STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335672	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Health Services Inc	690 West German Street Herkimer, NY 13350

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to self-administer drugs if determined clinically appropriate. Based on observations, record review, and interviews during the recertification survey the facility failed to ensure a resident's ability to safely self-administer medications was clinically appropriate for two (2) of (2) residents (Residents #4 and #137) reviewed, and three anonymous residents present at the resident group meeting. Specifically, Residents #4 and #137 applied their own prescription creams without an order or assessment for their ability to do so; and three anonymous residents present at the resident group meeting stated they wanted to administer their own medications or creams and were told by facility staff they could not be assessed to do so.Findings include:The pharmacy policy Self-Administration of Medications, effective date 05/2018, documented to maintain a resident's high level of independence residents who desired to self-administer medications were permitted to do so if the facility's interdisciplinary team determined the practice was safe and there was a medical order to do so. If a resident desired to self-administer medications, an assessment was conducted by the interdisciplinary team including the resident's cognitive and physical ability to do so. If the resident was assessed to be able to safely administer medications, an additional assessment of bedside medication storage was conducted. If a resident did not want to self-administer medications, it would be noted in their chart.1) During a resident meeting on 01/05/2026 at 2:06 PM, one resident stated they asked to be assessed to self- administer their heart medication to be able to administer when needed. Two other residents stated they wanted to be able self-administer medications or creams.The 06/05/2025 Resident Council meeting minutes documented a resident voiced they wanted to be able to self-administer their medication and store it in their room. The response by the Administrator was medications had to be kept in the medication room. There was no documented additional follow up. 2) Resident #4 had diagnoses including a Stage 2 pressure ulcer (partial skin loss) of the right buttock. The 11/27/2025 Minimum Data Set documented the resident was cognitively intact, was independent or required supervision for activities of daily living and had two Stage 2 pressure ulcers and received wound care.The 10/10/2022 Comprehensive Care Plan, revised 11/25/2025, documented the resident had pressure ulcers or the potential for pressure ulcers related to immobility to the right medial buttock and a resolved right inner gluteal wound. Interventions included to administer treatments as ordered, assess, monitor, and record wound healing weekly and as needed, and educate the resident as to the cause of skin breakdown. There was no documented evidence the resident was care planned to self-administer wound care. The 10/28/2025 physician order documented apply Calmoseptine (an over-the-counter ointment with zinc and menthol that protects, soothes, and promotes healing for minor skin irritations) External Ointment 0.44-20.6% every shift for wound care.There was no documented physician's order to self-administer the wound cream.The 12/18/2025 Skin/Wound Assessment documented the resident had a Stage 2 wound that was improving with pink epithelial (skin) tissue present and beefy red granulation tissue (new healthy skin) measuring 0.3 centimeters in length and 0.3 centimeters in width. The skin surrounding the wound was red.The 3/15/2025 Assessment of Ability for Self-Administration of Medication documented the resident was not safe to self-administer their medications.During an interview on 01/05/2026 at 10:33 AM Resident #4 stated they did their wound care, and the nurses only checked it occasionally. They stated they cut a napkin (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	into four pieces and put the medicine on the napkin pieces. They sat on the toilet to do their own wound care.During an observation and interview on 01/09/2026 at 9:25 AM, Resident #4 had a small pin hole on their right buttock with no redness, odor, or swelling. The resident explained they took care of the area twice a day with the menthol zinc cream. They stated the doctors told them it was not going to heal and to just continue to treat it. If there was drainage they took care of the wound three times a day. They did not want the nurse to bother with the wound every day so they asked if they could take care of it and the nurses let them. The nurses looked at the wound once a week but did not do any treatments for it unless they told the nurse there was bleeding. The resident did not want to show the wound care in progress but demonstrated the soft napkin they cut in half, took a fingertip amount of the menthol zinc ointment they kept in the room, put that on the napkin and applied it to the area while seated on the toilet seat. During an interview on 01/08/2026 at 1:13 PM, Licensed Practical Nurse #42 stated Resident #4 had a non-healing wound that was a hole but had skin surrounding it. The wound was not draining and did not have a dressing. The resident had Calmoseptine ointment applied. They stated the resident did all the washing of the area, but the nurses applied the ointment. They stated the resident was able to apply their own ointment.3) Resident #137 had diagnoses including venous insufficiency (poor circulation), lymphedema (chronic swelling), and high blood pressure. The 12/11/2025 Minimum Data Set documented the resident was cognitively intact and required moderate assistance or supervision for activities of daily living.The 05/11/2024 Comprehensive Care Plan, revised 05/28/2024, documented the resident had an activities of daily living self-care performance deficit related to impaired balance and limited mobility. Interventions included the resident required supervision for upper body dressing and moderate assistance for lower body dressing and to encourage the resident to discuss feelings about their self-care deficit.The 05/26/2025 physician order documented to apply Cerave itch relief cream 1% (pramoxine HCl) to arms, legs, and torso topically two times a day for eczema (skin condition), dry skin, and itching.The 06/12/2025 physician order documented apply Bengay Greaseless Cream (topical pain reliever) 10-15% (menthol-methyl salicylate) to the left side lower back topically three times a day for pain.The 07/22/2025 physician's order documented to apply Biofreeze Cool the Pain external gel 4% (topical pain reliever) to knees topically three times a day for arthritis in the knees.The 08/12/2025 physician's order documented to apply triamcinolone acetonide external cream 0.1% (a potent synthetic corticosteroid used to reduce inflammation, itching, redness, and swelling) to the arms and legs topically every 24 hours as needed for itchiness and rash.The 05/14/2024 Assessment of Ability for Self-Administration of Medication documented the resident was not able to self-administer medications.There was no updated assessment of the resident's ability to self-administer medications.During an interview on 01/05/2026 at 11:40 AM, Resident #137 stated they knew the Department of Health was in the building because a male staff member they did not know came in and took the prescription creams and Bengay they applied to themselves and put it in the nurses' cart. They stated their creams were never put in the cart. They stated they applied all their creams themselves except for the muscle rub; the nurses did that.During an interview on 01/09/2026 at 10:05 AM, Licensed Practical Nurse #24 stated Resident #137 had the Cerave in their rom at one point as the resident put that on themselves, but the other creams were kept in the medication cart. The resident could apply their own Cerave but not the muscle rub or Biofreeze. The resident expressed in the past wanting to apply their own creams. They stated they had not informed anyone the resident expressed wanting to apply their own creams. Residents had the right to apply their creams if they were able to do so and it should have been communicated to the care coordinator.During an interview on 01/09/2026 at 10:59 AM, Nursing Care Coordinator #31 stated the facility conducted self-administration assessments. The assessment was initiated if the resident's Brief Interview for Mental Status documented they were cognitively intact. If they were cognitively intact, they would likely be able to self-administer. It was mostly creams the residents wanted to apply. Nursing also had to make sure the resident could do the treatment appropriately, they could (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reach what they needed, and perform the task start to finish. They were unsure if there was a paper assessment, but they tried to do a note in the electronic medical record. They were also unsure if Resident #137 was assessed for the cream they wanted. They were unsure if Resident #4 was assessed for applying the wound cream. They knew the resident was cognitively intact. They were unsure if there was a list of residents who were able to self-administer their medications. If a resident wanted to self-administer their medications, it should be communicated to the Nursing Care Coordinator.During an interview on 01/09/2026 at 12:18 PM, the Director of Nursing stated they did not have many residents in the facility who could self-administer. There was an initial assessment and then an annual assessment. They just became aware the assessments were not being done annually. They stated they could not locate the facility's policy on self-administration so they pulled the pharmacy policies they had as the facility would follow that. They stated they knew there were residents doing creams in the facility they were not aware of. A resident who wanted to self-administer medications, should be assessed for self-administration even if there were concerns by the staff. The assessment would be documented in the electronic medical record.10NYCRR 415.3(e)(1)(vi)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews during the recertification survey, the facility failed to ensure residents who required nephrostomy tubes (a tube that drains urine from the kidney through an opening in the skin) received services consistent with professional standards of practice for one (1) of one (1) resident (Resident #161) reviewed. Specifically, Resident #161 had a nephrostomy tube and the physician orders did not include specific instructions to document the description of the output, when to change the drainage bag, to monitor for tube patency or blockage, and to monitor for signs and symptoms of infection; the care plan did not include care instructions or indicate what to monitor for and report; and staff were unsure if licensed practical nurses or certified nurse aides were responsible the drainage bag was emptied, measured, and documented. The drainage was not consistently measured and documented as ordered. Additionally, medical was not notified when there was no output. Findings include:There was no documented evidence of a facility policy addressing nephrostomy tube care.Resident #161 had diagnoses including nephrostomy placement, urinary tract infection, and sepsis (system wide infection). The 12/11/2025 Minimum Data Set (a health status assessment tool) documented the resident had moderate cognitive impairment, had an indwelling catheter (including nephrostomy tube), and did not reject care. The 12/05/2025 at 2:40 PM, Registered Nurse #31 Nursing admission Assessment documented the resident had a drain to their left back with bloody drainage. The urinary assessment was left blank and not completed.The 12/05/2025 Registered Nurse #31 progress note documented the resident had an incision with a drain noted to the left flank.There was no documented evidence Registered Nurse #31 requested clarification of the drain or notified the provider of the bloody drainage. The 12/08/2025 Physician #8 admission progress note documented the resident recently had a nephrostomy tube placed at the hospital on [DATE] for left staghorn calculus (a large kidney stone that fills the renal pelvis). The nephrostomy tube to the left back was draining bloody discharge and needed follow up. Physician orders documented:- From 12/06/2025-01/06/2025 apply gauze to left flank around drain and cover with a dry dressing once a day.