STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335693	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rosewood Rehabilitation and Nursing Center	284 Troy Road Rensselaer, NY 12144

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record reviews and interviews conducted during a surveys, the facility did not ensure that residents were treated with dignity respect throughout the facility for two (2) (Residents #1 and #4) of two (2) residents reviewed for dignity. Specifically, (a.) staff members used derogatory language in the resident hallways of the facility; (b.) Resident #1 was called pet names by the staff, and their personal belongings had been moved by staff without their knowledge; and (c.) Administrator #1preformed a search of Resident #4's personal belongings without their permission. This is evidenced by: Policy: The facility policy titled Quality of Life/Dignity revised dated 12/2019 (unsigned) documented each resident is to be cared for in a manner promoting quality of life, dignity respect, and individuality.Implementation Residents shall be treated with dignity and respect at all times. Residents private space and property will be respected at all times1. Staff will knock and get permission prior to entering a resident room2. Staff will not handle or move resident belongings without permission Staff shall speak respectfully to residents at all times addressing each resident by name of choice. Resident #1 Resident #1 was admitted to the facility with diagnoses of unspecified encephalopathy (brain disorder (cause unknown) leading to altered brain function), acute respiratory failure with hypoxia (sudden inability of the lungs to maintain adequate oxygen levels in the blood), and generalized muscle weakness. The Minimum Data Set (an assessment tool) dated 01/30/2026, documented the resident was understood, able to understand others, and was cognitively intact. Resident #4 Resident #4 was admitted to the facility with diagnoses of chronic obstructive pulmonary disease (progressive lung disease that makes it difficult to breathe), essential primary hypertension (abnormally high blood pressure that is not the result of a medical condition), and chronic pain (pain lasting over three (3) months). The Minimum Data Set, dated [DATE], documented the resident was understood, able to understand others, and was cognitive intact. Observation: During an observation on 2/13/2026 at 11:20 AM at the first-Floor rehabilitation unit nursing station, Maintenance Director #2 stated loudly that they Can't get fucking lucky as they were walking down the hallway approximately 20 feet from the nursing station. Interview: During an interview on 02/11/2026 at 11:25AM, Resident #1 stated the staff at the facility called them honey, sweetie, and even big-butt one night, they did not like being called any of those names. They were upset that their refresh eyedrops were taken away from them that they had been administering themselves for a long time. They did not think the staff considered evaluating for them to keep the eyedrops. The staff had moved their denture cream approximately two (2) nights ago and were still unable to locate it. They added that the nurses kept trying to give them melatonin at bedtime, although they had let the nurse know they did not want it. During an interview on 02/17/2026 at 11:45 AM, Resident #4 stated Administrator #1 came into their room the previous morning and looked through three (3) of their nightstand drawers. Resident #4 stated they had to ask Administrator #1 what they were doing. Administrator #1 then explained they (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	were looking for medications, scissors, or clippers. They proceeded to ask Resident #4 where their money was. Resident #4 stated they told them the facility had their money. Administrator #1 then asked if they had any money in the room, and they repeated the facility had their money. During an interview on 02/24/2026 at 2:25 PM, Certified Nursing Aide #3 stated when entering a resident room, they would knock and introduce themselves prior to entering. If they needed to go through a resident's belongings they would need to ask permission first.During an interview on 02/24/2026 at 2:31 PM, Licensed Practical Nurse #3 stated when entering a resident room, they would knock and introduce themselves prior to entering. If they needed to go through a resident's belongings they would need to ask permission first. If they were to see someone going through resident belongings, they would ask that person what they were looking for, receive resident permission, and notify nurse manager. During an interview on 02/24/2026 at 2:35 PM, Licensed Practical Nurse #4 stated when entering a resident room, that they would knock and introduce themselves. If they needed to go through a resident's belongings, they would need to ask for permission from the resident. If they heard inappropriate conversation in hallway by staff, they would notify nurse manager. During an interview on 02/24/2026 at 2:47 PM, Licensed Practical Nurse #7 stated when entering a resident room they would knock, introduce themselves, and then address issues that brought them to the room. If they needed to go through a resident room or belongings they would need to ask permission from resident prior. They stated if they heard inappropriate conversation in hallway, they would pull staff into their office and give them a verbal warning. If the behavior continued, they would bring the staff member to the director of nursing for further interventions. During an interview on 02/24/2026 at 2:14 PM, Certified Nursing Aide #9 stated they always ask permission if they needed to search a resident's room. They always knocked before entering a resident's room and introduced themselves. They stated cursing in front of residents or other staff was not okay, and they would address staff if they overheard it. During an interview on 02/24/2026 at 2:42 PM Licensed Practical Nurse #8 stated they would ask permission from the resident before searching a resident's belongings/drawers. During an interview on 02/24/2026 at 4:21 PM, Licensed Practical Nurse #2 stated they would talk to staff or correct them if they heard any foul language/cursing. They have witnessed staff arguing in front of the residents, and staff talking on their personal phones using foul language in front of residents. They stated both situations were dignity issues. 10 New York Codes, Rules, and Regulations 415.12(h)(1)(2)

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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 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews during a survey, the facility failed to ensure residents were afforded the right to formulate advanced directives including having a physician's order related to their code status (the level of medical interventions a person wishes to have started if their breathing stopped such as cardiopulmonary resuscitation or do not resuscitate), and establishing mechanisms for documentation and communicating the residents' choices to the staff responsible for their care, which had the likelihood to result in serious harm or death for nine (9) (Residents #6, 7, 8, 9, 10, 11, 12, 13, and 14) of 53 residents reviewed for advanced directives. Specifically, (a.) for Resident #'s 6, 7, 9, 10, 11, 12, and 13, there was no documented evidence of a physician's order related to the residents' code status or advanced directive; (b.) for Resident #'s 7, 9, 10, 11, and 12, there was no documented evidence of Medical Orders for Life Sustaining Treatment; and (c) for Resident #14, there was conflicting documented evidence of code status. This resulted in Immediate Jeopardy and Substandard Quality of Care to Resident #'s 6, 7, 8, 9, 10, 11, 12, 13, and 14. This is evidenced by: The policy titled Emergency Procedure Code Blue Cardiopulmonary Resuscitation, revised 01/23/2025, documented Advanced Directives are provided on admission. Before cardiopulmonary resuscitation was initiated the resident's wish for code status would be established through a code status identifier. The residents' electronic medical records would have a written Medical Doctor order and physical Medical Orders for Life-Sustaining Treatment status form. The undated Advanced Directive Policy documented upon admission and as required thereafter, residents or their legal representatives will be informed of their rights regarding advance directives. Upon admission, the facility will inquire as to whether the resident has an existing advanced directive and will document the resident's status in the medical record. Facility staff will follow advanced directives and related medical orders. Resident #6Resident #6 was admitted to the facility with diagnoses of wedge compression fracture of T11-T12 vertebra (a collapse of the vertebra), other forms of acute ischemic heart disease (occurs when plaque buildup narrows the heart's arteries, restricting blood flow and oxygen to the heart muscle), and hypertensive heart disease without heart failure (chronic high blood pressure where the heart adapts to increased workload). The Minimum Data Set (a resident assessment tool) dated 12/30/2025 documented they could understand, be understood, and were cognitively intact. Record review revealed no documented evidence of a physician order for basic life support interventions related to the resident's code status and advance directives. The Nursing Progress Note dated 01/11/2026 at 2:31 PM written by Licensed Practical Nurse #3, documented Resident #6 was unresponsive. They attempted to obtain vital signs and oxygen saturation level was 83% (normal is 95-100%). Oxygen was administered via nasal cannula at two (2) liters and oxygen saturation level dropped to 69%. Unable to obtain blood pressure. 911 was called at approximately 1:21 PM. Cardiopulmonary resuscitation was initiated by Licensed Practical Nurse #3 and #4 at 1:23 PM, until Emergency Medical Services arrived at 1:38 PM and took over Cardiopulmonary Resuscitation. A heart rhythm was obtained by Emergency Medical Services and stated they were transporting the resident to the hospital at approximately 1:56 PM. The Physician Progress Note dated 01/12/2026 at 10:44 AM written by Nurse Practitioner #1, documented they received an urgent phone call from nursing staff regarding Resident #6 who was found unresponsive. Nursing reported an inability to obtain blood pressure and no palpable pulses. No Medical Orders for Life Sustaining Treatment form or advance directive limiting resuscitation was on file at the time of the event. Nursing was immediately instructed to initiate cardiopulmonary resuscitation and treat the patient as a full code. Emergency (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Medical Services were activated and 911 was called. The Nursing Progress Note dated 01/12/2026 at 1:10 AM written by Licensed Practical Nurse #4, documented they called the hospital emergency department at 1:05 AM to obtain an update on Resident #6 and was informed the resident expired. During an interview on 02/03/2026 at 2:02 PM, Licensed Practical Nurse #3 stated that on 01/11/2026, Resident #6 was unresponsive, at one point had no pulse and cardiopulmonary resuscitation was started. They were unable to identify the resident's code status. Prior to the start of cardiopulmonary resuscitation, the nurse needed to know the resident's code status. The code status was checked by looking in the Medical Orders for Life Sustaining Treatment binder and in the electronic medical record. If they could not find the code status in the Medical Orders for Life Sustaining Treatment binder or electronic medical record, they treated the resident as though they were a Full Code (perform cardiopulmonary resuscitation). They were not aware of a facility policy for a resident's code status and said it was something that they were taught. The admission nurse was responsible for asking the resident what their advance directive and code status was and for completing the Medical Orders for Life Sustaining Treatment form. They stated the nurse manager was responsible for entering the resident's code status in the electronic medical record and for putting the Medical Orders for Life Sustaining Treatment form in the binder. They further stated there was a gap of time when they had no nurse manager. They did not recall calling Nurse Practitioner #1 about the resident's code status. During an interview on 02/03/2026 at 2:18 PM, Licensed Practical Nurse #4 stated they were asked to help with Resident #6 before the resident had no pulse. They checked the Medical Orders for Life Sustaining Treatment form book and there was no form for the resident. They had Licensed Practical Nurse #3 verify and they did not find a Medical Orders for Life Sustaining Treatment for the resident. Licensed Practical Nurse #4 called 911 and checked the electronic medical record and there was no code status. They stated it was unusual for a resident to have no code status in the electronic medical record. A staff member (unnamed) told them to do cardiopulmonary resuscitation because there was no other directive in place. Cardiopulmonary resuscitation was started once there was no pulse found. During an interview on 02/03/2026 at 2:45 PM, Nurse Practitioner #1 stated they were called on 01/11/2026 about Resident #6 by either Licensed Practical Nurse #3 or #4, that Resident #6 was unresponsive, and the nurse needed to know their code status because there was no Medical Orders for Life Sustaining Treatment form in the binder. They stated they knew the resident's code status was full code (cardiopulmonary resuscitation) because a Medical Orders for Life Sustaining Treatment form was completed at the time of admission and verified by Nurse Practitioner #1. The form was not in the binder on 01/11/2026 and was still missing. Nurse Practitioner #1 stated they completed the resident's admission physical examination on 12/29/2025 and did not document the resident's code status because it was not on the resident's profile in the electronic medical record. The nurse manager on the unit was responsible for putting the verified Medical Orders for Life Sustaining Treatment in the binder and then adding the code status to the resident's profile and a physician order for the code status in the electronic medical record. They stated they did not have the time to ensure the residents' code status was entered into the electronic medical record because they had residents to attend to and it was the nurse manager's responsibility to ensure it was done. It was the facility policy to treat the resident as though they wanted cardiopulmonary resuscitation if there was no advance directive or code status in place. Resident #7Resident #7 was admitted to the facility with acute and chronic respiratory failure with hypoxia (a critical condition where the lungs cannot transfer enough oxygen into the blood), chronic obstructive pulmonary disease with acute respiratory infection (a progressive, irreversible lung disease causing, obstruction, inflammation, and chronic airflow blockage), and (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	idiopathic nonspecific interstitial pneumonitis (a group of noninfectious, chronic, or acute lung disease of unknown cause characterized by inflammation and fibrosis (scarring) in the lung tissue). The Minimum Data Set, dated [DATE], documented they could be understood, understood others, and was cognitively intact. During first floor rehabilitation unit observation on 02/02/2026 at 10:30 AM, there were no Medical Orders for Life-Sustaining Treatment forms present on the unit for Resident #7. Record review revealed no documented evidence of a physician order for basic life support interventions related to the resident's code status and advance directives. admission provider assessments dated 01/27/2025 by Nurse Practitioner #1 did not have documented evidence of code status. During an interview on 02/02/2026 at 2:30 PM, Resident #7 stated they did not receive any admission paperwork; however, they could not sign anything because they were blind and anything that required a signature would be deferred to Family Member #1. They stated they wanted to be listed as full code. Family Member #1 was present during the time of interview and stated no admission paperwork was completed and no advanced directive done. Resident #8Resident #8 was admitted to the facility with encephalopathy (a group of conditions that cause brain dysfunction), acute respiratory failure with hypoxia, pneumonitis due to inhalation of food and vomit (a condition characterized by inflammation of the lungs which can happen when food or vomit enter the airways). The Minimum Data Set, dated [DATE], documented they could be understood, understood by others, and was cognitively intact. Record review revealed no documented evidence of a physician order for basic life support interventions related to the resident's code status and