview during the recertification and abbreviated surveys (NY00444179) from July 29, 2025, to August 5, 2025, the facility did not ensure that an effective pest control program was maintained to keep the facility free of mice in 2 of 2 Resident rooms (Resident #10 and Resident #66) reviewed. Specifically, Residents #10 and #66 complained of mice in their rooms and there was no documented evidence the rooms were inspected or that an effective pest control program was put in place. The findings are: The policy and procedure titled Pest Control revised 8/7/2025 documented: The Pest Control Policy outlines our approach to prevent, monitor, and control pest infestations within our premises, by applicable U.S. health and safety standards and regulations. Findings of any pest activity are reported to the Maintenance staff, and the Maintenance staff will forward findings to the pest control professional. A service inspection report dated November 12, 2024, documented the exterior building, rodent bait stations, and empty rodent feeding infestations at 75%–100%. A service inspection report dated December 10, 2024, documented that the exterior and all rodent bait stations were checked for activity, and bait was replaced as needed. A service inspection report dated December 24, 2024, documented the presence of ants in the kitchen behind the juice machine and the placement of ant gel bait in those areas to prevent and protect against seasonal and winter infestations. A service inspection report dated January 16, 2025, documented the treatment of ants with ant gel bait to prevent and protect against seasonal and winter invaders. A service inspection report dated January 28, 2025, documented a walk-through inspection conducted on the second floor, during which staff reported the presence of mice in the back room near the sink and refrigerator. Droppings were found in the cabinets, and glue boards were placed. There was no documented evidence that the residents’ rooms were inspected. During an observation and interview on 07/29/2025 at 10:00 AM, Resident #10 was in bed and stated that mice were present in the room, that mice had gotten on the table, the issue had been reported to staff, and that the problem persisted. The room was observed to be very cluttered, and no mouse droppings or traps were observed. During an interview and observation on 07/29/2025 at 11:22 AM, Resident #66 stated they have a mouse in their room which the observe frequently. They stated they have made unit staff and maintenance staff aware. An approximately five inches by three inch square hole was observed in wall behind resident bed during interview. During an interview on 08/01/2025 at 1:22 PM, Social Worker #19 stated Resident #10 had complained about mice in the room and no mice were seen. The office adjacent to the resident’s room had no mouse activity. The resident’s room was described as very unorganized. Multiple efforts (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had been made to organize the room, but the accumulation of items continued. During an interview on 08/01/2025 at 1:21 PM, Maintenance Worker #20 stated pest control companies were utilized at the facility but pest control staff did not observe resident rooms. They stated complaint regarding mouse sightings had been received from Resident #10. During an interview on 08/04/2025 at 11:45 AM, Registered Nurse #5 stated they were not aware of mouse in Resident #66’s room. They stated mice reports were placed in unit maintenance staff book on the unit. A review of the maintenance book did not document a report of any mice in Resident #66’s room, however there were numerous other mice concerns documented in book for the second floor, including resident rooms and the nurse station. During an interview and observation on 08/05/2025 at 8:41 AM, the Director of Maintenance stated the maintenance log book on units were checked daily. They stated some resident rooms reported having mice, mostly in resident rooms who keep food out. They stated a pest control company treated the facility monthly and a recent area of penetration was found outside building which was addressed. They stated staff encourage residents not to have excessive food in their rooms and encourage the use of plastic storage containers. They stated they were not aware of a mouse in Resident #66’s room. During an observation of Resident #66’ s room, the Director of Maintenance observed a hole in the wall behind the bed. They stated hole needed to be patched and food placed in plastic containers. 10 NYCRR 415.29(j)(5)