- On 12/08/2025 empty nephrostomy output and measure every shift. - On 01/06/2025 apply gauze to left flank around drain and cover with a dry dressing once daily on Mondays.There was no documented evidence of an order to empty and measure nephrostomy output from admission on [DATE] until 12/08/2025. There was no documented evidence of physician orders to monitor or record the description of the nephrostomy tube output, an order to change the bag, an order to monitor the tube for patency or blockage, or to monitor/ report any signs or symptoms of infection.The Comprehensive Care Plan initiated 12/18/2025 documented the resident had renal insufficiency related to left staghorn calculus status post left nephrostomy tube placement. Interventions included monitor labs and signs and symptoms of acute renal failure, document, and report such as urine output less than 400 milliliters in 24 hours. There was no documentation related to care instructions or monitoring of the nephrostomy tube. The December 2025 resident care completed by the certified nurse aides documented the nephrostomy was emptied and output was recorded every shift. There was no documentation of output measurements. Documentation that the nephrostomy was emptied was missing on the following days/ shifts:-On 12/06/2025 on the night shift.-On 12/07/2025 on the evening and night shifts.-On 12/10/2025 on the evening and night shifts.-On 12/11/2025-12/18/2025 on the evening shifts.-On 12/20/2025 on the evening shift.-On 12/21/2025 on the evening and the night shifts.-On 12/22/2025-12/23/2025 on the evening shifts.-On 12/25/2025-12/26/2026 on the evening shifts.-On 12/28/2025 on the evening shift.-On 12/30/2025-12/31/2025 on the evening shifts. The December 2025 Medication Administration Record documented by licensed staff the nephrostomy tube was emptied, and output was measured on every shift. There was no documentation this was completed on the following days/ shifts:-On 12/09/2025 on the day shift.-On (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12/13/2025 on the night shift.-On 12/14/2025 on the day shift.-On 12/15/2025 on the evening shift.-On 12/20/2025 on the evening shift.-On 12/24/2025 on the day shift.-On 12/26/2025 on the day shift.-On 12/28/2025 on the night shift.-On 12/30/2025 on the day shift. The 12/30/2025 outpatient Urology after visit summary documented the appointment was a new patient visit for left nephrostomy tube. There were no instructions regarding the tube. The check out note documented the resident needed a consult for percutaneous nephrolithotomy (a minimally invasive surgery to remove large or complex kidney stones).The 12/30/2025 Nursing Care Coordinator #32 progress note documented the resident returned from their urology appointment and needed a percutaneous nephrolithotomy consult. They would call the office for an appointment tomorrow (12/31/2025).The January 2026 resident care completed by the certified nurse aides documented the nephrostomy was emptied and output was recorded every shift. There was no documentation of output measurements. Documentation that the nephrostomy was emptied was missing on the following days/ shifts:-On 01/01/2026 on the evening and night shifts.-On 01/02/2026-01/03/2025 on the evening shifts.-On 01/04/2026 on the evening and night shifts.-On 01/06/2025 on the evening shift.-On 01/07/2025 on the day and night shifts.-On 01/08/2025 on the evening shift.The January 2026 Medication Administration Record documented by licensed staff the nephrostomy tube was emptied, and output was measured on every shift. There was no documentation this was completed on 01/04/2026 on the night shift and on 01/05/2026 on the evening shift. On 01/07/2026 Licensed Practical Nurse #33 documented there was zero (0) milliliters of output on the evening shift, Licensed Practical Nurse #34 documented zero (0) milliliters of output on the night shift. There was no documented evidence the medical provider was made aware there was no output. During an observation and interview on 01/05/2026 at 11:07 AM, Resident #161 was lying in bed with clothes on. They stated if they did not complain, they did not get the care they were supposed to. They were at the facility because they had kidney problems and needed an operation to get rid of a kidney stone. They had a stone on each side and a tube in between. During an observation on 01/07/2026 at 10:39 AM, Physician Assistant #35 was in the resident's room asking them questions. They did not ask the resident about their nephrostomy tube or look at it.The 01/07/2026 Physician Assistant #35 progress note documented the resident was seen for a mandatory 30-day review. There was no documented assessment or plan of the nephrostomy tube. During a follow up observation and interview on 01/07/2026 at 10:48 AM, the resident was in their room seated in their wheelchair. They stated their drainage bag was emptied once a day in the morning and maybe before bed. They were not sure the last time it was emptied. The tubing was visualized on the left side of the body and contained tea colored drainage. They stated they had just gotten back from therapy. There was a bed sheet tied around their torso with a knot. They tried to show the surveyor the drainage bag, but it was wrapped up in the bed sheet and they were unable to get to it. They stated the sheet was to hold the tubing during therapy. The resident leaned forward in the wheelchair and lifted their shirt. A dry, intact, undated dressing was present on their left lower back with a drainage tube coming out of the center of the dressing.The 01/08/2026 resident care record documented Certified Nurse Aide #36 emptied and recorded the output of the nephrostomy tube at 9:57 AM.During an interview on 01/08/2026 at 10:27 AM, Certified Nurse Aide #36 stated Resident #161 had a tube to their back. They were not sure what it was, the nurse took care of it, they did not do anything with the drainage bag.During an interview on 01/08/2026 at 10:32 AM, Licensed Practical Nurse #37 stated nephrostomy tube care involved making sure it was clean, and the dressing was changed. The drainage bag was like a urinary catheter bag and was emptied once a shift by the certified nurse aides or the nurses. If the certified nurse aides emptied the bag, they told them the output so it could be documented in the Medication Administration Record. Resident #161 was currently at an appointment, so they had emptied their drainage bag this morning before they left. During an interview on 01/08/2026 at 10:36 AM, Nursing Care Coordinator #32 stated the licensed practical nurses were responsible for the dressing changes and documented the output every shift on the Medication Administration Record. The nurses could delegate to the certified nurse aides to drain (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and measure the output but the certified nurse aides did not document on that so they would have to relay that information to the nurse. If there was no documentation it meant it was not done. Output should be monitored to see the trending and monitor the color for urology follow up. Resident #161 had consistently less drainage. If the bag was not draining or being emptied there was risk for infection. There was no formal education on nephrostomy tubes but if the licensed practical nurses had questions or were not familiar with them, there was always a registered nurse on they could go to for questions. During a telephone interview on 01/08/2026 at 1:22 PM, Licensed Practical Nurse #34 stated there was no training or education on nephrostomy tubes. They changed Resident #161's dressing early this morning because they had an appointment. As a nurse they were responsible to empty the drainage bag and make sure it was intact. It was important the bag was emptied to make sure fluid was coming out of the affected area. They were not sure if there was a problem if there was no drainage or if the bag was not emptied.During an interview on 01/08/2026 at 1:45 PM, the Director of Infection Control and Staff Development stated there was no education for care of a nephrostomy tube. The rehabilitation unit had them frequently, so they were up with the practices. There was an order for care of the nephrostomy tube, and it was signed off on the Medication Administration Record or the Treatment Administration Record. The order should be followed and if it was not documented, it was not done. The drainage bag should be emptied otherwise the urine could backflow to the kidney and the resident could get an infection. They were not sure who was responsible the drainage bag was emptied. 10NYCRR 415.12(k)(3)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, record review, and interviews during the recertification survey, the facility failed to ensure they established and maintained an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development of transmission of communicable diseases and infections for two (2) of six (6) residents (Resident #5 and #137) reviewed, and for the facility legionella (a bacteria in water that can cause Legionnaire's disease) program. Specifically,-Resident #5 was on enhanced barrier precautions for a urinary catheter (drains urine from the bladder through a tube). Urinary catheter care was provided by Certified Nurse Aide #6 and precautions were not followed; Licensed Practical Nurse #5 did wear appropriate personal protective equipment when administering medications; and the resident's care plan did not include the use of enhanced barrier precautions.-Resident #137 was on contact precautions for conjunctivitis (pink eye). Precautions were not ordered until three days after symptoms appeared and medication treatment was ordered; their care plan was not updated to include the use of contact precautions; and Certified Nurse Aide #41, Licensed Practical Nurse #42, and Housekeeper #43 did not practice appropriate use of personal protective equipment when entering and exiting the resident's room.