advance directives. admission provider assessments dated 01/29/2025 by Nurse Practitioner #1 did not have documented evidence of code status. During an interview on 02/02/2026 at 2:46 PM, Resident #8 stated they arrived at the facility a week ago. They stated they had not signed any admission paperwork and was unsure what advanced directives were. After learning what advanced directives and code status were, they stated they would like to be listed as Do Not Resuscitate. Resident #9Resident #9 was admitted to the facility with acute respiratory failure with hypoxia, pneumonia due to coronavirus disease 2019 (lung infection due to coronavirus disease 2019 also known as COVID-19), and acute pulmonary edema (a condition where there is a too much fluid in the lungs). The Minimum Data Set, dated [DATE], documented they could be understood, understood by others and was cognitively intact. During first floor rehabilitation unit observation on 02/02/2026 at 10:30 AM, there were no Medical Orders for Life-Sustaining Treatment forms present on the unit for Resident #9. Record review revealed no documented evidence of a physician order for basic life support interventions related to the resident's code status and advance directives for Resident #9. admission provider assessments dated 01/30/2025 written by Nurse Practitioner #1 did not have documented evidence of code status.During an interview on 02/02/2026 at 2:52 PM, Resident #9 stated they did not recall signing admission paperwork. They stated they did not know what advanced directives were. After learning what advanced directives and code status and resident stated they would like to be listed as full code. Resident #14Resident #14 was admitted to the facility with diagnoses of traumatic ischemia of muscle (occurs when there is a decrease in the blood supply to a muscle due to a traumatic injury), dehydration (loss of water and salts essential to body function), and muscle weakness (generalized). The Minimum Data Set, dated [DATE], documented they could be understood and understood by others with mild cognitive impairment. Record review of Medical Orders for Life Sustaining Treatment form dated 01/22/2026, documented the resident was to have cardiopulmonary resuscitation. Nurse Practitioner #1 signed the form on 01/27/2026. Record review of physician orders for Resident #14 documented: A physician order entered by Registered Nurse #1 on 01/22/2026 for Do Not Resuscitate/Do Not Intubate (insert a breathing tube). The order was signed by Nurse Practitioner #1 on 01/23/2026. On (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	01/27/2026, Licensed Practical Nurse #7 entered an order for code status full code and was signed by Nurse Practitioner #1 on 01/28/2026, while the Do Not Resuscitate/Do Not Intubate order dated 01/22/2026 was still active. On 02/04/2026, the order for Do Not Resuscitate/Do Not Intubate was discontinued by Licensed Practical Nurse #7 and an order for cardiopulmonary resuscitation was entered. During an interview on 02/03/2026 at 2:45 PM, Nurse Practitioner #1 stated they had conflicting information for Resident #14, which could be bad. Residents had individual charts which recently were removed from the units and now just have a Medical Orders for Life Sustaining Treatment binder on each unit. They stated there was no oversight, and no nursing oversight. They stated the process is for staff to first go to the electronic medical records to check code status because nursing had computers open and easy access to resident orders. Nurse Practitioner #1 reviewed Resident #14's Medical Orders for Life Sustaining Treatment and they stated the orders must have been entered incorrectly. During an interview on 02/04/2026 at 10:41 AM, Licensed Practical Nurse #7 stated they were asked by someone to add the code status to the top of resident's records in electronic medical records where it was shown earlier that same day. They stated they were not sure who asked them to do so, they were passing medications at that time. They stated they saw conflicting information in the electronic medical record for Resident #14. Licensed Practical Nurse #7 stated they put Do Not Resuscitate/Do Not Intubate into electronic medical record at 10:31 AM on 02/04/26. They stated they were going to look at Resident #14's information more after their break. They stated the Medical Orders for Life Sustaining Treatment forms were done or should be done with the admission assessments. They stated if the hospital discharge summary stated Do Not Resuscitate then they will sometimes add that to the resident's chart upon admission. During an interview on 02/04/2026 at 11:01 AM, Family Member #2 stated that the Director of Nursing (unnamed) did the Medical Orders for Life Sustaining Treatment form with them. They talked with Resident #14 about what they wanted, and they signed for them because resident could not. Resident #14 made the decision to be Full Code. They only had a conversation about code status one time. Additional Interviews: During an interview on 02/03/2026 at 12:58 PM, Licensed Practical Nurse #6 stated if they found a resident unresponsive; they would call for help, check the resident's pulse, and start sternal rub. They stated code status was in the electronic medical record, but they would assign looking up code status to appropriate staff responding to code. During an interview on 02/03/2026 at 11:45 AM, Licensed Practical Nurse #4 stated if they saw an unresponsive resident, they would first check the Medical Orders for Life Sustaining Treatment on the unit. If it was not in the binder, the resident would be full code. Code information and Medical Orders for Life Sustaining Treatment should also be the same in the electronic medical records and the physical form. They stated the electronic medical records sometimes did not match the Medical Orders for Life Sustaining Treatment. They stated the Medical Orders for Life Sustaining Treatment were most accurate because they were signed by the provider. If code status for the resident was not present in the electronic medical records or the Medical Orders for Life Sustaining Treatment orders were not present on the unit, the resident would be considered a Full code. They were unsure if there was a policy for advanced directives or code status. They stated there were no annual in-services on policy updates. During a subsequent interview on 02/03/2026 at 2:45 PM, Nurse Practitioner #1 stated they signed the code status orders electronically, trusting that it was entered correctly into the electronic medical record when they signed the orders. During an interview on 02/04/2026 at 1:20 PM, Medical Director #1 stated the facility had a lot of staff turnover. They stated this was an issue in 2025, which had been addressed at that time. Medical Director #1 stated with staff leaving and new staff starting, it appeared to be a problem again. They further stated going forward they would make sure this (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	would not happen again. During an interview 02/04/2026 at 2:07 PM, Administrator #1 stated the facility policy is to treat residents as full code when no advanced directive is in place. Administrator #1 stated that code status orders were matched to the Medical Orders for Life-Sustaining Treatment form when orders are entered into the electronic medical record. Moving forward, they would have a discussion with the Nurse Practitioner regarding the signing of orders without proper verification. Administrator #1 stated a registered nurse who began this role last week, was hired for admissions including admission assessments, initiating care plan, and Medical Orders for Life Sustaining Treatment form. Administrator #1also stated that additional registered nurses were available to provide coverage when the admissions registered nurse is off duty. Immediate Jeopardy was issued to the Assistant Administrator on 02/05/2026 at 5:15 PM. Facility Immediacy Removal Plan submitted on 02/05/2026 at 8:50 PM was approved. Immediate Jeopardy was lifted effective 02/06/2026 at 2:42 PM. The facility's immediacy removal actions included the following: On 02/05/2026 the admission Nurse was educated by the Administrator on their responsibilities to educate all residents/representees on admission/re-admission of their right to formulate advanced directives and ensuring a corresponding physician's order or code status and/or a Medical Order for Life sustaining Treatment form are entered into the resident's medical record.On 02/02/2026 and 02/03/2026, a facility-wide audit of each current resident was conducted by the facility management team to ensure that residents had physician orders for code statue and/or a Medical Order for Life Sustaining Treatment.All Residents without a Medical Order for Life Sustaining Treatment had advanced directives discussed with them or their representee by nursing staff.Corresponding Medical Order for Life Sustaining Treatment forms and physician's orders for advanced directives were entered into the electronic medical record by the unit manager and approved by the Nurse Practitioner. On 02/02/2026, the Administrator and Assistant Administrator reviewed the facility policy and Advanced Directives, and no revisions were made.On 02/05/2026, the facility initiated mandatory education to the Nurse Practitioner, all registered nurses, and a licensed practical nurse on the facility policy relating to educating all residents/representees on admission of their right to formulate advanced directives and ensuring a corresponding physician's order or code status and/or a Medical Order for Life sustaining Treatment form are entered into the resident's medical record.Education would be conducted verbally, either in person or by telephone, by the Nursing Supervisor and/or designee. Education was started on 02/05/2026 and 90% of facility staff would be educated by 02/05/2026 at 11:00 PM.Facility staff that had not been reached by telephone would not be permitted to work until they received the education.As of 02/06/2026, 95% of facility staff were educated. As of 02/06/2026, all current residents (77) had a corresponding physician's order or code status and/or a Medical Order for Life sustaining Treatment form entered into their medical record. 10 New York Codes, Rules, and Regulations 415.12(h)(1)(2)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews during a recertification and abbreviated survey (Case #s 598982 and 2586123), the facility did not ensure the resident representative was notified when there was a significant change in the resident's physical, mental, or psychosocial status for two (2) (Resident #'s 52 and 75) of two (2) residents reviewed. Specifically, (a.) for Resident #52, the resident's representative was not notified of a self-reported fall with injury on 8/05/2025; (b.) for Resident #75, the resident's representative was not notified of a resident-to-resident verbal/physical altercation on 6/22/2025, during the night shift. This is evidenced by: Cross-referenced to F609: Reporting of Alleged Violations The Policy and Procedure titled, Change in a Resident Condition or Status, revised 12/2019, documented the facility would promptly notify the representative of changes in the resident's medical/mental condition and/or status. Licensed nursing staff, which included either the nurse/unit manager/nursing supervisor/charge nurse or director/assistant of nurses, would notify the resident's family or representative when the resident was involved in any accident or incident and when there was a significant change in the resident's physical, mental, or psychosocial status. Resident #52: Resident #52 was admitted to the facility with diagnoses of hematuria (blood in the urine), overactive bladder (sudden, uncontrollable urge to urinate), and difficulty walking. The Minimum Data Set (an assessment tool) dated 11/30/2025, documented the resident had moderate cognitive impairment. The resident was able to make themselves understood and understand others. Nursing Progress Note dated 8/05/2025 at 2:41 PM, documented Resident #52 self-reported a fall on 8/05/2025 to their Certified Nurse Aide, who then told the writer. Writer then told the Nurse Practitioner and the resident was assessed. Resident had a skin tear on top of right hand. There was no documented evidence in Nursing Progress Notes that Resident #52's representative was notified of the self-reported fall with injury on 8/5/2025. During an interview on 2/19/2026 at 1:49 PM, Assistant Administrator #1 stated there was no documentation in Progress Notes that Resident #52's family was notified of the fall on 8/5/2025. Resident #75: Resident #75 was admitted to the facility with diagnoses of noninfective gastroenteritis (inflammation that spreads from the stomach into the intestines and cause, pain, vomiting, and diarrhea) and colitis (inflammation of the large intestine), chronic idiopathic constipation (functional bowel disorder characterized by difficult, infrequent and/or incomplete defecation) and slow transit constipation (slow movement of waste through the digestive system). The Minimum Data Set, dated [DATE], documented the resident had moderate cognitive impairment. The resident was able to make themselves understood and understand others. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rosewood Rehabilitation and Nursing Center	284 Troy Road Rensselaer, NY 12144

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Grievance Form dated 6/28/2025, documented Family Member #4 reported a grievance. The name/signature of the staff member who received the grievance was not documented, it was blank. Description of complaint/grievance documented the grievance was filed because Resident #34 entered Resident #75's room on Sunday night, 6/22/2025 to 6/23/2025 and harassed and assaulted Resident #75 with their water bottle. Resident #75 did not feel safe that Resident #34 still resided on the same floor as them. Resident #75 told Family Member #4 they felt shaky and scared every time they saw Resident #34. They respectfully requested that Resident #34 be moved to the first-floor unit. Additionally, the form documented: To ensure abuse and neglect were ruled out promptly, did grievance require further investigation? The answer was not documented, it was blank. Investigation/Follow-up to Complaint/Grievance was not documented, it was blank. Resident/Family Follow-Up: o It was documented that the person filing the complaint/grievance was notified of actions taken and they were satisfied. An undated note by Licensed Practical Nurse Manager #2 documented a meeting was held with family and appropriate staff members. Residents had been kept in separate areas, as requested by the family. No further incidents occurred, no concerns voiced, and Resident #75 was observed to be free of anxiety due to the interaction. There was no documented evidence in Nursing Progress Notes that Resident #75's representative was notified of the resident-to-resident verbal/physical altercation with Resident #34 on 6/22/2025, during the night shift. During an interview on 2/13/2026 at 3:28 PM, Family Member #4 was with Resident #75 in the dining room. Family Member #4 stated they usually only visited Resident #75 on the weekend. They stated that in June 2025, Resident #75 was calling out for help after Resident #34 had entered their room around 2:00 AM and yelled at Resident #75 and then dumped water from the resident's tall refillable water bottle onto Resident #75. No staff came to help, and Resident #75 called 911. The 911 dispatcher called the facility and staff entered Resident #75's room. They stated no one from the facility reported the incident to them. Family Member #4 stated they learned about the incident from Resident #75 when they came into the facility to address an issue with the resident's phone charger. They stated Resident #75 was still scared when they told Family Member #4 about the incident. Resident #75 acknowledged they were afraid when the incident occurred. During an interview on 2/25/2026 at 9:55 AM, Medical Director #1 stated the family should be notified when there was a resident-to-resident altercation because the family needs to be aware of what goes on. During an interview on 2/25/2026 at 10:17 AM, Director of Nursing #1 stated the family was to be notified when there was a resident-to-resident altercation. During an interview on 2/25/2026 at 11:05 AM Administrator #1 stated they would expect the health care proxy to be notified when there was a change in a resident's status. They stated Family Member #4 was not the health care proxy. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10 New York Code of Rules and Regulations 415.3(e)(2)(ii)(a)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews during a survey, the facility did not ensure the resident's right to be free from abuse and neglect for two (2) (Resident #'s75 and 87) of nine (9) residents reviewed. Specifically, (a.) Resident #75 was not free from abuse on 6/22/2025, during the night shift when Resident #34 entered their room, verbally harassed them and then poured water from their water bottle onto them. No staff responded to Resident #75 when they yelled out for help and Resident #75 called 911; (b.) Resident #87 was not free from neglect when the resident fell on 1/13/2026 and it was not reported to the registered nurse. As a result, the oncoming licensed practical nurse was not informed of the fall. When the family member called the facility in response to the resident's concern for refracture of their hip, the licensed practical nurse told the family member the resident did not fall and was lying. The family member called 911 and the resident was taken to the hospital. This is evidenced by: Cross-referenced to F609: Reporting of Alleged Violations Cross-referenced to F610: Investigate/Prevent/Correct Alleged Violation The undated Policy and Procedure titled, Cleaning Reporting Resident Abuse, Mistreatment, Neglect or Misappropriation of Property, documented abuse was inappropriate physical contact with a resident of a residential health care facility, while the resident was under the supervision of the facility, which harms or was likely to harm the resident. Mental abuse included harassment. Neglect was the failure to provide timely, consistent, safe, adequate, and appropriate services, treatment and/or care to a resident of a residential health care facility, while the resident was under the supervision of the facility. Failure to follow the plan of care was considered an incident of neglect. Resident #34: Resident #34 was admitted to the facility with diagnoses of dementia with other behavioral disturbance, parkinsonism (umbrella term that refers to brain conditions that cause slowed movements, rigidity (stiffness) and tremors (looks like trembling or shakiness), and seizures (sudden burst of electrical activity in the brain that causes changes in behavior, movements, feelings and levels of consciousness). The Minimum Data Set (an assessment tool) dated 12/25/2025, documented the resident had severe cognitive impairment. The resident was able to make themselves understood and understand others. Review of Resident #34's comprehensive care plan did not have documented evidence of a care plan with interventions for abuse and neglect. Resident #75: Resident #75 was admitted to the facility with diagnoses of noninfective gastroenteritis (inflammation that spreads from the stomach into the intestines and cause, pain, vomiting, and diarrhea) and colitis (inflammation of the large intestine), chronic idiopathic constipation (functional bowel disorder characterized by difficult, infrequent and/or incomplete defecation) and slow transit constipation (slow movement of waste through the digestive system). The Minimum Data Set, dated [DATE], (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented the resident had moderate cognitive impairment. The resident was able to make themselves understood and understand others. Review of Resident #75's comprehensive care plan did not include a care plan with interventions for abuse and neglect. Grievance Form dated 6/28/2025, documented Family Member #4 reported a grievance. The name/signature of the staff member who received the grievance was not documented, it was blank. Description of complaint/grievance documented the grievance was filed because Resident #34 entered Resident #75's room on Sunday night, 6/22/2025 to 6/23/2025 and harassed and assaulted Resident #75 with their water bottle. Resident #75 did not feel safe that Resident #34 still resided on the same floor as them. Resident #75 told Family Member #4 they felt shaky and scared every time they saw Resident #34. They respectfully requested that Resident #34 be moved to the first-floor unit. Additionally, the form documented: To ensure abuse and neglect were ruled out promptly, did grievance require further investigation? The answer was not documented, it was blank. Investigation/Follow-up to Complaint/Grievance was not documented, it was blank. Resident/Family Follow-Up: o It was documented that the person filing the complaint/grievance was notified of actions taken and they were satisfied. An undated note by Licensed Practical Nurse Manager #2 documented a meeting was held with family and appropriate staff members. Residents had been kept in separate areas, as requested by the family. No further incidents occurred, no concerns voiced, and Resident #75 was observed to be free of anxiety due to the interaction. Review of Nursing Progress Notes dated June 2025, did not have documented evidence of notes about a resident-to-resident altercation or assessment following the incident for Resident #s 75 and 34. The Comprehensive Care Plan for Resident #s 75 and 34 did not have document interventions to prevent recurrence of abuse. The facility could not provide evidence of a documented investigation of the incident dated 6/22/2025, during the night shift and there was no documented evidence that the incident was reported to the New York State Department of Health. During an interview on 2/13/2026 at 3:28 PM, Family Member #4 was with Resident #75 in the dining room. Family Member #4 stated they usually only visited Resident #75 on the weekend. They stated that in June 2025, Resident #75 was calling out for help after Resident #34 had entered their room around 2:00 AM and yelled at Resident #75 and then dumped water from the resident's tall refillable water bottle onto Resident #75. No staff came to help, and Resident #75 called 911. The 911 dispatcher called the facility and staff entered Resident #75's room. They stated no one from the facility reported the incident to them. Family Member #4 stated they learned about the incident from Resident #75 when they came into the facility to address an issue with the resident's phone charger. They stated Resident #75 was still scared when they told Family Member #4 about the incident. Resident #75 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	acknowledged they were afraid when the incident occurred. During an interview on 2/19/2026 at 11:51 AM, Licensed Practical Nurse Manager #2, stated they were not notified of an altercation between Resident #34 and 75 until they were brought into a meeting with the social worker, former administrator, former director of nursing, and resident's son and daughter, after a grievance was filed about the incident. They stated the resident's daughter was very nervous for Resident #75 because the resident was very nervous. Licensed Practical Nurse Manager #2 did not know if the incident was reported to the New York Department of Health. They were not involved in any notification, investigation, or care planning for the incident. They did not investigate the incident and did not ask any staff on the unit about the incident. After the meeting with the family, they put a stop sign across Resident #75's door and entered an order to locate Resident #34 every 2 hours. During an interview on 2/19/2026 at 2:17 PM, Assistant Administrator #1 stated they were not notified of an incident between Resident #s 34 and 75. They were unable to locate an incident report or investigation but found a grievance report in the former administrator's grievance binder, made by Resident #75's family member. There should have been an assessment of both residents to ensure there was no harm, and they were content. During an interview on 2/25/2026 at 9:42 AM, Medical Director #1 stated resident-to-resident altercations were a common occurrence in most facilities and were not always made aware. During an interview on 2/25/2026 at 10:17 AM, Director of Nursing #1 stated they were not working in the facility when the alleged resident-to-resident altercation occurred. They would have expected staff to respond to Resident #75 when they were yelling for help. There was a flashing light above the nurse station that indicated movement down the hall, where Resident #75 resided and staff should have responded accordingly. During an interview on 2/25/2026 at 11:05 AM, Administrator #1 stated they were not the administrator when the alleged altercation between Resident #s 34 and 75 occurred and was not made aware of it. The facility's responsibility was to ensure safety and health for all residents. Resident #87: Resident #87 was admitted to the facility with diagnoses of unspecified fracture of head of left femur (a break in the ball-shaped upper end of the left thighbone where it connects to the hip socket), malignant neoplasm of cerebral meninges (a rare, aggressive, and cancerous tumor arising from the brain's protective membranes), and anxiety (mental health condition characterized by excessive fear or anxiety that interferes with daily activities). The Minimum Data Set, dated [DATE], documented the resident was independent with making decisions regarding tasks of daily living.? An Incident and Accident form, dated 1/13/2026, documented that Resident #87 was found on the floor during rounds and stated that they had fallen while trying to close their door. The immediate action taken was that the licensed nurse assessed Resident #87 immediately, the resident was able to move all extremities without difficulties, vital signs were stable, the resident denied any pain or hitting their head during the fall and the family was notified. Nursing Progress Note dated 1/14/2026 at 7:12 AM by Licensed Practical Nurse #12, documented the resident stated they fell and refractured their hip. The resident had been in bed all shift. The (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident called their family to go to the hospital. The family called 911 to take them out to the hospital around 7:10 AM. A Provider Note signed 1/15/2026 at 12:29 PM by Nurse Practitioner #1, documented on 1/13/2026 evening shift, nursing staff reported the resident experienced a fall while attempting to close a door. At the time of the incident, nursing assessment indicated no apparent injury. The resident denied head strike, denied pain, and no acute complaints were reported. Vital signs were obtained and remained stable. No immediate transfer was deemed necessary based on clinical assessment. On the morning of 1/14/2026, the resident and family independently contacted emergency services, stating concern that the resident had re-fractured their hip and required hospital evaluation. The resident was transferred to the emergency department via emergency medical services. The on-call provider was not notified prior to the transfer. This incident had been reviewed for communication processes and escalation protocols. Education and reinforcement of provider notification requirements were indicated to ensure timely clinical assessment and appropriate decision-making in future similar situations. During an interview on 2/12/2026 at 3:53 PM, Ombudsman #1 stated that there was inconsistency with quality of care. During an interview on 2/18/2026 at 1:36 PM, Family Member #5 stated they received multiple calls from Resident #87 stating that no one was attending them, and then eventually received a call from the resident stating they had fallen and laid on the floor for an hour before being put back into bed. Family Member #5 stated that they called the nurses station, and an unnamed staff member told them that Resident #87 was lying and hung up on Family Member #5. Family Member #5 stated that when they called Resident #87 back, Resident #87 stated that staff had come into the room and yelled at them for calling their family and lying about falling. Family Member #5 stated they called 911 to have Resident #87 taken to the emergency room to be evaluated. Family Member #5 stated that Resident #87 still had nightmares regarding their experience at the facility. During an interview on 2/19/2026 at 4:43 PM, Licensed Practical Nurse #12 stated that Resident #87 did not fall on their shift. They stated Licensed Practical Nurse #14 took care of Resident #87 on the 3:00 PM to 11:00 PM shift when their fall occurred and did not tell Licensed Practical Nurse #12 the resident had fallen when Resident #87 was moved to their assignment at 11:00 PM. The Certified Nurse Aides that were working at the time stated to Licensed Practical Nurse #12 that Resident #87 had fallen but did not say that the resident actually fell. In the morning, when Family Member #5 called and said Resident #87 fell, Licensed Practical Nurse #12 did not know what they were talking about, because they were not informed of the fall. On 2/24/2026 at 11:49AM and 4:30 PM, attempts were made to contact Licensed Practical Nurse #14 but were unsuccessful and there was no option to leave a message. During an interview on 2/25/2026 at 9:29 AM, Medical Director #1 stated that when something out of the ordinary occurred, they would usually get a call from the Nurse Practitioner for clarification. There was no documented evidence that Medical Director #1 was aware of Resident #87's experience. During an interview on 2/25/2026 at 11:04 AM, Director of Nursing #1 stated that if a resident fell, they would want a thorough investigation and explanation of what happened. The Licensed Practical Nurse should start the Incident and Accident Report, the event should be documented in the electronic health record, and the family would be notified. Ideally, it would be reviewed in morning report. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During subsequent interview on 2/25/2026 at 12:25 PM, Administrator #1 stated that they were aware that there were issues surrounding documentation and that staff needed to be educated on the processes regarding what to do for adverse events, reporting them appropriately, and closing the loop after things happened. New York Code of Rules and Regulations 415.4(b)(1)(i)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews during a survey, the facility did not ensure that all alleged violations involving abuse, neglect, and injuries of unknown source were reported immediately, but not later than 2 hours after the allegation was made, if the events that cause the allegation involved abuse or resulted in serious bodily injury, or not later than 24 hours if the events that cause the allegation did not involve abuse and did not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency) for five (5) (Resident #s 75, 34, 43, 54, and 90) of nine (9) residents reviewed. Specifically, (a.) for Resident #s 75 and 34, the facility did not ensure the administrator was notified of a resident-to-resident verbal/physical altercation that included a call to 911 by Resident #75 on 6/22/2025, during the night shift. On 6/28/2025, Resident #75 told their family member about the incident, who then filed a facility complaint/grievance. The incident was not reported to the New York State Department of Health; (b.) Resident #43 reported an allegation of abuse by a Certified Nurse Aide on 2/18/2026 at 9:43 PM. The incident was not reported to the administrator within two (2) hours and was not reported to the New York State Department of Health until 2/19/2026 at 9:30 PM; (c.) Resident #54 had an unwitnessed fall on 2/19/2026 and was admitted with a hip fracture (break in upper thigh). The injury was not reported to the New York State Department of Health; and (d.) On 1/05/2026, Resident #90, was noted to have a left hip fracture with an unknown source. The injury was not reported to the New York State Department of Health. This is evidenced by: Cross-referenced to F600: Free from Abuse and Neglect Cross-referenced to F610: Investigate/Prevent/Correct Alleged Violation The undated Policy and Procedure titled, Cleaning Reporting Resident Abuse, Mistreatment, Neglect or Misappropriation of Property, documented staff were to immediately call the New York State Department of Health toll-free hotline if they witnessed or suspected abuse, mistreatment, neglect, exploitation, or misappropriation of resident property. Immediately report the incident to the nursing supervisor, director of nursing, or the administrator, who would begin the investigation. The facility would report the alleged abuse to the Department of Health in addition to the staff member. Immediate action would be taken to ensure the resident received any needed care/services and to prevent further potential abuse while the incident was under investigation. All cases were thoroughly investigated by the facility. The director of nursing would coordinate the investigation unless otherwise directed by the administrator. Whenever there was a reasonable cause to believe resident physical abuse, mistreatment, neglect, or appropriation of property had occurred by staff, or a family member, the suspecting staff member would call the New York State Department of Health: All alleged violations and injuries of unknown source were to be reported immediately, but not later than two (2) hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury. Not later than 24 hours if the allegation did not involve abuse and did not result and did not result in serious bodily injury, to the administrator of the facility and to other officials (i.e. State Survey Agency and adult protective services). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Registered nurse assessment would be completed. A psychosocial assessment would be completed to identify any potential psychosocial harm. Any staff member accused of abusing, mistreating, neglecting a resident or misappropriating resident property would be immediately interviewed and then suspended from work until a thorough investigation was completed and a determination made. Resident #75: Resident #75 was admitted to the facility with diagnoses of noninfective gastroenteritis (inflammation that spreads from the stomach into the intestines and cause, pain, vomiting, and diarrhea) and colitis (inflammation of the large intestine), chronic idiopathic constipation (functional bowel disorder characterized by difficult, infrequent and/or incomplete defecation) and slow transit constipation (slow movement of waste through the digestive system). The Minimum Data Set (an assessment tool) dated 12/31/2025, documented the resident had moderate cognitive impairment. The resident was able to make themselves understood and understand others. Review of Resident #75's comprehensive care plan did not include a care plan with interventions for abuse and neglect. Resident #34: Resident #34 was admitted to the facility with diagnoses of dementia with other behavioral disturbance, parkinsonism (umbrella term that refers to brain conditions that cause slowed movements, rigidity (stiffness) and tremors (looks like trembling or shakiness), and seizures (sudden burst of electrical activity in the brain that causes changes in behavior, movements, feelings and levels of consciousness). The Minimum Data Set, dated [DATE], documented the resident had severe cognitive impairment. The resident was able to make themselves understood and understand others. Review of Resident #34's comprehensive care plan did not include a care plan with interventions for abuse and neglect. Grievance Form dated 6/28/2025, documented Family Member #4 reported a grievance. The name/signature of the staff member who received the grievance was not documented, it was blank. Description of complaint/grievance documented the grievance was filed because Resident #34 entered Resident #75's room on Sunday night, 6/22/2025 to 6/23/2025 and harassed and assaulted Resident #75 with their water bottle. Resident #75 did not feel safe that Resident #34 still resided on the same floor as them. Resident #75 told Family Member #4 they felt shaky and scared every time they saw Resident #34. They respectfully requested that Resident #34 be moved to the first-floor unit. Additionally, the form documented: To ensure abuse and neglect were ruled out promptly, did grievance require further investigation? The answer was not documented, it was blank. Investigation/Follow-up to Complaint/Grievance was not documented, it was blank. Resident/Family Follow-Up: o It was documented that the person filing the complaint/grievance was notified of actions taken and they were satisfied. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An undated note by Licensed Practical Nurse Manager #2 documented a meeting was held with family and appropriate staff members. Residents had been kept in separate areas, as requested by the family. No further incidents occurred, no concerns voiced, and Resident #75 was observed to be free of anxiety due to the interaction. Review of Nursing Progress Notes dated June 2025, did not have documented evidence of resident-to-resident altercation or assessment following the incident for Resident #s 75 and 34. The Comprehensive Care Plan for Resident #s 34 and 75 did not have documented evidence of interventions to prevent recurrence of abuse. The facility could not provide documented evidence of an investigation of the incident dated 6/22/2025, during the night shift, and there was no documented evidence that the incident was reported to the New York State Department of Health. During an interview on 2/13/2026 at 3:28 PM, Family Member #4 was with Resident #75 in the dining room. Family Member #4 stated they usually only visited Resident #75 on the weekend. They stated that in June 2025, Resident #75 was calling out for help after Resident #34 had entered their room around 2:00 AM and yelled at Resident #75 and then dumped water from the resident's tall refillable water bottle onto Resident #75. No staff came to help, and Resident #75 called 911. The 911 dispatcher called the facility and staff entered Resident #75's room. They stated no one from the facility reported the incident to them. Family Member #4 stated they learned about the incident from Resident #75 when they came into the facility to address an issue with the resident's phone charger. They stated Resident #75 was still scared when they told Family Member #4 about the incident. Resident #75 acknowledged they were afraid when the incident occurred. During an interview on 2/19/2026 at 11:51 AM, Licensed Practical Nurse Manager #2, stated they were not notified of an altercation between Resident #'s 34 and 75 until they were brought into a meeting with the social worker, former administrator, former director of nursing, and resident's son and daughter, after a grievance was filed about the incident. They stated the resident's daughter was very nervous for Resident #75 because the resident was very nervous. Licensed Practical Nurse Manager #2 stated they did not know if the incident was reported to the New York Department of Health. They were not involved in any notification, investigation, or care planning for the incident. They did not investigate the incident and did not ask any staff on the unit about the incident. After the meeting with the family, they put a stop sign across Resident #75's door and entered an order to locate Resident #34 every 2 hours. During an interview on 2/19/2026 at 2:17 PM, Assistant Administrator #1 stated they were not notified of an incident between Resident #s 34 and 75. They were unable to locate an incident report or investigation but found a grievance report in the former administrator's grievance binder, made by Resident #75's family member. The incident was reportable to the New York State Department of Health, and the administrator should have been notified at the time of the incident. There should have been a full investigation that included interviews from both residents, staff, and family members. There should have been an assessment of both residents to ensure there was no harm, and they were content. During an interview on 2/25/2026 at 9:42 AM, Medical Director #1 stated resident-to-resident altercations were a common occurrence in most facilities and were not always made aware. There were times when they reviewed and signed off on incident and accident reports. They stated they were not always notified of incidents/accidents that were reportable to the New York State Department of Health. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rosewood Rehabilitation and Nursing Center	284 Troy Road Rensselaer, NY 12144

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	They would expect the facility to conduct an investigation of all incidents/accidents. During an interview on 2/25/2026 at 10:17 AM, Director of Nursing #1 stated they were not working in the facility when the alleged resident-to-resident altercation occurred. They would have expected staff to respond to Resident #75 when they were yelling for help. There was a flashing light above the nurse station that indicated movement down the hall, where Resident #75 resided and staff should have responded accordingly. The expectation was for staff to complete an incident/accident report and conduct a thorough investigation, especially since Resident #75 called 911. As director of nursing, they would expect a phone call from staff immediately following the incident and stated the administrator was to be notified within two (2) hours. Director of Nursing #1 stated the incident was reportable to the New York State Department of Health because Resident #75 stated they were afraid and were assaulted, because contact was made by Resident #34. The family should have been notified within (two) 2 hours of the incident. During an interview on 2/25/2026 at 11:05 AM, Administrator #1 stated they were not the administrator when the alleged altercation between Resident #s 34 and 75 occurred and was not made aware of it. They stated they would expect immediate reporting of a resident-to-resident altercation to the director of nursing and administrator, and a thorough investigation. They stated they could not fix something they did not know about. If they were doing the investigation, they would have asked the unit manager about the incident. The facility's responsibility was to ensure safety and health for all residents. Resident-to resident altercations were reportable to the New York State Department of Health. Resident #90 Resident #90 was admitted to the facility with diagnoses of dementia (a group of conditions that cause a progressive decline in cognitive abilities), peripheral vascular disease (a condition that affects the blood vessels outside of the heart), and chronic kidney disease (long-term irreversible loss of kidney function). The Minimum Data Set, dated [DATE], documented the resident had severe cognitive impairment, could be understood, and could understand others. Nursing Progress Note dated 1/01/2026 at 12:46 AM by Licensed Practical Nurse #13, documented Resident #90 was found on the floor in their bathroom. Resident #90 had a laceration to the back of their scalp and bilateral arms. The resident was coherent and at baseline. The Nurse Practitioner and the resident's family were notified. Nursing Progress Note dated 1/01/2026 at 11:01 AM by Licensed Practical Nurse #10, documented Resident #90 was found on the floor in between the bathroom door. There was bleeding noted from the back of Resident #90's head. The Nurse Practitioner was notified and ordered Resident #90 be sent to the hospital. Provider Note dated 1/02/2026 at 12:00 AM by Nurse Practitioner #1, documented chief complaint: emergency room return status post fall with head laceration. Resident #90 had a fall with positive head strike. On assessment, a laceration was noted to the posterior scalp. The area was cleansed with normal saline. No closure was required. Later, on 1/02/2026, the provider received a call from nursing reporting Resident #90 had a second fall with positive head strike. The resident sustained a larger scalp laceration with active bleeding that required closure. The resident was sent to the emergency department for evaluation and management. Resident #90 returned from the hospital with staples intact to the scalp and new orders for bacitracin (topical antibiotic ointment). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Nursing Progress Note dated 1/05/2026 at 8:23 PM by Licensed Practical Nurse #13, documented Resident #90 had an x-ray completed of their bilateral hips. The x-ray showed fracture of the left hip (broken hip). The Nurse Practitioner was notified and advised the resident go to the hospital. Provider Note dated 1/05/2026 at 12:00 AM by Nurse Practitioner #1, documented Resident #90 was evaluated following reports of acute hip pain and functional decline after suspected injury. Resident reported significant pain with movement and inability to bear weight on the affected extremity. There was no report of additional trauma. Resident was being transferred from the facility to the hospital for acute evaluation of left hip pain and inability to bear weight following suspected injury. It further documented imaging was obtained and demonstrated an acute complete intertrochanteric femoral fracture with mild displacement (hip fracture). Signed by Nurse Practitioner #1 on 1/06/2026 at 10:01 AM. Nursing Progress Note dated 1/19/2026 at 10:05 PM, written by Licensed Practical Nurse #8, documented Resident #90 returned from the hospital via stretcher around 3:00 PM. Resident #90 had a fracture of the left femur and was covered with a dressing. Will monitor. Nursing Progress Note dated 1/20/2026 at 6:40 AM by Licensed Practical Nurse #5, documented Resident was a readmission to the facility with a diagnosis of left femur fracture status post-surgical procedure. The resident slept peacefully most of the shift. It further documented, when Licensed Practical Nurse #5 and a Certified Nurse Aide would reposition or provide care, Resident #90 would moan out when moved. When Resident #90 was asked if they were in pain, they did not respond. During an interview on 2/20/2026 at 10:43 AM, Licensed Practical Nurse #2 stated Resident #90 was a frequent faller. They stated Resident #90 ambulated with a walker. Licensed Practical Nurse #2 stated on 1/01/2026 Resident #90 had 2 unwitnessed falls and was sent to the hospital after the second fall because of a laceration. They stated the resident returned from the hospital on 1/01/2026 but was more confused. They stated Resident #90 was still able to ambulate with their walker. Licensed Practical Nurse #2 stated Resident #90 was fine during dinner on 1/04/2026 and then when they returned to work on the 1/05/2026, they were informed of the resident's increased pain. They stated an x-ray was done and the resident was sent out for surgery. Licensed Practical Nurse #2 stated they did not know if anything was reported about the fall, but something would have had to happen to cause the pain or change in Resident #90's condition. They further stated in their opinion Resident #90 had a fall which led to the fracture. Licensed Practical Nurse #2 stated Resident #90's fracture led to their overall decline. They stated the resident was not the same after surgery, they could no longer ambulate and used a geriatric chair. During an interview on 2/20/2026 at 12:14 PM, Acting Director of Nursing #1 stated if a resident had an injury of unknown origin, they would report it to the Director of Nursing, Administrator, Nurse Practitioner, and the Department of Health. They stated they were not familiar with Resident #90 or their fracture. During an interview on 2/20/2026 at 2:24 PM, Certified Nurse Aide #6 stated that before Resident #90 was hospitalized for the fracture, the resident was up, walking with a walker, putting on their own clothes, and would come down to socialize at the desk. They stated after Resident #90 returned from the hospital following their fracture, they did not want to eat, they could no longer stand or walk, and they did not know what was going on. They stated the resident changed a lot. An attempt to call Licensed Practical Nurse #13 was made on 2/23/2026 at 2:00 PM with no return (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	call received. During a subsequent interview on 2/23/2026 at 2:24 PM, Nurse Practitioner #1 stated that on 1/05/2026, nursing reported pain in Resident #90's hip, so they did an x-ray which showed a hip fracture. Nurse Practitioner #1 stated it was their understanding at the time that there was no injury in between the hospitalizations. They stated the fracture could been a result of the falls on 1/01/2026. The hospital did not complete any x-rays or full body tests on 1/01/2026. They stated they were in the building when notified of the increased pain. Nurse Practitioner #1 stated they could not say whether the resident's fracture was something that should be reported to the Department of Health. They stated every member of the interdisciplinary team including the Director of Nursing and Administrator was notified via email when someone was sent to the hospital and that it was probably reviewed at morning report. During an interview on 2/24/2026 at 11:29 AM, Family Member #7 stated they were made aware of Resident #90's falls on 1/01/2026 and agreed that that resident be sent to the hospital. After Resident #90's hospital trip on 1/01/2026, they started acting like they had dementia. They were more confused. They further stated that when they went to visit, Resident #90 would not stand after their falls on 1/01/2026 and the resident complained that their leg hurt, and they massaged it. The resident did not indicate that they had pain in their hip. They stated the family felt bad that they did not pick up on it sooner, but Resident #90 was so confused. Family Member #7 stated they did not think that any kind of abuse or neglect occurred. During an interview on 2/25/2026 at 9:29 AM, Medical Director #1 stated they were made aware of falls, skin tears, etc. through Incident and Accident Reports. It was their responsibility to sign off on them. They stated falls were one of the biggest issues that they faced in long-term care. They stated they would expect the facility to complete an investigation for an injury of unknown origin, and it should be reported to the Department of Health. During an interview on 2/25/2026 at 11:04 AM, Director of Nursing #1 stated an injury of unknown origin should be reported within two (2) hours to the Department of Health, and the Director of Nursing or Administrator was responsible for reporting. They stated they would then complete an investigation for an injury of unknown origin. During an interview on 2/25/2026 at 12:25 PM, Administrator #1 stated they reported anything in the regulations that needed to be reported to the Department of Health. They stated it was a team effort on what should be reported. They stated some things such as abuse should be reported to the Department of Health within two (2) hours. Administrator #1 further stated they would report an injury of unknown origin to the Department of Health. 