-the facility's legionella policy was not reviewed annually as required, facility water risk assessments were not completed annually as planned, water samples were not collected at the first draw as planned, and water samples tested were received outside the 48-hour hold window. The assessment forms and sampling results were not retained on site for a minimum of three years as required.Findings include:PRECAUTIONS The facility policy Infection Control, revised 11/2025, documented transmission-based precautions were used in accordance with the clinical presentation and were placed at the time the resident exhibited signs of a transmissible disease. There were four categories including contact, droplet, enhanced barrier, and airborne. Residents placed on precautions required an order, a progress note documented the type of precaution and reason, and a care plan was initiated. The appropriate sign was placed outside the resident's door when precautions were initiated. Signs designated the appropriate personal protective equipment to be worn, and the equipment was available outside the room. Bins for linen and garbage were placed inside the resident's room. Any equipment used and removed from the resident's room needed to be cleansed and disinfected between uses. Meal trays removed from resident rooms were placed in a plastic bag and placed on the dirty cart to return to the kitchen. This alerted kitchen staff to wear gloves when dealing with the dirty tray. Staff donned the appropriate personal protective equipment prior entering the room to perform cleaning duties. 1)Resident #137 had diagnoses including venous insufficiency and obesity. The 12/11/2025 Minimum Data Set assessment (a health status assessment tool) documented the resident was cognitively intact and required supervision or partial to moderate assistance for most activities of daily living. Nursing progress notes documented:-On 01/02/2026 at 12:25 PM by Licensed Practical Nurse #42 the resident's left eye had increased drainage, redness, and puffiness. The resident complained of discomfort to the area. Nursing Care Coordinator #29 was made aware.-On 01/02/2026 at 9:33 PM by Registered Nurse #25 they went to see the resident who complained of redness and irritation to their left eye. Yellow drainage was noted, on call medical provider was made aware, and there was a new order for azithromycin (antibiotic) four times a day for five days. Physician orders documented:-On 01/02/2026 azithromycin ophthalmic solution one percent, one application to left eye, four times a day for conjunctivitis for five days. This order was discontinued at 9:41 PM.-On 01/03/2026 erythromycin ophthalmic (antibiotic for the eye) ointment five milligrams per gram. Instill one application in left eye four times a day for conjunctivitis for five days.-On 01/05/2026 (three days after the onset of symptoms) contact precautions for conjunctivitis to the left eye. Staff to wear gown and gloves for all interactions with the resident. There was documented evidence of a Comprehensive Care Plan the resident was on contact precautions. During an observation and interview on 01/06/2026 at 1:24 PM, Licensed (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Practical Nurse #42 walked in and out of Resident #137's room, removed the resident's lunch tray without wearing any personal protective equipment. Licensed Practical Nurse #42 placed the dirty tray on the tray cart. Licensed Practical Nurse #42 stated Resident #137 was on contact precautions for pink eye. They stated they picked up the roommate's lunch tray, they probably should have worn personal protective equipment, but they were in a hurry.During an observation and interview on 01/07/2026 at 12:17 PM, Certified Nurse Aide #41 entered the resident's room with a water pitcher they just filled. They did not perform hand hygiene prior to entering the room and did not wear any personal protective equipment. They stated they remembered the resident was on precautions when they dropped off their lunch tray, but they forgot when they brought their water pitcher back.During an observation and interview on 01/07/2026 at 2:13 PM, Housekeeper #43 was in the resident's room replacing the trash bag. They did not have a gown on. They used their gloved hands to take out the used trash bag and put a new trash bag in. They stated they did not do patient care and therefore they were not in contact with resident's fluids, so they did not need to wear personal protective equipment. They stated they wore a gown when they cleaned the room, but they were just grabbing the garbage, so they did not need to.During an interview on 01/09/2026 at 2:32 PM, the Director of Infection Control and Staff Development stated a resident with pink eye was on contact precautions and staff should wear gown and gloves in that room. If a resident was on contact precautions, any time the room was entered by any staff, a gown and gloves were required to be worn. This included picking up lunch trays, changing the trash, and returning a water pitcher. 2) Resident #5 had diagnoses including retention of urine. The 11/15/2025 Minimum Data Set assessment documented the resident was cognitively intact and had an indwelling catheter. The Comprehensive Care Plan initiated 07/30/2025 documented the resident had a chronic indwelling catheter due to urinary retention. Interventions included signs and symptoms of discomfort and infection were monitored for and documented. The care plan did not address enhanced barrier precautions. The 12/01/2025 physician order documented the resident was on enhanced barrier precautions; staff was to don a gown and gloves with all hands on care every shift for urinary catheter. The following observations were made:-On 01/05/2026 at 10:16 AM, Resident #5 was seated in their wheelchair in their room. There were two enhanced barrier precaution signs outside their door frame.-On 01/07/2026 at 11:43 AM Licensed Practical Nurse #5 was administering Resident #5's medications wearing only gloves and no gown.During an interview on 01/08/2026 at 11:06 AM, Certified Nurse Aide #6 stated Resident #5 had a urinary catheter. That morning, they provided care including cleaning the catheter insertion area, draining the bag, and changing the bag from the bed bag to the leg bag. They stated they only wore gloves to provide this care. The gowns were only used if a resident was coughing and not when providing catheter care. Enhanced Barrier Precautions used were to prevent droplets and contaminations. They stated the sign outside the room was new and they were reading it for the first time. They stated they should have worn a gown according to the sign and nobody told them that before. During an interview on 01/08/2026 at 12:27 PM, Licensed Practical Nurse #5 stated the certified nurse aides emptied the catheter bags and documented the output. They had to wear gloves to do this and if they were on precautions a gown was also worn. Enhanced Barrier Precautions meant there were extra precautions to make a sterile field to put equipment on if they had wounds or catheters. It was to keep residents from getting infections.During an interview on 01/08/2026 at 12:51 PM, Nursing Care Coordinator #4 stated for urinary catheter care, staff should wear gown, gloves, and masks because it was direct care. Residents with urinary catheters were on enhanced barrier precautions. Staff knew they needed to wear this personal protective equipment because of the sign outside the door. Enhanced barrier precautions prevented the spread of bacteria. During an interview on 01/08/2026 at 1:45 PM, the Director of Infection Control and Staff Development stated there was annual education on infection control and included enhanced barrier precautions. This education was also provided upon hire. They placed signs daily and staff were expected to follow the signage. LEGIONELLAThe facility policy Water Sampling and Management Plan, revised 10/31/2023, documented the Director of (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Environmental Services was responsible for environmental surveillance for Legionella through water sampling and conducting an annual environmental assessment of the water system in collaboration with the Administrator and the Director of Infection Control. Sampling was completed annually, and the plan was reviewed and revised annually in accordance with the findings from the environmental assessment. Water samples were first draw samples. The assessment forms, water sampling and management plan, and sampling results were retained onsite for a minimum of three years, in accordance with applicable rules and regulations. There was no documented evidence the policy was reviewed annually in 2024 or 2025 as required.The facility's water risk assessments and testing results since the last standard survey were requested on 01/05/2026. On 01/06/2026 the surveyor again requested the facility's water risk assessments and testing results, and the Director of Infection Control and Staff Development stated they were still working on gathering that information. The information requested was received on 01/07/2026.The Environmental Assessment of Water Systems in Healthcare Settings, Department of Health Form 5222 completed by the former Administrator documented there was one known case of Legionnaires' disease that was possibly or definitely facility acquired on 10/10/2023. The date of assessment was blank. There was no documented evidence a facility water risk assessment was completed annually in 2024 or 2025. The Legionella water testing results documented:-samples were collected on 05/29/2024 between 1:15 PM and 1:40 PM, received by the lab on 05/31/2024 at 11:45 AM, and processed on 05/31/2024 at 2:00 PM.-samples were collected on 08/28/2024 between 9:53 AM and10:33 AM, received by the lab on 08/30/2024 at 11:45 AM, and processed on 08/30/2024 at 1:00 PM. The report commented that samples were received past the 48 hour hold time.-samples were collected on 12/10/2024 between 9:50 AM and 10:25 AM, received by the lab on 12/12/2024 at 10:00 AM, and processed on 12/12/2024 at 4:00 PM.