10 New York Code of Rules and Regulations 415.4(b)(2)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Respond appropriately to all alleged violations. Based on observation, record review, and interviews during a survey, the facility did notensure in response to allegations of abuse/neglect they had evidence that all alleged violations were thoroughly investigated; they prevented further potential abuse/neglect while the investigation was in progress; and reported the results of all investigations to the administrator or their designated representative and to the State Survey Agency, within five (5) working days of the incident, and if the alleged violation was verified appropriate corrective action must be taken for six (6) (Resident #s 34, 43, 54, 75, 87, and 90) of 9 residents reviewed. Specifically, (a.) for Resident #s 75 and 34, the facility did not have documented evidence of an investigation of a resident-to-resident verbal/physical altercation on 6/22/2025, during the night shift; (b.) for Resident #43, the facility did not initiate an immediate investigation and prevention of further potential abuse when the resident reported they were hurt by a Certified Nurse Aide on 2/18/2026. As a result, the facility did not identify the accused staff member at the time of the report and the staff member continued to provide care to the residents; (c.) for Resident 54, the facility did not have evidence of a thorough investigation for documented falls dated 3/07/2025, 3/16/2025, 5/02/2025, 5/05/2025, 9/25/2025, 12/29/2025, and an injury of unknown origin dated 3/18/2025; (d.) for Resident #87, the facility did not have documented evidence of a thorough investigation of an unwitnessed fall dated 1/13/2026; (e.) for Resident #90, the facility did not have documented evidence of a thorough investigation for two (2) unwitnessed falls on 1/01/2026 and an injury of unknown source identified on 1/05/2026.This is evidenced by: Cross-referenced to F600: Free from Abuse and Neglect Cross-referenced to F609: Reporting of Alleged Violations The undated Policy and Procedure titled, Cleaning Reporting Resident Abuse, Mistreatment, Neglect or Misappropriation of Property, documented staff were to immediately call the New York State Department of Health toll-free hotline if they witnessed or suspected abuse, mistreatment, neglect, exploitation, or misappropriation of resident property. Immediately report the incident to the nursing supervisor, director of nursing, or the administrator, who would begin the investigation. The facility would report the alleged abuse to the Department of Health in addition to the staff member. Immediate action would be taken to ensure the resident received any needed care/services and to prevent further potential abuse while the incident was under investigation. All cases were thoroughly investigated by the facility. The director of nursing would coordinate the investigation unless otherwise directed by the administrator. Whenever there was a reasonable cause to believe resident physical abuse, mistreatment, neglect, or appropriation of property had occurred by staff, or a family member, the suspecting staff member would call the New York State Department of Health: All alleged violations and injuries of unknown source were to be reported immediately, but not later than two (2) hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury. Not later than 24 hours if the allegation did not involve abuse and did not result and did not result in serious bodily injury, to the administrator of the facility and to other officials (i.e. State Survey Agency and adult protective services). Registered nurse assessment would be completed. A psychosocial assessment would be completed to identify any potential psychosocial harm. Any staff member accused of abusing, mistreating, neglecting a resident or misappropriating resident property would be immediately interviewed and then suspended (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	from work until a thorough investigation was completed and a determination made. Resident #34: Review of Resident #34's comprehensive care plan did not include a care plan with interventions for abuse and neglect. Resident #75: Review of Resident #75's comprehensive care plan did not have documented evidence of a care plan with interventions for abuse and neglect. Grievance Form dated 6/28/2025, documented Family Member #4 reported a grievance. The name/signature of the staff member who received the grievance was not documented, it was blank. Description of complaint/grievance documented the grievance was filed because Resident #34 entered Resident #75's room on Sunday night, 6/22/2025 to 6/23/2025 and harassed and assaulted Resident #75 with their water bottle. Resident #75 did not feel safe that Resident #34 still resided on the same floor as them. Resident #75 told Family Member #4 they felt shaky and scared every time they saw Resident #34. They respectfully requested that Resident #34 be moved to the first-floor unit. Additionally, the form documented: To ensure abuse and neglect were ruled out promptly, did grievance require further investigation? The answer was not documented, it was blank. Investigation/Follow-up to Complaint/Grievance was not documented, it was blank. Resident/Family Follow-Up: o It was documented that the person filing the complaint/grievance was notified of actions taken and they were satisfied. An undated note by Licensed Practical Nurse Manager #2 document a meeting was held with family and appropriate staff members. Residents had been kept in separate areas, as requested by the family. No further incidents occurred, no concerns voiced, and Resident #75 was observed to be free of anxiety due to the interaction. The facility could not provide evidence of a documented investigation of the incident dated 6/22/2025, during the night shift and there was no documented evidence that the incident was reported to the New York State Department of Health. During an interview on 2/19/2026 at 11:51 AM, Licensed Practical Nurse Manager #2, stated they were not notified of an altercation between Resident #34 and 75 until they were brought into a meeting with the social worker, former administrator, former director of nursing, and resident's son and daughter, after a grievance was filed about the incident. They were not involved in any notification, investigation, or care planning for the incident. They did not investigate the incident and did not ask any staff on the unit about the incident. After the meeting with the family, they put a stop sign across Resident #75's door and entered an order to locate Resident #34 every 2 hours. During an interview on 2/19/2026 at 2:17 PM, Assistant Administrator #1 stated there should have (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	been a full investigation that included interviews from both residents, staff, and family members. During an interview on 2/25/2026 at 9:42 AM, Medical Director #1 stated they would expect the facility to conduct an investigation of all incidents/accidents. During an interview on 2/25/2026 at 10:17 AM, Director of Nursing #1 stated they were not working in the facility when the alleged resident-to-resident altercation occurred. The expectation was for staff to complete an incident/accident report and conduct a thorough investigation, especially since Resident #75 called 911. During an interview on 2/25/2026 at 11:05 AM, Administrator #1 stated they were not the administrator when the alleged altercation between Resident #s 34 and 75 occurred and was not made aware of it. They stated they would expect immediate reporting of a resident-to-resident altercation to the director of nursing and administrator, and a thorough investigation. They stated they could not fix something they did not know about. If they were doing the investigation, they would have asked the unit manager about the incident. The facility's responsibility was to ensure safety and health for all residents. Resident-to resident altercations were reportable to the New York State Department of Health. Resident #90 An Accident and Incident Report for Resident #90 dated 1/01/2026 at 12:15 AM initiated by Licensed Practical Nurse #13, documented Resident #90 had an unwitnessed fall in their bathroom. It further documented that the resident had lacerations to their scalp and their arms and that neuro checks were started. There was no documented evidence that a Registered Nurse assessment was completed for Resident #90 after their fall. Nursing Progress Note dated 1/01/2026 at 12:46 AM by Licensed Practical Nurse #13, documented Resident #90 was found on the floor in their bathroom. Resident #90 had a laceration to the back of their scalp and bilateral arms. The resident was coherent and at baseline. The Nurse Practitioner and the resident's family were notified. There was no documented evidence of a thorough investigation, including resident and staff statements following the fall. Nursing Progress Note dated 1/01/2026 at 11:01 AM, written by Licensed Practical Nurse #10, documented Resident #90 was found on the floor in between the bathroom door. There was bleeding noted from the back of Resident #90's head. The Nurse Practitioner was notified and ordered Resident #90 be sent to the hospital. A provider note dated 1/02/2026 at 12:00 AM, written by Nurse Practitioner #1, documented chief complaint: emergency room return status post fall with head laceration. Resident #90 had a fall with positive head strike. On assessment a laceration was noted to the posterior scalp. The area was cleansed with normal saline. No closure was required. Later, on 1/02/2026, the provider received a call from nursing reporting Resident #90 had a second fall with positive head strike. The resident sustained a larger scalp laceration with active bleeding that required closure. The resident was sent to the emergency department for evaluation and management. Resident #90 returned from the hospital with staples intact to the scalp and new orders for bacitracin (topical antibiotic ointment). The plan was to continue bacitracin to scalp laceration as ordered, monitor staples for signs of infection or (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	bleeding, continue neuro checks per protocol, maintain fall precautions and safety interventions, and continue urinary tract infection treatment as previously ordered. Signed by Nurse Practitioner #1 on 1/05/2026 at 9:40 AM. There was no documented evidence that an Accident and Incident Report was initiated or completed and/or an investigation was started for Resident #90's second fall on 1/01/2026 which resulted in a positive head strike, larger scalp laceration with active bleeding, and required treatment at the hospital. A provider note dated 1/05/2026 at 12:00 AM, written by Nurse Practitioner #1, documented Resident #90 was evaluated following reports of acute hip pain and functional decline after suspected injury. Resident reported significant pain with movement and inability to bear weight on the affected extremity. There was no report of additional trauma. Resident was being transferred from the facility to the hospital for acute evaluation of left hip pain and inability to bear weight following suspected injury. It further documented imaging was obtained and demonstrated an acute complete intertrochanteric femoral fracture with mild displacement and (hip fracture). Signed by Nurse Practitioner #1 on 1/06/2026 at 10:01 AM. There was no documented evidence that an investigation or an Accident and Incident Report was initiated after Resident #90 was found to have a hip fracture to rule out possible abuse or neglect. During an interview on 2/20/2026 at 10:34 AM, Licensed Practical Nurse #2 stated they would start the incident and accident report, get statements, and then pass it along to the Director of Nursing. They stated Incident and Accident Reports were reviewed at morning report with the interdisciplinary team and then updates would be made to the resident's care plan by the Registered Nurse. They further stated this process was not happening like it should have been due to staff turnover and vacant positions. They stated an Incident and Accident Report should have been completed for Resident #90's fracture on 1/05/2026. During an interview on 2/20/2026 at 12:14 PM, Acting Director of Nursing #1 stated they had no involvement with completing Incident and Accident Reports and was not sure how they were completed at the facility. They were not sure if Licensed Practical Nurse's started Incident and Accident Reports. Acting Director of Nursing #1 stated the facility should complete an Accident and Incident Report for an injury of unknown origin as it should be investigated. During an interview on 2/23/2026 at 2:24 PM, Nurse Practitioner #1 stated nursing would handle Incident and Accident Reports and they did not have involvement with the reports. They stated their impression was that Resident #90's fracture would need an Incident and Accident Report. They stated that usually an Incident and Accident Report was completed for everything like a skin tear or bruise. They further stated they would think the facility needed to complete an Incident and Accident Report for an injury of unknown source. During an interview on 2/25/2026 at 9:29 AM, Medical Director #1 stated they were made aware of falls, skin tears, etc. through Incident and Accident Reports. It was their responsibility to sign off on them. They stated falls were one of the biggest issues that were faced in long-term care. Medical Director #1 further stated they had not seen or signed any Incident or Accident Reports in the past few months. They stated they would expect the facility to complete an investigation for an injury of unknown origin, and it should be reported to the Department of Health. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 2/25/2026 at 11:04 AM, Director of Nursing #1 stated they would complete an investigation for an injury of unknown origin. If there was a fall they would want to know where on the floor was the resident found, what footwear were they wearing, they would want a roommate interview, want to know what the resident said, statements from staff about what the resident was like before the fall. Director of Nursing #1 stated a Licensed Practical Nurse could start an Incident and Accident Report and that a video call was okay if necessary for a Registered Nurse assessment. They stated an incident or accident should be documented in both the electronic medical record and on the Incident and Accident Report form. They stated the Registered Nurse should write a note of their assessment, whether in the facility or offsite. The interdisciplinary team would complete Incident and Accident Reports together. The reports were reviewed during morning report. During an interview on 2/25/2026 at 12:25 PM, Administrator #1 stated the Director of Nursing was responsible for making sure Incident and Accident Reports were completed for injuries of unknown origin. They stated they had to follow the regulations. 10 New York Code of Rules and Regulations 415.4(b)(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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews conducted during a survey, the facility did not ensure that comprehensive care plans were developed and implemented for residents according to professional standards for eight (8) (Resident #'s 2, 9, 11, 14, 34, 43,75 and 86) of 22 residents reviewed. Specifically, (a.) Resident #2's comprehensive care plan did not contain care areas that reflected the bowel needs of the resident, the side effects of the psychotropic medications taken by Resident #2 or signs and symptoms of hypertension for which the resident took medications; (b.) Resident #9 receiving an anti-depressant and a corresponding mood or psychiatric care plan was not developed and implemented that indicated its use; (c.) Resident #11's comprehensive care plan did not contain care areas that reflected the urinary tract issues Resident #11 regularly experienced, including but not limited to temporary foley catheters and urinary tract infections; (d.) Resident #14's comprehensive care plan did not contain care areas that highlighted complications and signs and symptoms of issues related to the Alzheimer's Medications being given to them; (e.) for Resident #34, care plan for abuse was not developed after the resident was identified as the aggressor in a resident-to-resident altercation; (f.) Resident #43 had a diagnosis of obstructive sleep apnea and a care plan for respiratory care was not developed and implemented; (g.) Resident #75 a care plan for abuse or at risk for abuse was not developed and implemented after they were identified as the victim in a resident-to-resident altercation; and (h.) for Resident #85 an advanced directive care plan was not developed, although the resident had a completed MOLST (medical orders for life sustaining treatment) form.This is evidenced by: The facility policy titled Care planning process reviewed 08/2018 documented that individualized comprehensive care plan that included measurable objectives and timetables to meet the resident's medical, nursing, mental, and psychological needs were to be developed for each resident. Each resident's comprehensive care plan was to be designed to: (1.) incorporate identified problems; (2.) incorporate risk factors associated with identified problems; (3.) build on resident's strengths; (4.) reflect the resident's expressed wishes regarding care and treatment goals; (5.) reflect treatment goals, timetables and objectives in measurable outcomes; (6.) identify the professional services that are responsible for each element of care; (7.) aid in preventing or reducing declines in the resident's functional status and/or functional levels; (8.) enhance the optimal functioning of the resident by focusing on a rehabilitative program; and (9.) reflect currently recognized standards of practice for problem areas and conditions. Resident #34 Resident #34 was admitted to the facility with diagnoses of dementia (a group of conditions that cause a progressive decline in cognitive abilities), Parkinsonism (a clinical syndrome characterized by a combination of movement-related symptoms, most notably bradykinesia, rigidity, resting tremors, and postural instability), and age-related physical debility (the gradual decline in physical function and strength that occurs with aging). The Minimum Data Set (an assessment tool) dated 12/25/2025, documented the resident was understood, able to understand others, and had severe cognitive impairment. A grievance form dated 6/28/2025, written by Family Member #4 on behalf of Resident #75, documented Resident #34 entered Resident #75 room Sunday night/early Monday morning (6/22/2025-6/23/2025) and harassed and assaulted the resident with Resident #75's water bottle. Resident #75 did not feel safe that Resident #34 still resided on the same floor as them. They requested that Resident #34 be moved to the first floor. During an interview on 2/19/2026 at 11:51 AM, Licensed Practical Nurse #2 stated that on 6/29/2025 an order was entered for the Certified Nurse Aides to complete safety checks on Resident #34 every 2 hours. There was no documented evidence that a care plan for abuse or at risk for abuse was developed and (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	implemented with interventions after Resident #34 was identified as the aggressor in a resident-to-resident altercation that occurred in June 2025. Resident #43 Resident #43 was admitted to the facility with diagnoses of obstructive sleep apnea (most common sleep-related breathing disorder), diabetes mellitus type 2 with hyperglycemia (when the body cannot use insulin correctly and the sugar builds up in the blood), hemiplegia and hemiparesis following cerebral infarction affecting left non dominant side (paralysis or weakness on one side of the body). The Minimum Data Set, dated [DATE], documented the resident could usually be understood and could usually understand others with intact cognition.A Report of Consultation dated 8/19/2025, documented Resident #43 had a diagnosis of obstructive sleep apnea, and the recommended plan of care documented patient needed an auto continuous positive airway pressure machine.A physician order dated 10/18/2025, documented apply continuous positive airway pressure mask and turn machine on at bedtime. Continuous positive airway pressure setting: 12-20 on H2O (water). There was no documented evidence that a care plan for respiratory care was developed or implemented for Resident #43, although they had a diagnosis of obstructive sleep apnea and used a continuous positive airway pressure machine to manage their diagnosis. Resident #75 Resident #75 was admitted to the facility with diagnoses of noninfective gastroenteritis and colitis (inflammation of the stomach, small intestine, and/or colon), chronic idiopathic and slow transit constipation (functional bowel disorder characterized by persistent, infrequent bowel movements, hard stools, or difficult defecation without a known organic cause) and type 2 diabetes (an endocrine dysfunction causing unregulated blood glucose levels). The Minimum Data Set, dated [DATE], documented the resident had moderate cognitive impairment, was able to make themselves understood and understand others. A grievance form dated 6/28/2025, written by Family Member #4 on behalf of Resident #75, documented Resident #34 entered Resident #75 room Sunday night/early Monday morning (6/22/2025-6/23/2025) and harassed and assaulted the resident with Resident #75's water bottle. Resident #75 did not feel safe that Resident #34 still resided on the same floor as them. They requested that Resident #34 be moved to the first floor. During an interview on 2/19/2026 at 11:51 AM, Licensed Practical Nurse #2 stated they implemented a stop sign across Resident #75's door after they were made aware of the grievance. There was no documented evidence that a care plan for abuse or at risk for abuse was developed and implemented with interventions after Resident #75 was identified as the victim of a resident-to-resident altercation that occurred in June 2025.During an interview on 2/24/2026 at 9:51 AM, Licensed Practical Nurse #8 stated if they noticed that something needed to be added to a resident's care plan, such as fall risk they would notify the unit manager.During an interview on 2/25/2026 at 11:04 AM, Director of Nursing #1 stated care planning was a significant issue at the facility. They stated they did not have many Registered Nurses to assist with care planning but were interviewing for an Assistant Director of Nursing. They further stated care planning would be part of their education plan and followed with audits.During an interview on 2/25/2026 at 12:25 PM, Administrator #1 stated care plans should be individualized. They further stated care plans assured residents were safe and cared for accordingly. 10 New York Code of Rules and Regulations 415.11(c)(1)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews conducted during a survey, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan for five (5) (Resident #'s 1, 23, 24, 85, and 87) of 22 residents reviewed. Specifically,(a.) Resident #1 was hospitalized three (3) times between 11/11/2025 and 02/17/2026 related to bowel constipation. Provider instructions for bowel regimen and assessment were not followed by the facility. As a result, Resident #1 required fecal disimpaction under general anesthesia.(b.) Resident #85 had symptoms of urinary tract infection identified on 09/19/2025. The provider ordered a urinalysis (urine test) six (6) days later on 09/25/2025. The resident was diagnosed with septic shock secondary to urinary tract infection (a life-threatening, critical condition where an untreated urinary tract infection enters the bloodstream and leads to sepsis and septic shock with symptoms that include change in mental status, very low blood pressure, and decreased urine output).(c.) Resident #87 complained of a fall on 1/13/2026 on the evening shift and was not documented as assessed by a nurse. Subsequently, Resident #87 complained to their family member about the fall and was sent back to the hospital within the first 24 hours of admission.(d.) For Resident #24, the facility did not ensure administration of as needed bowel medications in November 2025 and did not notify the provider; and(e.) For Resident #23, the facility did not ensure administration of as needed bowel medications in December 2025 and January 2026.This resulted in actual harm and Substandard Quality of Care for Resident #'s 1 and 85 that was not Immediate Jeopardy. This is evidenced by:Bowel Management Policy, revised/updated July 2020, documented it was the facility's policy to provide the tools, people, and systems to ensure the bowel function of all residents was monitored and managed as indicated on an individual basis to promote regularity. Residents who demonstrated a risk for constipation would have an individualized care plan.A. Resident #1Resident #1 was admitted to the facility with diagnoses of noninfective gastroenteritis (inflammation that spreads from the stomach into the intestines and cause, pain, vomiting, and diarrhea), colitis (inflammation of the large intestine), chronic idiopathic constipation (functional bowel disorder characterized by difficult, infrequent and/or incomplete defecation), and slow transit constipation (slow movement of waste through the digestive system). The Minimum Data Set (a resident assessment tool) dated 12/31/2025, documented the resident had moderate cognitive impairment. The resident was able to make themselves understood and understand others.Care Plan for At Risk for Constipation related to impaired mobility and history of large bowel obstruction, revised 10/14/2025, documented the goal that Resident #1 would pass soft, formed stool at a frequency perceived as normal for the resident. Interventions included following facility bowel protocol for bowel management, observe medications for side effects of constipation, and notify provider of any problems.Review of physician orders and the Medication Administration Record for Resident #1 revealed the resident received the following routine medications to manage their diagnosis of constipation: Linaclotide Oral Capsule 145 micrograms once daily; Senna S Oral Tablet 8.6-50 milligrams at bedtime; Lactulose Solution 10 grams/15 milliliters, 30 milliliters twice daily.Review of physician orders for as needed bowel medications revealed Resident #1 was to receive: Milk of Magnesia 30 milliliters by mouth every 24 hours as needed for constipation if no bowel movement after two (2) days; Bisacodyl Suppository insert one (1) suppository rectally every 24 hours as needed for constipation if no bowel movement 24 hours after Milk of Magnesia; Fleet Enema insert one (1) application rectally every 24 hours as needed for constipation if no bowel movement fours (4) hours after Bisacodyl Suppository.Hospitalist Discharge summary, dated [DATE], documented Resident #1 returned from (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	the hospital on [DATE] after being treated for severe constipation.Encounter Progress Note dated 11/13/2025 at 00:00 by Nurse Practitioner #1, documented Resident #1 was evaluated on 11/13/2025 following return from the Emergency Department with diagnosis of large stool burden. Bowel regimen and comfort focused management was to be continued as previously ordered. Nursing was to closely monitor bowel movements, abdominal distention, nausea, vomiting, and overall comfort. Continue routine assessment and family communication as clinically indicated. Plan of care updated accordingly.As of 11/13/2025 when Nurse Practitioner #1 charted, there was no documented evidence updates were made to the Care Plan for At Risk for Constipation since 10/14/2025.Review of the Follow Up Question Report (bowel movements documented each shift by the certified nurse aide), Medication Administration Record, and Nursing Progress Notes for Resident #1 dated December 2025 and January 2026 did not have documented evidence of routine assessments when there was no bowel movement, administration of as needed bowel medications per physician orders and facility policy, or reporting of bowel status to the provider.Review of Nursing Progress Notes dated 12/01/2025 to 01/08/2026 revealed no documented evidence of abdominal assessments by nursing staff.Encounter Progress Note dated 01/09/2026 at 00:00 by Nurse Practitioner #1, documented Resident #1 was re-evaluated on 01/09/2026 due to worsening gastrointestinal symptoms. Nursing reported increased episodes of vomiting with progressive abdominal distention. Upon examination, abdomen was markedly distended and firm with diffuse tenderness (pain or sensitivity is spread across a wide arear rather that being in one specific spot) to palpation. Bowel sounds were diminished. Given the worsening emesis (vomiting) and abdominal distention with concern for recurrent fecal impaction or evolving obstruction, further evaluation was required. The family was notified of the change in condition and agreed with hospital transfer.Hospital History and Physical dated 01/09/2026, documented a chief complaint of constipation, abdominal pain, bloating, and nausea. The resident was admitted with severe sepsis (the body responds improperly to an infection) and proctocolitis (inflammation of both the rectum and the lower colon). The resident had chronic idiopathic constipation Difficult, infrequent, and/or incomplete defecation) and was taking Linaclotide. The resident was supposed to take oral lactulose; however, they reported they refused it at the nursing home because they did not like the taste. It was uncertain how long the resident had refused the lactulose. Since being in the hospital, the resident had passed copious amounts of liquid stool.Physician order with start date of 11/13/2025 read for facility staff to observe that Resident #1 took all medications and notify of any refusals immediately. There was no documented evidence on the Medication Administration Records dated December 2025 and January 2026, that Resident #1 refused lactulose or that the physician was notified.The resident was discharged from the hospital on [DATE].Encounter readmission History and Physical Progress Note dated 01/20/2026 at 00:00 by Nurse Practitioner #1, documented that during hospitalization, Resident #1 was found to be septic secondary to proctocolitis in the setting of severe chronic constipation and intermittent nonadherence with their bowel regimen. Bowel regimen was adjusted with lactulose increased from twice daily to four (4) times daily in an effort to prevent recurrent constipation and colonic complications. The plan was for nursing to monitor bowel movements each shift and document stool frequency, consistency, and response to regimen. The provider was to be notified for no bowel movement greater than 24 hours, worsening abdominal distention, abdominal pain, nausea, vomiting, or decreased oral intake. Abdominal exam was to be monitored routinely. Emphasized importance of adherence with bowel regimen to nursing staff. The resident was to be followed closely during early readmission period due to high risk for recurrence given their chronic gastrointestinal disease history.There was no documented evidence of Nurse Practitioner #1's instructions for nursing staff on the Resident #1's care plan or in physician orders.Encounter (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Progress Note dated 01/23/2026 at 00:00 by Nurse Practitioner #1, documented the resident was seen on 01/23/2026 for follow-up after recent hospitalization for increased stool burden, which had been a chronic ongoing issue. Additional bowel protocol medications remained in place as ordered. Plan was to continue current bowel regimen with close monitoring of bowel movements and hydration status.Review of the Follow Up Question Report (bowel movements documented each shift by the Certified Nurse Aide), Medication Administration Record, and Nursing Progress Notes for Resident #1 dated January 2026 documented no bowel movements on 01/19/2026, 01/20/2026, 01/21/2026, and 01/22/2026. In January 2026, there was no documented evidence of notification to the provider when Resident #1 had no bowel movement in greater than 24 hours including but not limited to 01/24-26/2026; 01/29-30/2026; 02/10-11/2026.Nursing Progress Note dated 01/23/2026 at 6:11 AM by Licensed Practical Nurse #5, documented they placed Resident #1 on the bowel list because per documentation, it had been three (3) days since their last bowel movement. During morning rounds of 01/23/2026, the resident had an extra-large bowel movement. No further interventions were required.Review of Nursing Progress Notes dated 01/24/2026 to 02/16/2026 revealed no documented evidence of notes about the status of the resident's bowel movements, no abdominal assessments, and no notification to the provider when the resident went over 24 hours with no bowel movement.Nursing Progress Note dated 02/17/2026 at 5:30 PM by Director of Nursing #1, documented they were called to assess Resident #1, as they had a distended