-samples were collected on 03/11/2025 between 8:00 AM and 8:50 AM, received by the lab on 03/13/2025 at 10:20 AM, and processed on 03/13/2025 at 1:50 PM. The report commented that samples were received past the 48 hour hold time. During an interview on 01/08/2025 at 01/08/2026 at 1:11 PM, the Environmental Services Manager stated they were responsible for collecting the water samples and sending them out for testing. There was a company that came out to do monochloride treatments and they dealt with the vendors. They heard the facility had a Legionella issue before the monochloride system was implemented. They had only been employed by the facility since September 2025, so they did not know all the details and had only collected samples once. They were not sure how often the samples needed to be collected. There was a Legionella plan, but they were unsure of the details. They spoke with the laboratory they dropped the samples off to and was educated on the process of collecting the samples. They were told they needed to collect the samples first thing in the morning, and the laboratory needed to receive them by 9:00 AM to get them sent to the testing laboratory timely. They were not sure of the details of how long the sample was good for before testing was completed. Legionella was a hazard in the water, it was very dangerous in nursing homes, and people could get sick. During an interview on 01/08/2026 at 1:45 PM, the Director of Infection Control and Staff Development stated maintenance was responsible for collecting the water samples and they reviewed the results. Testing was completed annually per the policy. Risk assessments were completed annually, and the policy was reviewed annually. The Administrator initiated the process of reviewing and revising policies. When they had started there was a resident that had tested positive for Legionnaires' disease so there was a lot of testing that was being done, and the situation was monitored closely by the Department of Health. They were going to check on the annual risk assessments because the former Administrator was really involved, and they were sure at they were completed. They needed to be more involved as apparently, and they were not following their plan. They were working with the Administrator under a performance improvement plan on updating policies annually as that was not being done. On 01/09/2026 at 11:03 AM, the Director of Infection Control and Staff Development sent a secured electronic communication indicating they reached out to the former Administrator, and they were able to direct them to the 2025 water risk (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assessment. At 12:09 PM, the 01/14/2025 water risk assessment was received.During an interview on 01/09/2026 at 2:03 PM, the Administrator stated they were responsible to ensure policies were reviewed annually. They were also responsible to provide oversight with Legionella. The water system company trained their team for water sampling. The laboratory also helped with procedures. They were not sure of the window of time for samples to be sent for testing. As the Administrator they were familiar with Legionella testing but they were not an expert yet. 10NYCRR 415.19(a)(b)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observations, record review, and interview during the recertification survey, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, for one (1) of one (1) resident (Resident #144) reviewed. Specifically, Resident #144 did not have their tap bell (manual device used to request assistance) in reach when out of their room as planned. Findings include:The undated facility policy Fall Prevention, documented when a resident was identified at risk for falls a plan of care would be implemented. All residents would have a fall risk assessment upon admission, quarterly, annually, and as needed. Once identified as a risk for falls the Nursing Care Coordinator and the interdisciplinary team would establish a comprehensive plan of care, addressing the individual needs of each resident.Resident #144 had diagnoses including dementia with behavioral disturbances, fractures of the arm and thigh bone. The 12/05/2025 Minimum Data Set documented the resident had severely impaired cognition, had periods of inattention and disorganized thinking, had no behaviors, used a wheelchair, was dependent or required moderate assistance for all activities of daily living, had a fall with major injury and used a bed and chair alarm.The 12/05/2025 Incident Report documented on 12/05/2025 the resident was found on the floor in the hallway next to their wheelchair. The resident sustained a fracture to their left humerus (arm), left patella (knee), and left great toe. A new order was obtained for a chair alarm when out of bed and the resident would be evaluated for further interventions upon the resident's return to the facility.The 12/05/2025 physician order documented to have a tap bell in the resident's reach when they were not in their room every shift for safety.The 01/08/2024, Comprehensive Care Plan, revised 12/05/2025, documented the resident was at moderate risk for falls related to deconditioning, gait, balance, recent fall at home, and a fall out of the wheelchair on 12/05/2025. Interventions included to have a tap bell in reach when they were not in their room.The following observations were made of Resident #144:-on 01/05/2026 at 11:33 AM in the hallway in their wheelchair sleeping with their hands across their lap. There was no tap bell on the overbed table next to them.-on 01/06/2026 at 1:09 PM in their wheelchair in the hallway across from the nurses' station with no tap bell within reach.-on 01/07/2026 at 9:39 AM sitting in hallway in their wheelchair across from the nurses' desk eating breakfast with no tap bell on the overbed table.-on 01/08/2026 at 4:42 PM sitting in their wheelchair down the hallway from the nurses' station between rooms [ROOM NUMBERS] with no tap bell within reach. During an interview on 01/09/2026 at 10:25 AM Licensed Practical Nurse #42 stated fall interventions were on the care plan. Resident #144 was supposed to have a tap bell when they were out of bed to use if they needed something. They stated they were not aware the resident was missing their tap bell, but other staff sometimes brought the resident back to the hallway and did not put the tap bell out.During an interview on 10/09/2025 at 10:32 AM, Licensed Practical Nurse #24 stated fall interventions were on the care plan. Resident #144 was supposed to have their tap bell within reach when out of bed even if they did not use it.During an interview on 01/09/2026 at 10:59 AM, Nursing Care Coordinator #31 stated they oversaw all the care plans on the unit. They expected if a resident had a fall intervention on the care plan, it should be in place. Resident #144 should have a tap bell when they were not in their room so if they were in the hallway, they should have a tap bell. The resident had a fall with broken bones on 12/05/2025 and was to have a tap bell in case they needed attention.During an interview on 01/09/2026 at 12:18 PM, the Director of Nursing stated Resident #144 fell in December 2025 and had several fractures. The intervention for a tap bell to be within reach when not in their room was added to the resident's fall care plan so the resident had something when they were in the hallway. The resident was in the hallway frequently and staff was not always around. They did not know if the resident was fully capable of using it, but it would be there if they needed it. The resident should always have the tap bell when in the hallway outside their room.10NYCRR 415.11(c)(1)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on observations, record review, and interviews during the recertification survey, the facility failed to provide ongoing programs to support each resident in their choice of activities, for one (1) of one (1) Resident (Resident #70) reviewed. Specifically, Resident #70 did not have a person-centered care plan that reflected their interests and preferences and was not offered meaningful activities that met their interests and preferences.Findings include:The facility policy Activities Program, last reviewed 8/2025, documented the Activities Program was a structured plan of social, recreational, cultural, spiritual and therapeutic events designed to enhance quality of life. Activities were to include cognitive stimulation, physical activity, creative expressions, spiritual practices, and social interaction. Activities would be adapted to meet the needs of residents with cognitive or physical impairments. Activities staff were to be trained and receive ongoing education in resident's rights, person-centered programming, and dementia-specific approaches. Residents were to be evaluated on admission and at least quarterly by the Activities staff to develop and maintain a person-centered care plan. Participation and resident responses to activities were documented in the medical record by Activities staff.Resident #70 had diagnoses including Parkinson's disease (progressive neurological disorder), severe dementia, and aphagia (inability or refusal to swallow). The 12/24/2025 Minimum Data Set (assessment tool) documented the resident had severely impaired cognition, was dependent for all activities of daily living, and activity preferences included listening to music.The 1/6/2026 Comprehensive Care Plan documented the resident was alert and disorientated, eye movement was sometimes used for responses, however, the resident frequently chose to keep their eyes closed. The resident was dependent on staff for activities and awareness and attended programs with assistance from staff as a passive participant. Interventions included encourage ongoing family involvement, invite the resident's family to attend special events and activities as able, invite the resident to scheduled activities, provide an activities calendar and update with changes, thank the resident for attendance at activities functions, assist with activities of daily living as required during an activity, and escort to activity functions. When the resident was unable to participate in organized activities, offer social and sensory stimulation. The resident enjoyed hand massages, being read to, and listening to the radio.The 9/25/2025, Resident Ability and Preference Form documented the resident liked to be read, go outside when they could, listen to music, and have their window drapes open. The resident liked Country Western music, being read to with no type of book identified, and sunlight on their face. The resident was non-verbal, and the plan was to continue with one-to-one visits including hand massages and reading.The resident's activity participations documented:- on 09/01/2025 Activities Aide #15 sat with them with while they had their hair cut.- on 09/27/2025 was visited and seemed to respond to Activities Aide #15's voice.- on 10/19/2025 Activities Aide #15 stopped to check in on the resident and play music. The resident reacted to their voice.- on 10/26/2025 Activities Aide #16 talked to the resident about the weather and provided a gentle hand massage- on 12/20/2025 the resident appeared asleep, and Activities Aide #15 played music from the phone.The following observations of Resident #70 were made:- on 01/05/2026 at 12:23 PM sitting up in bed with the radio on a hip-hop/pop music station.- on 01/06/2026 at 10:13 AM sitting in their wheelchair near the nursing station with five other residents, staring at the ceiling. The television was off and there was no radio on in the area.- on 01/07/2026 at 10:00 AM sitting up in bed staring at the ceiling with the room lights off. Neither the television nor the radio was on. At 11:03 AM, in bed with their eyes closed. Neither the television nor the radio was on. At 12:23 PM, in bed, eyes closed, and the room lights off. Neither the television nor the radio was on. At 3:43 PM in bed with their head tilted towards the wall with eyes open. The room lights were off and neither the television nor the radio was on.During an interview on 01/09/2026 at 10:37 AM Certified Nurse Aide #12 stated Resident #70 was gotten up by the overnight shift and then usually laid down after lunch. When the resident was up, they usually sat in front of the television in the common area. When the resident was (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in their room, the radio was put on. They were unsure what kind of music the resident liked, and the radio was primarily tuned to today's hits and occasionally country music. The resident could not talk but they could hear and should not sit in a quiet room all day.During an interview on 01/09/2026 at 10:43 AM, Licensed Practical Nurse #14 stated Resident #70 always had their eyes closed and there was not much the resident could physically do but they enjoyed music. The radio in the resident's room should be on a music station with the genre of music they enjoyed. The resident enjoyed classic rock music per their family. The resident also enjoyed when activities staff came and did massages.During an interview on 01/09/2026 at 10:49 AM, Nursing Care Coordinator #7 stated the resident should have a television or radio on in their room if they were in there for an extended period. The resident's preference in music should be played and it should be on their care plan. The radio stations were limited in the building, even in the dining room only one radio station would come in. They stated some residents had compact disks to play their favorite music type.During an interview on 01/09/2026 at 11:48 AM, the Director of Activities stated there was an initial activities assessment done when the resident was admitted , and preferences were updated once a year on a form kept in a binder in the activities office. The care plan was updated to reflect likes and dislikes based on the form. Families were also interviewed to get input for residents who could not communicate their preferences. For those residents they tried to play music in their rooms or have them attend live entertainment. All participation or refusal in activities was recorded in a note in the resident's electronic medical record. The activities staff were encouraged to check in with residents monthly or twice a month, it depended on what the resident wanted from activities and what their care plan included. Resident #70 was non-verbal, and their family did not come very often. The resident mostly communicated through eye movement. They were unsure how often Resident #70 was seen by activities staff, but it should be more than once a month. Resident #70's care plan should reflect what kind of music they liked to listen to. 10NYCRR 415.5(f)(1)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, record review, and interview during the recertification survey, the facility did not ensure a resident with limited mobility received appropriate services, equipment, and assistance to maintain or improve mobility for one (1) of one (1) resident (Resident #115) reviewed. Specifically, Resident #115 was not re-evaluated by therapy for positioning in their Broda chair (a specialty positioning wheelchair) and staff used a wedge pillow in the chair which did not maintain proper body alignment. Findings include:The facility policy Adaptive Positioning Equipment, dated 7/10/2025, documented residents requiring wheelchairs, positioning chairs, splints, and other adaptive equipment will be assessed by rehabilitation staff, and issued adaptive equipment as needed. If concerns arise after admission regarding the resident's positioning needs, the Nursing Care Coordinator was responsible for documenting the concern/need and sending occupational therapy or physical therapy rehabilitation request for wheelchair, splints, and positioning devices. The resident would be assessed for needs by the appropriate discipline. Resident #115 had diagnoses including contractures (restricted joint mobility) of left and right lower legs. The 10/22/2025 Minimum Data Set assessment documented the resident had severely impaired cognition, did not use a wheelchair, was dependent for most activities of daily living, had functional limitation in range of motion in both legs, and did not receive physical and occupational therapy. The 08/06/2025 Comprehensive Care Plan documented the resident had an alteration in musculoskeletal status related to contractures of the bilateral extremities. Interventions included anticipate needs, give analgesic (pain) medications as ordered by the physician, and monitor for fatigue and falls. The care plan did not document the use of a wedge pillow for positioning. The 11/03/2025 at 10:11 AM, Nursing Care Coordinator #7 progress note documented the resident had a witnessed fall, slid out of their chair towards the left side and landed on their left side (shoulder and head) when they hit the floor. Emergency medical assistance was called to assist with transfer from the floor to stretcher and transport to the hospital. The 11/07/2025 Hospital Discharge Summary documented the resident was admitted for observation after a ground level fall with head trauma. The plan was to return to long term care facility. The 11/08/2025 physician order documented occupational therapy evaluation for range of motion/muscle strength and positioning bed/chair. The 11/10/2025 Physician #8 readmission progress note documented the resident was seen for readmission after a ground level fall with a head strike on 11/03/2025. The resident had mobility impairment related to bilateral knee contractures. The resident was seated in a recliner chair with arms flexed, knees flexed, was unable to straighten, and did not raise arms at shoulder level. The 11/08/2025 through 11/15/2025 Occupational Therapists #10 and #11 progress notes documented continued occupational services were initiated to increase safety awareness and facilitate independence with activities of daily living to enhance the resident's quality of life. The plan was to trial an abductor/contracture cushion while in bed and in positioning chair to maintain proper position. Staff and the resident were educated on use of the knee contracture cushion. The 01/09/2026 care instructions documented the resident should have an abductor/contracture cushion placed between their knees, two rolls behind the back of the knees used in bed and in the positioning chair (Broda chair). There was no documentation that included the use of a wedge pillow or how to ensure the resident was properly positioned in their Broda chair. Resident #115 was observed in their Broda chair: -On 01/06/2026 at 9:20 AM, reclined, leaning to the right. Staff raised the chair to sitting position.-On 01/07/2026 at 10:20 AM, leaning far to the right, moaning, and not able to sit up straight; at 12:15 PM, in the dining room, reclined and leaned to the right while asleep; and at 1:00 PM, sitting near the 2 East nursing station, leaning to the right side.- On 01/08/2026 at 11:35 AM, sitting near the 2 East nursing station leaning forward and to the right side. At 11:48 AM, Certified Nurse Aide #8 repositioned the resident by centering them in the chair. During an observation and interview on 1/08/2026 at 1:06 PM, Certified Nurse Aide #13 stated the resident leaned a lot in their chair because (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	their legs hurt with the contractures. The resident was able to move themselves, but staff also helped to reposition them. During an interview on 01/09/2026 at 9:35 AM, Certified Nurse Aide #8 stated the resident required one person to reposition and provide care. The resident was able to move their arms but not their legs. The resident required repositioning frequently as they held the side of the chair and pulled themselves down. They used a wedge pillow to help prop the resident on the side of the chair to prevent them from pulling themselves down. They stated without the wedge pillow the resident leaned into the crack of the chair and could fall out of the chair. They were not sure who initiated the blue wedge pillow. During an interview on 01/09/2024 at 10:16 AM, Licensed Practical Nurse #14 stated the resident had a wedge pillow that was supposed to be on their right side. The resident was hard to keep in a good position. They had a pillow under their legs that was from therapy, and they thought the wedge pillow on the right was from therapy to keep the resident from leaning to the right. The pillows needed to be adjusted often. The wedge was important to have in place because it kept the resident from falling out of the chair. The resident went to the hospital a month ago for a fall out of their chair. They thought physical therapy assessed the resident when they returned and added the blue wedge pillow. Physical therapy would not reevaluate the resident unless the nursing staff requested an evaluation. During an interview on 01/09/2026 at 11:13 AM, Occupational Therapist #11 stated the resident used a Broda chair and had an abductor pillow. The resident was given the abductor contracture pillow in November 2025. The resident required repositioning throughout the day. They had done frequent education with staff. The abductor pillow was for the knees which helped with the upper body positioning and would center the resident. If the resident side sat, staff should re-center the resident. They were not aware of the blue wedge pillow, and it was not issued by therapy. Nursing should reach out to therapy to work on positioning for the resident. If nursing noticed position issues, they should request a therapy evaluation. During an interview on 01/09/2026 at 11:54 AM, Nursing Care Coordinator #7 stated the resident was assessed when they were readmitted from the hospital in November 2025. They added the abductor wedges between the knees at that time. They should have issued a positioning chair, but they issued the Broda chair. The resident required repositioning by staff and liked to be reclined. If nursing staff noticed impaired positioning, they should reposition the resident. They were not sure where the blue wedge pillow came from. They had not sent a therapy referral, and the handwritten referral would need to be completed for a repositioning evaluation and should be given directly to the Director of Therapy. 10 NYCCR 415.11(c)(2)(iii)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observations, record review, and interviews during the recertification survey, the facility failed to ensure that residents who required dialysis (used to filter waste products from the blood when the kidneys stop working properly) received such services consistent with professional standards of practice for one (1) of one (1) resident (Resident #117) reviewed. Specifically, Resident #117 received hemodialysis treatments at a community-based dialysis center and did not have on-going assessments and oversight before and after dialysis treatments including assessment of the dialysis access site, and there was not consistent ongoing communication and collaboration between the facility and the dialysis center. Findings include:There was no documented evidence of a facility policy addressing dialysis.Resident #117 had diagnoses including end-stage kidney disease. The 10/19/2025 Minimum Data Set assessment (a health status assessment tool) documented the resident was cognitively intact, did not reject care, and required hemodialysis treatments.The Comprehensive Care Plan initiated 01/07/2024 documented the resident needed hemodialysis related to kidney failure. Interventions included dialysis three times a week; and not to draw blood or take blood pressure in the arm with graft (dialysis access site). The care plan did not address the type or location of the dialysis access site, a plan for monitoring, or completion of pre and post dialysis assessments. The 05/28/2025 physician order documented the resident attended dialysis on Monday, Wednesday, and Friday at 5:30 AM. The order did not include pre or post dialysis assessments or access site monitoring. There was no documented evidence the dialysis site was monitored or that pre or post dialysis assessments were completed. The dialysis communication book (used for communication between facility and dialysis center) dated December 2025-January 2026 documented:-Outpatient dialysis daily treatment summaries were completed by the dialysis facility and included pre and post dialysis weights, blood pressures, any medications administered, or labs obtained for all dialysis days (12/01/2025, 12/03/2025, 