abdomen. Resident #1 had a distended abdomen, mild bowel sounds in all four (4) quadrants, and on palpation expressed pain with deep palpation in the lower left quadrant. Resident #1 was sent to the hospital.Hospital Discharge summary dated [DATE] documented the reason for admission and discharge diagnosis was fecal impaction. Hospital Course documented the resident presented to the Emergency Department with abdominal pain and distention. Was found to have severe stercoral colitis (a rare, severe, and potentially fatal inflammatory condition of the colon caused by extreme, chronic constipation) on Computed Tomography (computerized x-ray imaging procedure). Was unable to undergo manual disimpaction and required general anesthesia in addition to flex sigmoidoscopy (a flexible tube with a camera attached used to examine the lower large intestine) for disimpaction. During the procedure the resident was found to have severe fecal impaction.During an interview on 02/24/2026 at 2:08 PM, Certified Nurse Aide #9 stated they documented bowel movements in the electronic medical record under toileting. They reported to the nurse when a resident did not have a bowel movement in three (3) days. The nurse would then give Milk of Magnesia or another bowel medication. They stated some residents were on laxatives daily and usually had a bowel movement the next day. They stated they were familiar with Resident #1, who used to have a lot of bowel movements; licensed practical nurses had a list of residents who did not have bowel movements.During an interview on 02/24/2026 at 2:25 PM, Licensed Practical Nurse Manager #2, reviewed the electronic medical record and stated they were aware that Resident #1 had two (2) admissions to hospital, with the most recent for fecal impaction. They stated bowel protocol was triggered when there was no bowel movement after three (3) days. They stated they were not aware Nurse Practitioner #1 wanted to be notified if there was no bowel movement in greater than 24 hours and said there was no order.During an interview on 02/24/2026 at 4:03 PM, Registered Nurse #2 stated they were not responsible for the day-to-day management of a resident's bowel status and was not familiar with the clinical alerts on the computer system. Registered Nurse #2 stated they were responsible for assessments, care planning, and progress notes, and readmitted Resident #1 two (2) times for bowel related issues. They stated nurse unit managers were responsible for managing the resident's bowel status and would run a report that showed how many shifts it had been with no bowel movement. They stated the facility had standing orders for as needed bowel medications that were to be (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	given when there was no bowel movement in two (2) days. The orders were entered into the electronic medical record by the unit managers upon admission/readmission to the facility.During an interview on 02/24/2026 at 4:35 PM, Nurse Practitioner #1 stated Resident #1 had chronic constipation and was on a daily bowel medication regimen. In addition to the routine bowel medications, the resident had orders for as needed bowel medications. Per the facility's bowel protocol, the resident was supposed to receive Milk of Magnesia if no bowel movement in 24 hours, a suppository if no bowel movement in 48 hours, an enema with notification to the provider if no bowel movement in 72 hours. They stated the resident had a hospitalization for fecal impaction and when the resident returned, they gave nursing staff specific verbal instructions for the management of the resident's bowel movements. They stated they did not recall a specific order for the instructions and stated the unit manager was ultimately responsible for managing the resident's bowel status and communicating the instructions to the unit staff. They were not aware that the as needed bowel medications were not given prior to the resident's hospitalization. They stated they were never notified of any bowel related concerns for Resident #1. They stated that given the resident's diagnoses, routine bowel medications, and history of fecal impaction, the expectation was nursing staff would utilize the bowel protocol and notification process.During an interview on 02/25/2026 at 9:51 AM with Medical Director #1, they stated most nursing home residents had a bowel regimen, and the expectation was that bowel movement status and assessments would be documented. For Resident #1 with a history of constipation and fecal impaction, the resident was at high risk and nursing staff should have been monitoring the resident closely.During an interview on 02/25/2026 at 11:05 AM, Administrator #1 stated Resident #1 had chronic constipation. They reviewed Resident #1's records and stated the resident was getting their daily bowel medications. They were not aware the resident had not received the as needed bowel medications per the facility's protocol. They stated a resident's bowel alerts were on the nurse's dashboard and the unit manager and Director of Nursing #1 were responsible for addressing them. B. Resident #85Resident #85 was admitted to the facility with diagnoses of unspecified dementia severe, without behavioral disturbance (cognitive decline with no notable behavioral, psychotic, mood, or anxiety symptoms), type two (2) diabetes mellites with hyperglycemia (when the body cannot use insulin correctly and the sugar builds up in the blood), and hypersensitive chronic kidney disease with Stage one (1) through stage four (4) chronic kidney disease, or unspecified chronic kidney disease (the presence of kidney damage or decreased kidney function). Minimum Data Set, dated [DATE], documented the resident had severe cognitive impairment. The resident usually made themselves understood and usually understand others.Record review of a peer-reviewed journal article titled, Systematic Review of Interventions to Reduce Urinary Tract Infection in Nursing Home Residents ([NAME] et al., J Hosp Med. 2017 May;12(5):356-368. doi: 10.12788/jhm.2724. Retrieved at https://pmc.ncbi.nlm.nih.gov/articles/PMC5557395/) noted that Several practices, often implemented in bundles, appear to reduce Urinary Tract Infections or Catheter-Associated Urinary Tract Infections in nursing home residents such as improving hand hygiene, reducing and improving catheter use, managing incontinence without catheters, and enhanced barrier precautions.A note dated 09/18/2025 with date of service 09/19/2025 by Nurse Practitioner #1, documented Resident #85 had lower back pain and family was concerned resident had a urinary tract infection. Plan was to consider sending urinalysis.A note dated 09/24/2025 with date of service 09/25/2025 by Nurse Practitioner #1, documented nursing reported decreased oral intake. Plan was to provide 240 milliliters of extra fluids with medication pass and obtain urine sample for urinalysis.Review of physician orders revealed no documented evidence of an order for a urinalysis on 09/25/2025.There was no documented evidence in a review of progress notes about the resident's condition on (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	09/26/2025.A note dated 09/26/2025 with date of service 09/27/2025 by Nurse Practitioner #1, documented Resident #85 was not eating or drinking and nursing staff were still unable to obtain urine sample. Plan was Rocephin two (2) grams x one (1) dose (antibiotic) intermuscular, consider intravenous fluids, and straight catheterization (a flexible tube inserted through the urethra to drain urine from the bladder) as needed to obtain urine.A note dated 09/27/2025 at 7:27 PM by Registered Nurse #4, documented provider made aware of resident lethargy (unusual decrease in consciousness), had not voided through the shift, and had no intake or output.Provider orders dated 09/27/2025 documented obtain urine analysis and culture and sensitivity. Completed 09/27/2025 at 7:30 PM.The Nurse Practitioner Note dated 09/27/2025 with date of service 09/28/2025 by Nurse Practitioner #1, documented resident was straight catheterized, had 100 milliliters of blood visible to naked eye, and was lethargic. Plan was to send resident to the emergency room.The Hospital Discharge summary dated [DATE], documented admission diagnosis of septic shock and discharge diagnosis of resolved septic shock secondary to urinary tract infection.During an interview on 02/20/2026 at 11:40 AM, Nurse Practitioner #1 stated their expectations were if they ordered a urinalysis, the sample would be obtained and sent to the lab within 24 hours.During an interview on 02/25/2026 at 9:29 AM, Medical Director #1 stated when a urinalysis was ordered their expectation would be to send the urine specimen out probably within an hour or two (2).During an interview on 02/25/2026 at AM, Director of Nursing #1 stated lab orders appeared on the dashboard in the resident's electronic medical record, and they could review the lab reports for residents who had labs obtained.C. Resident #87Resident #87 was admitted to the facility with diagnoses of unspecified fracture of head of left femur (a break in the ball-shaped upper end of the left thighbone where it connects to the hip socket), malignant neoplasm of cerebral meninges (a rare, aggressive, and cancerous tumor arising from the brain's protective membranes), and anxiety (mental health condition characterized by excessive fear that interferes with daily activities). The Minimum Data Set, dated [DATE], documented the resident was independent with making decisions regarding tasks of daily living.An Incident and Accident form dated 01/13/2026, documented Resident #87 was found on the floor during rounds and stated they fell while trying to close their door. It documented that the licensed nurse assessed Resident #87 immediately, the resident was able to move all extremities without difficulties, vital signs were stable, the resident denied any pain or hitting their head during the fall, and the family was notified. There was no documented evidence that an assessment was conducted by a registered nurse after the fall.A Nursing Note dated 01/14/2026 at 7:12 AM by Licensed Practical Nurse #12, documented Resident #87 stated they fell and refractured their hip. The resident had been in bed all shift. The resident called their family to go to the hospital. The family called 911 to take them out to the hospital around 7:10 AM. A Physician Note dated 01/15/2026 at 12:29 PM by Nurse Practitioner #1, documented on the 01/13/2026 evening shift, nursing staff reported the resident experienced a fall while attempting to close a door. At the time of the incident, nursing assessment indicated no apparent injury. The resident denied head strike, denied pain, and no acute complaints were reported. Vital signs were obtained and remained stable. No immediate transfer was deemed necessary based on clinical assessment. On the morning of 01/14/2026, the resident and family independently contacted emergency services, stating concern that the resident had re-fractured their hip and required hospital evaluation. The resident was transferred to the emergency department via emergency medical services. The on-call provider was not notified prior to the transfer. This incident was reviewed for communication processes and escalation protocols. Education and reinforcement of provider notification requirements were indicated to ensure timely clinical assessment and appropriate decision-making in future similar situations. During an interview on 02/19/2026 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rosewood Rehabilitation and Nursing Center	284 Troy Road Rensselaer, NY 12144

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	at 4:43 PM, Licensed Practical Nurse #12 stated Resident #87 did not fall on their shift. They stated Licensed Practical Nurse #14 took care of Resident #87 on the 3:00 PM to 11:00 PM shift when their fall occurred and did not tell Licensed Practical Nurse #12 about the fall when Resident #87 was moved to their assignment at 11:00 PM. The certified nurse aides that were working at the time told Licensed Practical Nurse #12 that Resident #87 fell but did not say when the resident actually fell. In the morning, when Family Member #5 called and stated Resident #87 fell, Licensed Practical Nurse #12 did not know what they were talking about, which was why they documented what they did. On 02/24/2026 at 11:49AM and 4:30 PM, attempts were made to contact Licensed Practical Nurse #14 but were unsuccessful and there was no option to leave a message. During an interview on 02/25/2026 at 9:29 AM, Medical Director #1 stated that when something out of the ordinary occurred, they would usually get a call from the Nurse Practitioner for clarification. During an interview on 02/25/2026 at 11:04 AM, Director of Nursing #1 stated if a resident fell, they would want a thorough investigation and explanation of what happened. The Licensed Practical Nurse should start the Incident and Accident Report, the event should be documented in the electronic health record, and the family would be notified. Ideally, it would be reviewed in morning report. During an interview on 02/25/2026 at 12:25 PM, Administrator #1 stated they were aware there were issues surrounding documentation and that staff needed to be educated on the processes regarding what to do for adverse events, reporting them appropriately, and closing the loop after things happened. 10 New York Codes, Rules, and Regulations 415.12

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews during a survey), the facility failed to ensure the resident environment remained as free of accident hazards as is possible for two (2) (Resident #s 2 and 3) of three (3) residents reviewed. Specifically, on 01/29/2026 at 12:13 PM, Resident #2, who had severe cognitive impairment, had three (3) prescription medications (Sertraline HCl 50 milligram (antidepressant), Eliquis five (5) milligram (blood thinner), and Levetiracetam 500 milligram (antiseizure) in prescription medication bottles inside a plastic bag on their nightstand. Additionally, on 01/29/2026 at 12:01 PM, the front cover of Resident #3's electric baseboard heater in their bathroom was removed and laying on the floor in front of the running heater. This resulted in Immediate Jeopardy and Substandard Quality of Care for Resident #s 2 and 3, and placed all residents at risk for serious injury, serious harm, serious impairment, or death.This is evidenced by:The policy and procedure titled, Accidents and Supervision, documented the resident environment would remain as free of accident hazards as possible. Resident #2 was admitted to the facility with diagnoses of recurrent moderate major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest), atrial fibrillation (an irregular heart rhythm that can lead to blood clots), and seizures (sudden burst of electrical activity in the brain that causes changes in awareness and muscle control). The Minimum Data Set (an assessment tool) dated 12/20/2025, documented that the resident had severe cognitive impairment. The resident usually made themselves understood (had difficulty communicating some words or finishing thoughts but was able if prompted or given time) and usually understand others (missed some part/intent of the message but comprehended most conversation).The undated policy and procedure titled, Administering Medications, documented medications were never left at the bedside. Medications brought in with a resident would be returned to the family/Health Care Proxy. Medications would be reordered and filled by the facility/vendor pharmacy. Review of the Medication Administration Record dated January 2026 documented Resident #2 had a physician order and received: sertraline HCl 50 milligrams, give one (1) tablet by mouth in the morning for depression. apixaban (Eliquis) five (5) milligrams, give one (1) tablet by mouth every morning and at bedtime for atrial fibrillation. levetiracetam Extended Release 24 Hour tablet 500 mg, give two (2) tablets by mouth in the morning for seizures.During an observation on 01/29/2026 at 12:13 PM, Resident #2 was asleep in bed. There was a clear plastic bag on their nightstand that contained prescription medication bottles for Sertraline 50 milligrams, Eliquis (Apixaban) five (5) milligrams, and Levetiracetam 500 milligrams. Each of the prescription medication bottles was labeled with the resident's name and contained medication.During an interview on 01/29/2026 at 1:30 PM, Certified Nurse Aide #2 stated that if medications were observed at the bedside, they would remove them and report them to the nurse.During an interview on 01/29/2026 at 1:33 PM, Licensed Practical Nurse #1 stated medications from home were locked in the medication cart and then the family would either take them home or they would be destroyed. The surveyor then brought Licensed Practical Nurse #1 to Resident #2's room and showed them the medications that were on the nightstand. Licensed Practical Nurse #1 