12/05/2025, 12/08/2025, 12/10/2025, 12/12/2025, 12/15/2025, 12/17/2025, 12/19/2025, 12/21/2025, 12/23/2025, 12/25/2025, 12/28/2025, 12/30/2025, 01/02/2026, 01/05/2026, and 01/07/2026). There was no documented evidence the information was reviewed by the facility upon the resident's return from dialysis treatments. -The dialysis center registered dietitian Monthly Nutrition Reports dated 12/02/2025 and 01/07/2026 were completed by the dialysis center. There was no documented evidence the reports were reviewed by the facility. -There was no documented evidence of communication from the facility to the dialysis center.During an observation and interview on 01/05/2026 at 3:11 PM, Resident #117 was sitting in their wheelchair in their room. They stated they were on dialysis for the past eight years and went three times a week. They were picked up at 5:30 AM and returned between 11:00-11:30 AM. Before they left, the nurse just took their blood sugar. A dry, intact, white gauze dressing was observed just above their right antecubital (front of elbow). During a follow up observation and interview on 01/06/2026 at 1:07 PM, Resident #117 was sitting in their wheelchair in their room. There was no dressing to their right arm. They stated they took their own dressing off the day after dialysis as it had to be kept on for 12 hours. The facility staff never looked at their dialysis site. There was an arteriovenous fistula (a surgically created connection between an artery and a vein for dialysis access) on the right arm. The resident stated they recalled a time they had bleeding from their access site, and they had to go to the hospital, but they did not remember the details regarding how long ago. They stated they took a binder to dialysis, but did not know what the facility did with the binder after they got back.During an interview on 01/08/2026 at 11:01 AM, Certified Nurse Aide #6 stated they helped to get Resident #117 cleaned up and dressed before dialysis. There was a binder that went with them. When the resident returned to the facility, they helped them get settled back in and the binder was turned into the nurse's station.During an interview on 01/08/2026 at 12:25 PM, Licensed Practical Nurse #5 stated after Resident #117 returned from dialysis they looked over the information in the binder to make sure everything went ok, gave them their pills, checked their blood (continued on next page)

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	335672	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Health Services Inc	690 West German Street Herkimer, NY 13350

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sugar, and then the resident went to lunch. If the binder had something noted, they let Nursing Care Coordinator #4 know. Otherwise, nothing special was done for dialysis residents. Resident #117 had something for dialysis to their right arm, but they were not sure what it was called. They came back with a dressing over it, but they were not sure who took the dressing off, but they were not responsible to do anything with it.During an interview on 01/08/2026 at 12:59 PM, Nursing Care Coordinator #4 stated there was a binder that went with Resident #117 to dialysis treatments. Dialysis filled out information in the binder and the nurse looked at it when they returned. The nurse would let them know if any changes were needed and they updated the orders. They believed the resident had an access site in their left arm but could not remember what it was called. The facility staff did not monitor the site, the dressing just stayed in place, and the facility did not do anything with it at all, just left it alone. Dialysis sites were monitored when they worked in the hospital but since they had worked at the facility, it was not something that was done. They thought without monitoring the site could move. There were no pre or post dialysis assessments. They stated they and the nurses had a general knowledge of dialysis, but everything related was handled by the dialysis center and not the facility. During an interview on 01/08/2026 at 1:45 PM, the Director of Infection Control and Staff Development stated they were not sure of the standards of practice for a dialysis resident. They were not sure if there was any documentation or if the site was monitored. Dialysis was not common in the facility. 10NYCRR 415.12(k)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. Based on observations, record review, and interviews during the recertification survey, the facility failed to ensure a residents who was a trauma survivor received culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for the resident's experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident for one (1) of one (1) resident (Resident #7) reviewed. Specifically, Resident #7 had a history of trauma with episodes of night terrors, and did not have a person centered care plan to address potential triggering events to avoid re-traumatization; and there was no social work follow up addressing the resident's night terrors.Findings include:The facility policy Trauma Informed Care, revised 05/23/2025, documented any care plan that referenced or discussed the resident's trauma must be clearly marked at the beginning of the care plan as confidential. All staff were to be trained on trauma informed care upon hire and annually. Training included defining and discussions of key terms such as event, experience, effect, realization, recognition, response, triggers, and care planning considerations. Social Services staff were to use an assessment tool for identifying residents that have experienced a traumatic event/post-traumatic stress disorder. A plan of care was to be developed to address the trauma with appropriate interventions to support the resident identified as having suffered a traumatic event/post-traumatic stress disorder. Triggers and events were identified and care planning initiated to limit traumatization.The facility policy Provision of Social Services, last reviewed 11/4/2009, documented the facility was to provide a Social Services Program to meet psychological needs of the individual resident. Services were provided based upon a comprehensive assessment which assured the resident the maximum attainable quality of life with their emotional and physical well-being, self-determination, self-respect, and dignity.Resident #7 had diagnoses including anxiety disorder, insomnia, and chronic obstructive pulmonary disease (lung disease). The 11/19/2025 Minimum Data Set (assessment tool) documented the resident was cognitively intact, had no behaviors, required supervision or moderate assistance with most activities of daily living, and was taking an antipsychotic (mood stabilizer) with an indication noted.The 5/2/2024 Comprehensive Care Plan documented the resident was on quetiapine (an antipsychotic) related to insomnia, could receive psychiatric consults as needed, and was stable. Interventions included to administer psychotropic medications as ordered, consult with the pharmacy and medical provider to consider dose reduction when clinically appropriate, discuss with the medical provider and the family regarding ongoing use of medication, review behaviors and interventions and alternate therapies attempted and their effectiveness, and to monitor and document any signs of adverse reactions of psychotropic medications.The 10/28/2024 physician order documented the resident was to receive quetiapine (an antipsychotic) 25 milligrams once daily for insomnia. The Comprehensive Care Plan initiated 7/15/2025 documented the resident had a trauma history from early adulthood as the resident served in a combat zone in the military. Interventions included to allow the resident time to answer questions and verbalize feelings, perceptions, and fears as needed and to consult with pastoral care, social services, psychiatric services, and others as needed. There was no documented evidence of factors that could trigger the trauma. The 07/17/2025 note by Social Worker #28 documented a trauma assessment was completed with the resident, their care plan was reviewed and updated.There was no documented evidence of a trauma assessment in the resident's medical record. The 12/04/2025 Pharmacist #38 miscellaneous note documented the resident's medication was reviewed by the interdisciplinary team. The use of the resident's quetiapine for sleep was discussed and the resident being adamant about its continued use. A gradual dose reduction trial was suggested to determine the lowest possible dose.The 12/09/2025 Nursing Care Coordinator #7 progress note documented the resident agreed with the gradual dose reduction trial of their quetiapine. The resident was to start a 12.5 milligram dose that evening. They would monitor for changes in behavior or sleep pattern.The 01/6/2025 Nurse Care Coordinator #7 progress note (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented the resident had a complaint of not sleeping well due to night terrors since their quetiapine was decreased. The nurse practitioner was made aware, and the quetiapine was increased to 25 milligrams. The resident was updated.There was no documented assessment of the resident by social services or the provider following the statement of the resident having night terrors.During an interview on 01/09/2025 at 10:49 AM, Nursing Care Coordinator #7 stated they, social work, activities, and dietary were all responsible for care plans; it was an interdisciplinary care plan. Resident #7's expression of night terrors was new to them. They had done a gradual dose reduction of the resident's quetiapine the resident had agreed to trial. The resident came to them and informed them they were having night terrors at night since the reduction. Nursing Care Coordinator #7 stated they informed medical, and they increased the resident's quetiapine back to 25 milligrams. There were no other recommendations besides increasing the quetiapine back to its original dose. Social Services was made aware of the resident stating they were having night terrors, but they did not believe the resident was offered mental health services.During an interview on 01/09/2026 at 12:35 PM, the Director of Social Services stated if they were alerted to a resident having nightmares or night terrors through staff report or morning report, they would check in with the resident and see how things were going. They were informed of Resident #7 experiencing night terrors in morning report. When they first met the resident, the resident told them they experienced night terrors in the past. A history of night terrors should be care planned and the resident's care plan did not include night terrors but did indicate a trauma history from serving in a war zone. They had not followed up with the resident regarding their night terrors because the resident had not been feeling well, and they were waiting on influenza results. The Director of Social Services stated they received some trauma-informed training in orientation and following up on symptoms such as night terrors was a part of trauma-informed care. There should have a been a conversation with the resident regarding their night terrors and to see if there was anything in the environment that triggered the resident and could be addressed. 10 NYCCR 415.12(f)(1-2)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. Based on observations, record review, and interview during the recertification survey the facility failed to ensure that residents who displayed or were diagnosed with a mental disorder or psychosocial adjustment difficulty, received appropriate treatment and services to correct the assessed problem to attain the highest practicable mental and psychosocial well-being for one (1) of one (1) resident (Resident #136) reviewed. Specifically, Resident #136 exhibited symptoms of depression following their admission to the facility and need for long-term care and did not receive mental health counseling or routine psychiatric evaluations. Findings include: The facility policy Provision of Social Services, dated 11/24/2009, documented the facility would provide a social service program to meet the psychological needs of the individual resident. Services were provided based upon a comprehensive assessment, which assured the residents' maximum attainable quality of life (i.e., emotional and physical well-being, self-determination, self-respect, and dignity).Resident #136 had diagnoses including hemiplegia (one sided paralysis) and hemiparesis (one sided weakness) following a stroke. The 07/01/2025 admission Minimum Data Set (an assessment tool) documented the resident was admitted from a hospital; had moderate cognitive impairment; had no symptoms of feeling down, depressed, or hopeless; no behaviors; felt it was very important to do things with groups of people; required extensive assistance for most activities of daily living; was frequently incontinent of urine; and did receive antidepressant or antianxiety medications.The 06/26/2025 physician order documented Aricept 10 milligrams (a medication used to treat dementia), one tablet by mouth at bedtime for mood stabilizer. The Minimum Data Set did not include a diagnosis of dementia or Alzheimer's.The 7/03/2025 Comprehensive Care Plan documented:-the resident used psychotropic medications related to disease process, treatment with Aricept and psychiatry consult as needed. Interventions included consult with pharmacy, physician to consider dosage reduction when clinically appropriate at least quarterly; and educate the resident/family/care givers about risk, benefits and the side effects.-the resident had a mood problem related to disease process. The treatment included Aricept, psychology consult offered upon admission, however, resident declined; mood was stable at the time. Interventions included to assist the resident, family, care giver to identify strengths, positive coping skills and reinforce these; behavioral health consults as needed (psycho-geriatric team, psychiatrist etc.); and encourage the resident to talk and express their feelings.The 10/04/2025 at 9:45 PM, Licensed Practical Nurse #26's progress note documented the resident was very weepy and upset that morning. The resident made the comment I wish I was not here anymore. The resident seemed depressed. During the evening shift, the resident was very agitated, stating how they would call the police and have everyone fired. The resident said they just wanted to go to bed and refused their dinner and drank very little this shift.The 10/04/2025 at 9:50 PM, Director of Nursing's progress note documented they spoke with the resident regarding their previous comments about not wanting to be here anymore. The resident appeared sad and frustrated with their situation and denied a plan to harm themselves.The 10/05/2025 at 3:43 PM, Registered Nurse #29 progress note documented they were called to see Resident #136 because of their depressed mood. The resident stated they felt sad and ready to give up. The resident stated they had no plans of suicide or hurting themselves.The 10/07/2025 at 3:36 PM, Director of Social Worker progress note documented they attempted to visit with the resident to follow up on a change in mood and making passive suicidal statements regarding wishing to be dead. The resident was sleeping soundly at the time and unable to rouse. A mental health consult was submitted for follow up, and social services would follow up.The 10/08/2025 at 7:09 PM, Social Worker #28 progress note documented they attempted to see the resident for a mental health consult. The resident stated they needed to go to the hospital, as they were burning up all day. Nursing staff entered the room to change the resident's clothing. The resident was unwilling to (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	engage in a mental health consult at that time. There was no documented evidence that a mental health consult was submitted.The 11/19/2025 Minimum Data Set documented the resident had moderate cognitive impairment, no documented symptoms of feeling down, depressed or hopeless; sometimes felt lonely or isolated; did not reject care; and required substantial/maximal assistance with toileting, and partial/moderate assistance for dressing and bathing.The 12/08/2025 Nurse Practitioner #27 90-day mandatory assessment documented the resident was discouraged about their recent stroke and not being able to live independently. They discussed the resident's current weepiness and frustration. The plan was to consider a low dose antidepressant, but they would wait for family input. The resident was weepy and teary during the assessment. The resident's problem list included stroke with left hemiparesis, dysphagia (difficulty swallowing), and dementia.There were no documented physician orders for psychiatry consults, or social service consults addressing the resident's psychological status. Nursing progress notes documented the following: -on 12/23/2025 at 1:27 PM by Licensed Practical Nurse #26 the resident refused to eat breakfast and lunch this shift. The resident was weepy and refusing to get out of bed for lunch. The resident became easily agitated when asked to get out of bed. -on 12/27/2025 at 10:40 PM by Registered Nurse #25 the resident was increasingly agitated and confused this shift. Registered Nurse #25 spoke to the resident's family who was concerned the resident may attempt to leave the building. A wander alert device was applied to the resident's wheelchair. The Resident was resistive to care and refused medications this shift. -on 12/31/2025 at 2:09 PM by Licensed Practical Nurse #22 the resident continued to refuse medications and had a poor appetite. The family was in to visit, and the resident refused to talk with the family member. The family requested a mental health evaluation.-on 01/02/2026 at 6:49 PM by Licensed Practical Nurse #24 the resident refused to eat breakfast or take medications. The resident refused to get out of bed for lunch and supper. The resident stated, I do not want to get out of bed. I do not want to eat; I want to die. The resident was agitated when approached by staff who assured the resident the nurses were there to help.-on 01/02/2026 at 7:50 PM by Licensed Practical Nurse #23 the resident refused their medications despite encouragement and reapproach, emotional support was provided.-on 01/03/2026 at 1:54 PM by Licensed Practical Nurse #22's progress note documented the resident refused out of bed for most of the shift. The resident got up for breakfast, and ate half their meal, and demanded to return to bed after their meal and refused lunch and medications. -on 01/05/2026 at 11:15 AM by Nursing Care Coordinator #7 the nurse practitioner was updated on the resident's behaviors. The resident noted to be weepy and anxious at times and refusing medication and meals. The nurse practitioner ordered to start mirtazapine (antidepressant/appetite stimulant) 7.5 milligram. The resident's family agreed. There was no documented evidence of physician orders for psychiatry consults, or social service consults. The 01/09/2026 at 11:04 AM, secure file transfer electronic email documented there were no psychiatry or psychology consults.Resident #136 was observed:-On 1/05/2026 at 11:37 AM in bed asleep with the room dark and the curtains pulled closed.-On 01/05/2026 at 1:05 PM in bed asleep. The resident did not attend the dining room to eat lunch and there was no meal tray in the room.-On 01/06/2026 at 12:51 PM in bed asleep, their room was dark, and their curtains were pulled closed.-On 01/07/2026 at 10:28 AM in bed asleep, the room was dark, and the blinds were pulled closed.-On 01/07/2026 at 12:13 PM in asleep in bed during lunch.-On 01/07/2026 at 12:43 PM in their room asleep. At 12:47 PM, a maintenance staff knocked on the door to enter and the resident did not wake up. At 12:58 PM, all the hallway lunch trays were passed, and the resident remained asleep in their room. -On 01/08/2026 at 11:03 AM in bed asleep with the curtains pulled closed.During a telephone interview on 01/5/2026 at 3:02 PM, Resident #136's family member/health care proxy stated the resident had dementia and recently started to be mean to staff and family. They stated the registered nurse notified them they were starting the resident on a new medication for depression.During an interview on 01/08/2026 at 11:31 AM, Resident Aide #21 stated Resident #136 seemed to be having a hard time adjusting to long term care. They were doing okay at first and now seemed very depressed. They stated the resident ate breakfast on (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	01/07/2026 but they would not eat lunch. They stated the resident would get really upset if they got to the dining room and other residents were already there and eating. They would refuse to eat and demand to go back to bed. The resident already mentioned they would not be eating lunch today.During an interview on 01/08/2026 at 1:11 PM, Certified Nurse Aide #20 stated the resident seemed more depressed and confused. The resident would usually go to breakfast if they were approached a certain way, but after breakfast, they wanted to go right back to bed. They were going to all the activities and then started to refuse all medication, meals and activities. The resident was on their own in the community and had a stroke and was just admitted to long term care. The resident was refusing all drinks and food and would get irritated with staff when they ask the resident to attend activities or meals. During an interview on 01/09/2026 at 11:37 AM, Nursing Care Coordinator #7 stated Resident #136 was admitted to the facility's rehabilitation unit after a stroke and in August 2025 they were transferred to long-term care. They stated the interventions in place to assist with the resident's mood was one to one visits, and family visits with the resident's niece. The resident was weepier lately and was started on mirtazapine because of decreased appetite. The resident ate breakfast and then would ask to lie down and would not get back up for the rest of the day. They thought the resident has only been this way for a week or two. The resident was having a hard time adjusting to the facility. The facility had a Licensed Mastered Social Worker that conducted mental health rounds. Resident #136 was not on the list to be seen during the recent mental health rounds. They stated it would be beneficial for the resident to be seen by mental health social work to give the team recommendation for the resident. During an interview on 01/09/2026 at 12:23 PM, the Director of Social Services stated on 01/05/2025 they put in a mental health consult for Resident #136. The request went directly to their consultant social worker who was a Licensed Masters Social Worker. They stated the resident had a little bit of increased confusion with mood change, refusing out of bed and refusing meals and medications. The consultant would do a one on one and would do an assessment of the resident and review their preexisting diagnoses and make suggestions for the physician to make medication changes. They stated the mood issues were recent. The resident became a long-term care resident in August 2025. When the resident was sleeping more and not coming out of their room for meals, staff should encourage the resident to come out for their meals and participate in activities During an additional interview on 01/09/2026 at 1:04 PM, the family member/health care proxy stated, they noticed more changes to the resident's behavior in the last month. The nurses were aware of this change in behavior, but it was worse. There were two nurses that really understood the resident but when those nurses were off, the resident would get very agitated. They had not been seen by psychiatry; it was winter, and the resident was depressed and had dementia. 10 NYCRR 415.12(f)(1)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observations, record review, and interviews, the facility failed to ensure residents were free of any significant medication errors for one (1) of one (1) resident (Resident #5) reviewed. Specifically, Resident #5 was administered lispro insulin (a fast-acting insulin) that was opened and undated. Findings include:There was no documented evidence of a facility policy addressing insulin administration or storage. Manufacturer specifications for insulin lispro documented opened vials/ pens were discarded after 28 days.Resident #5 had diagnoses including diabetes. The 11/15/2025 Minimum Data Set assessment (a health status assessment tool) documented the resident was cognitively intact and received hypoglycemic (lowers blood sugar) medications (including insulin). The 10/24/2025 physician order documented insulin lispro was administered before meals and at bedtime based on the following sliding scale (amount of insulin administered based on blood glucose levels):-if glucose level 0-150 milligrams/deciliter give 0 units-if glucose level 151-200 milligrams/deciliter give 2 units-if glucose level 201-250 milligrams/deciliter give 4 units-if glucose level 251-300 milligrams/ deciliter give 6 units-if glucose level 301-350 milligrams/ deciliter give 8 units-if glucose level 351-400 milligrams/ deciliter give 10 units The 01/07/2026 blood sugar summary documented the resident's blood sugar at 7:25 AM was 165 milligrams/deciliter and at 11:51 AM the blood sugar was 331 milligrams/deciliter. The January 2026 Medication Administration Record documented on 01/07/2026 at 7:30 AM Licensed Practical Nurse #5 administered 2 units of insulin lispro and at 11:30 AM they administered 8 units of insulin lispro. The following observations were made during medication administration on 01/07/2026 from 11:43 AM- 11:49 AM with Licensed Practical Nurse #5:-at 11:46 AM, Licensed Practical Nurse #5 obtained the resident's blood sugar with a result of 331 milligrams/deciliter. -at 11:48 AM, Licensed Practical Nurse #5 handed the insulin lispro pen to the surveyor to show the dial was set at 8 units. The surveyor did not observe an opened date on the pen and asked if the nurse could find an opened date. They stated the label with the opened date must have come off. -At 11:49 AM Licensed Practical Nurse #5 entered the resident's room with the insulin pen and an alcohol swab. They lifted the resident's shirt, rubbed their skin with the alcohol wipe, and injected the insulin into the resident's left lower abdomen.There was no documented evidence the administered insulin had an opened date and was used within the recommended time frame after opening. During an interview on 01/07/2025 at 11:50 AM, Licensed Practical Nurse #5 stated insulin was good for 28 or 30 days after opening. Whoever opened the insulin pen was responsible for labelling it with an opened date. They stated they used the same insulin pen for both insulin administrations at 11:49 AM and the breakfast dose. They did not check the date on the pen, and they should have. They just figured it was ok because it was in the resident's insulin pen bag. Without an opened date they did not know if the medication was expired. Residents should not receive expired medications because it could hurt them. They went through the cart all the time and the evening and night shifts did not label the pens when they opened them. They said they would discard the pen.During an interview on 01/07/2026 at 11:58 AM, Nursing Care Coordinator #4 stated opened dates were expected to be checked prior to insulin administration to ensure the insulin was not expired. Insulin did not last long after opening; they thought 30 days was all it was good for. If there was not a date, the nurse should discard the pen, get a new pen and label it with the date opened. Expired medications may not be effective. The night shift was responsible to go through the cart nightly and discard any expired medications. During an interview on 01/08/2026 at 1:45 PM, The Director of Infection Control and Staff Development stated there was no formal education on medication administration. It used to be part of orientation, but they had gotten away from it when COVID hit. They wanted to get back in the process. When administering insulin, the opened date should be checked prior to administration as it was part of the right medication in the five medication rights to ensure it was not expired. Licensed staff should have general knowledge from schooling. Insulin was a high risk/ significant medication. Residents should not receive expired insulin as it could be (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Health Services Inc	690 West German Street Herkimer, NY 13350

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	detrimental to their health, it might not even work, and residents should receive the most effective treatment for their diabetes. 10NYCRR 415.12(m)(2)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observations and interviews the facility failed to ensure a safe, functional, sanitary, and comfortable environment for residents, staff, and the public for one (1) of four (4) shower/tub units (2 [NAME] shower/tub unit) reviewed. Specifically, four anonymous residents present at the resident group meeting stated the shower/tub floors were a mess, the drains did not work, and the tubs leaked. The shower/tub unit on 2 [NAME] was observed to have standing, discolored water underneath it for multiple days of survey.Findings include:The undated facility policy Residents' [NAME] of Rights & Responsibilities, documented the residents had the right to dignified existence. The residents had the right to receive services in the facility with reasonable accommodations of their needs and preferences.During a resident group meeting on 01/05/2026 at 2:06 PM, four anonymous residents stated the resident shower floors were a mess, the showers and tubs did not work, the drains in the shower rooms did not work, and the tubs leaked.The 2 [NAME] Maintenance Request and Requisition forms from 12/012025-01/09/2026 documented no maintenance request notifications for the tubs and/or shower roomDuring an observation on 01/07/2026 at 9:52 AM the tub in the 2 [NAME] shower room was filling. There was standing water under the top of the tub under the pipe connecting to the tub. The water was not draining anywhere. At 12:57 PM standing water remained at the head of the tub under the pipe that connected to the tub. At 2:07 PM, the puddle under the top of the tub had extended outward underneath the tub to the side and the middle. There was visible discoloration along the edges of the puddle. The water was light tan in color.During an observation and interview on 01/07/2026 at 2:10 PM, Certified Nurse Aide #18 was squeegeeing the outer most water across the shower room into the shower drain across from the tub. Certified Nurse Aide #18 stated they gave a shower next to the tub in the shower room in a shower chair because the shower in that room would flood into the hallway due to the way the floors were. The water was a light tan to brow with grayish flecks in it.During an observation on 01/08/2026 at 10:20 AM the 2 [NAME] shower room had a musty wet odor near the tub. The tub had a brownish gray puddle under the pipes under top of the tub. The tubing pipe was rusting and frayed laying in the puddle. There was a drain under the tub that was crusted with grey matter. There was gray matter floating in the water. At 12:47 PM, the greyish brown puddle was still under the top of the tub with tubing piping sitting in the water.During an interview on 01/09/2026 at 10:20 AM, Certified Nurse Aide #18 stated there was a puddle under the tub in the 2 [NAME] shower room all the time. They stated they did not know why it was there but sometimes the seal leaked on the tub when the door was shut. They stated maintenance fixed the tub seal many times.During an observation and interview on 01/09/2026 at 10:16 AM, the Environmental Services Manager stated they had not received any work orders for the standing water underneath the tub in the 2 [NAME] Shower room. The water was greyish brown and had things floating in it. They stated they were unaware of the issue, and the problem was the drain may not be draining as it should. 10NYCRR 415.29

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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 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. Based on observations and interview during the recertification survey, the facility failed to post on a daily basis at the beginning of each shift, the current resident census and the total number and the actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift, in a prominent location readily accessible to residents and visitors for five (5) of five (5) days (01/05/2025-01/09/2025). Specifically, the current daily resident census, staffing hours, and nurse staffing schedules were located on the Unit 1 [NAME] nursing office door and window that was not easily accessible to all visitors or residents. Findings include: The facility policy Posting of Nurse Staffing Information, dated 01/16/2024 documented the facility complied with regulations including posting of nurse staffing information. The daily staffing information would be posted on the first floor next to the window of the nursing office at the beginning of each shift. Data would be legible and posted in a prominent place accessible to residents and visitors.During multiple observations from 01/05/2025-1/09/2025, there was a sign in the main lobby above the visitors' sign-in sheet about 5 feet from ground on a pillar documenting the staffing numbers and sheets were on the 1st floor nursing office. During multiple observations from 01/05/2025-01/09/2025, the daily nursing schedule, daily staffing numbers, and daily census was posted on the Unit 1 [NAME] nursing office door and window across from the Unit 1 [NAME] elevator. During an interview on 01/09/2026 at 12:53 PM, the Director of Nursing stated the staffing numbers was posted on the glass window of the nursing office on the first floor. There was no staffing sheet posted on the second floor at the facility's main entrance. The facility could provide transport to the posting if a resident wanted to see it and they could tell a visitor where it was located if they wanted to know. They stated the sign was not easily seen from wheelchair height. 10 NYCRR 415.13