looked at the prescription medication bottles and stated they were filled on 03/31/2025, 04/05/2025, and 09/02/2025. Licensed Practical Nurse #1 removed the medications from the room. During an interview on 01/29/2026 at 2:20 PM, Licensed Practical Nurse #2 stated they were not aware Resident #2 had medications on the nightstand and stated staff should have seen them and removed them. They stated Resident #2 was cognitively impaired and was unable to self-administer medications.During an interview on 01/29/2026 at 3:34 PM, Acting Director of Nursing/Acting Assistant Director of Nursing #1 stated the medications found (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	at Resident #2's bedside could have caused serious harm if taken by another resident. All three (3) were lethal medications, and could have caused serious harm, depending on what was taken and how much was taken. They further stated medications brought in at the time of admission were typically brought home or destroyed. During an interview on 02/05/2026 at 1:21 PM, Family Member #3 stated they visited Resident #2 in the facility three (3) times per week. They stated a bag that contained the resident's medications was handed to them at the hospital and they were told by the Emergency Medical Technician to bring them home. When the resident was admitted to the facility, Family Member #3 gave the bag with the medications to an unnamed nurse on the first floor. The nurse told them they did not need the medications; they would be ordered at the facility and told them to put the medications in the bedside table. On 02/03/2026, staff on the second floor gave them the medications and told them to take them home because they were not supposed to be in the facility. During an interview on 02/03/2026 at 10:23 AM, Nurse Practitioner #1 stated that if a resident's medications were left in their room unattended, the resident's roommate could potentially access the medications, which could result in a medication error and increased medication risk in the facility.During an interview on 02/03/2026 at 11:40 AM, Assistant Administrator #1 stated Resident #2 did not have assessments supporting self-administration of medications. The facility recognized the need for heightened safety awareness, as residents may require additional guidance due to cognitive limitations. They stated Resident #2's unit housed long-term care residents with varying levels of cognition. Residents' roommates may have varying degrees of confusion or cognitive impairment.During an interview on 02/03/2026 at 12:53 PM, Medical Director #1 stated all medications were under the control of nursing staff. Nurses should not leave medications at the bedside and were expected to remain with the resident until all medications had been administered and taken by the resident. Upon admission to the facility, the facility should be made aware of all medications the resident was taking at home. For residents transferred from the hospital, this information was obtained through hospital discharge records. All prescribed medications were to be administered by nursing staff while the resident resided in the facility. Medical Director #1 stated they were not aware of every single issue in the facility. If medications were left at bedside, it was a nursing issue that nursing should be taking care of. Medical Director #1 stated that if a resident had medications in the room or there was concern another resident might have accessed them, Nurse Practitioner #1 was notified first or the on-call provider after hours. Resident #3 was admitted to the facility with diagnoses of ataxia (poor muscle control that causes clumsy movements and can affect walking and balance), history of falling, and spinal stenosis (narrowing of the spinal canal which results in pressure on the nerves and pain). The Minimum Data Set, dated [DATE], documented the resident was cognitively intact. The resident was able to make themselves understood and understand others. The resident used a wheelchair for mobility.During an observation on 01/29/2026 at 12:01 PM, Resident #3's bathroom door was open, and a small electric baseboard heater was visualized with the front cover removed and laying on the floor in front of the heater. The heater was producing heat along with a burning smell. Surveyor placed their hand close to the exposed heating elements, and they were hot enough to cause injury if the heating elements came in direct contact with skin or clothing. During an interview on 01/29/2026 at 1:41 PM, Certified Nurse Aide #1 was shown the heater in Resident #3's bathroom. They stated that on 01/28/2026, they saw the cover from the electric heater on the floor and stated they should have reported it to the Maintenance Department at that time but did not and they did not report it today.During an interview 01/29/2026 at 2:10 PM, Director of Maintenance #1 stated Acting Director of Nursing/Acting Assistant Director of Nursing #1 told them about the heater in Resident #3's bathroom and they put the cover back on. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 01/29/2026 at 2:20 PM, Licensed Practical Nurse #2 stated the bathroom heater in Resident #3's room was hot, and the cover was placed back on. Staff should have reported the missing cover immediately.The Immediate Jeopardy was lifted effective 02/09/2026. The facility's immediacy removal actions included the following:?During an interview on 01/29/2026 at 3:34 PM, Acting Director of Nursing/Acting Assistant Director of Nursing #1 stated Resident #2's medications that the surveyor observed were 'home medications,' and were removed from their room and secured. Nurse Practitioner #1 was notified, and the family was to be notified according to facility process.During an interview on 02/03/2026 at 11:40 AM, Assistant Administrator #1 stated education had since been provided to all staff on medication administration and was currently ongoing until all staff are educated. Assistant Administrator #1 stated staff rounds occurred during care delivery, activities, therapy, and routine safety checks multiple times a day. Staff education was ongoing, including a full-house in-service, to reinforce medication safety, admission procedures, and environmental monitoring.During a subsequent interview on 02/03/2026 at 12:10 PM, Assistant Administrator #1 stated they notified Administrator #1 regarding the prescription medications left at Resident #2's bedside. Nurse Practitioner #1 was notified and determined that the medication was brought into the facility by the resident's family following a hospital discharge.On 01/29/2026, a facility-wide audit of each resident room, including drawers and cabinets, was conducted by the facility management team to ensure that no other residents had medications in their rooms. There were no findings of any medications in resident rooms during the audit.A second facility-wide audit of each resident room, including drawers and cabinets, was initiated on 02/06/2026 at 2:58 PM and completed on 02/06/2026 at approximately 4:00 PM. There were no findings of any medications in resident rooms during this audit.On 01/30/2026, Administrator #1 and Assistant Administrator #1 reviewed the facility policy, Administering Medications, and no revisions were made.On 02/03/2026, medications from Resident #2's room were given back to Family Member #3 to take home and destroy.On 02/03/2026, the facility initiated mandatory education to all staff and re-educated that residents were not to have medications in their room and if any medications were found they were to immediately be given to a nurse.Education would be conducted verbally, either in person or over the telephone by the Nursing Supervisor and/or designee.Education was started on 02/03/2026 and 90% of facility staff would be educated by 02/06/2026 at 11:00 PM.Facility staff that had not been reached by telephone would not be permitted to work until they received the education.On 02/03/2026, Director of Maintenance #1 replaced the cover on the baseboard heater in Resident #3's bathroom.On 02/03/2026, Director of Maintenance #1 conducted an audit of the electric baseboard heaters in the facility, ensuring they had covers in place.On 02/06/2026, Assistant Administrator #1 and Director of Maintenance #1 reviewed the facility Work Request Policy, and no revisions were made.On 02/06/2026, the facility initiated mandatory education to all staff regarding the process for reporting damaged, broken and/or malfunctioning equipment.Education would be conducted verbally, either in person or by telephone by the Nursing Supervisor and/or designee. Education was started on 02/06/2026 and 90% of facility staff would be educated by 02/06/2026 at 11:00 PM.Facility staff that had not been reached by telephone would not be permitted to work until they received the education.As of 02/09/2026, 93% of facility staff were educated. 10 New York Codes, Rules and Regulations 415.12(h)(1)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observation, record review and interviews conducted during a survey, the facility did not ensure the provision of sufficient nursing staff to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident throughout the facility. Specifically, residents stated they were not assisted with care when requested; staff stated they were unable to consistently provide and/or document incontinence care, showers, or bed baths due to being short-staffed; and an analysis of the actual staffing schedule showed that on multiple occasions from 11/30/2025 to 2/24/2025, the facility minimum staffing levels were not met based on the facility assessment.This is evidenced by: The Facility Assessment, dated 1/2026, documented that Nursing Administration required one (1) full time Registered Nurse on day shift to serve as Director of Nursing, one (1) full time Registered Nurse on day shift to serve as the Assistant Director of Nursing, two (2) full time Registered Nurses or Licensed Practical Nurses, one for each unit, to serve as Unit Nurse Manager, one (1) Registered Nurse or Licensed Practical Nurse for 3 PM-11 PM shift, and/or one (1) Registered Nurse or Licensed Practical Nurse for 11 PM-7 AM shift to serve as Nursing Supervisor and weekend staffing for Registered Nurses is 8-hour days, evenings or 8-hour nights.Direct care staff required per unit per shift (2-40 bed units) seven (7)days per week was as follows: Day shift (7 AM-3 PM) two (2) full time Licensed Practical Nurses and three (3)-four (4) full time Certified Nurse Aides; Evening shift (3 PM-11 PM) two (2) full time Licensed Practical Nurses, and three (3)-four (4) Certified Nurse Aides; Night shift (11 PM-7 AM) one (1) full time Licensed Practical Nurse, and two (2) full time Certified Nurse Aides.The facility staffing sheets provided documented that:On 11/30/2025, the nursing schedule had three (3) nursing staff during the day shift instead of four (4), and one (1) for night shift instead of two (2), with one (1) Nurse Supervisor noted. The Certified Nurse Aide schedule had five (5) aides during the day shift instead of six (6), five (5) for the evening shift instead of six (6), and two (2) for the night shift instead of four (4). On 12/01/2025, the nursing schedule had no nurses for night shift, with one (1) Nurse Supervisor noted. The Certified Nurse Aide schedule had four (4) aides during the day shift instead of six (6), zero (0) aides for the evening shift, and two (2) for the night shift instead of four (4). On 12/02/2025, the nursing schedule had one (1) nurse for night shift instead of two (2), with one (1) Nurse Supervisor noted. The Certified Nurse Aide schedule had five (5) aides during the day shift instead of three (6), three (3) for the evening shift instead of six (6), and one (1) for the night shift instead of four (4). On 12/03/2025, the nursing schedule had no nurses for night shift, with one (1) Nurse Supervisor noted. The Certified Nurse Aide schedule had four (4) aides for the evening shift instead of six (6), and one (1) for the night shift instead of four (4). On 12/04/2025, the Certified Nurse Aide schedule had five (5) aides during the day shift instead of six (6), and two (2) for the night shift instead of four (4). On 12/05/2025, the Certified Nurse Aide schedule had four (4) for the evening shift instead of six (6), and two (2) for the night shift instead of four (4). On 12/06/2025, the nursing schedule had three (3) nursing staff during the evening shift instead of four (4). The Certified Nurse Aide schedule had two (2) aides for the night shift instead of four (4). On 12/07/2025, the nursing schedule had two (2) nursing staff during the evening shift instead of four (4), and one (1) for night shift instead of two (2). The Certified Nurse Aide schedule had one (1) aide during the night shift instead of four (4). On 12/08/2025, the nursing schedule had three (3) nursing staff during the evening shift instead of four (4), and one (1) for night shift instead of two (2), with one (1) Nurse Supervisor noted. The Certified Nurse Aide schedule had five (5) aides during the day shift instead of six (6), five (5) for the evening shift instead (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	of six (6), and two (2) for the night shift instead of four (4). On 12/09/2025, the nursing schedule had one (1) nursing staff during the night shift instead of two (2), with one (1) Nurse Supervisor noted. The Certified Nurse Aide schedule had one (1) aide during the night shift instead of four (4). On 12/10/2025, the nursing schedule had one (1) nursing staff during the night shift instead of two (2), with one (1) Nurse Supervisor noted. The Certified Nurse Aide schedule had one (1) aide during the night shift instead of four (4). On 12/11/2025, the nursing schedule had one (1) nursing staff during the night shift instead of two (2), with one (1) Nurse Supervisor noted. The Certified Nurse Aide schedule had two (2) aides during the night shift instead of four (4). On 12/12/2025, the nursing schedule had two (2) nursing staff during the evening shift instead of four (4). The Certified Nurse Aide schedule had three (3) aides during the day shift instead of six (6), and zero (0) for the night shift. On 12/13/2025, the nursing schedule had three (3) nursing staff during the day shift instead of four (4), and one (1) for night shift instead of two (2). The Certified Nurse Aide schedule had two (2) aides during the evening shift instead of six (6), and three (3) for the night shift instead of four (4). On 12/14/2025, the nursing schedule had one (1) nursing staff during the night shift instead of two (2), with one (1) Nurse Supervisor noted. The Certified Nurse Aide schedule had three (3) aides during the evening shift instead of six (6), and two (2) for the night shift instead of four (4). On 12/15/2025, the nursing schedule had one (1) nursing staff during the night shift instead of two (2), with one (1) Nurse Supervisor noted. The Certified Nurse Aide schedule had one (1) aide during the night shift instead of four (4). On 12/16/2025, the nursing schedule had zero (0) nursing staff during the night shift, with one (1) Nurse Supervisor noted. The Certified Nurse Aide schedule had four (4) aides during the day shift instead of six (6). On 12/17/2025, the Certified Nurse Aide schedule had five (5) aides during the evening shift instead of six (6), and one (1) for the night shift instead of four (4). On 12/18/2025, the Certified Nurse Aide schedule had two (2) aides during the night shift instead of four (4). On 12/19/2025, the nursing schedule had one (1) nursing staff during the night shift instead of two (2). The Certified Nurse Aide schedule had three (3) aides during the day shift instead of four (4). On 12/20/2025, the Certified Nurse Aide schedule had zero (0) aides during the night shift. On 12/21/2025, the nursing schedule had two (2) nursing staff during the evening shift instead of four (4). The Certified Nurse Aide schedule had five (5) aides during the day shift instead of six (6), and zero (0) aides for the night shift. On 12/22/2025, the nursing schedule had one (1) nursing staff during the night shift instead of two (2), with one (1) Nurse Supervisor noted. The Certified Nurse Aide schedule had one (1) aide during the night shift instead of four (4). On 12/23/2025, the nursing schedule had one (1) nursing staff during the night shift instead of two (2). The Certified Nurse Aide schedule had four (4) aides during the day shift instead of six (6), five (5) aides for evening shift instead of six (6), and two (2) aides for night shift instead of four (4).On 12/24/2025, the nursing schedule had three (3) nursing staff during the evening shift instead of four (4), and zero (0) nurses on the night shift, with one (1) Nurse Supervisor noted. The Certified Nurse Aide schedule had three (3) aides during the night shift instead of four (4). On 12/25/2025, the nursing schedule had three (3) nursing staff during the evening shift instead of four (4), with one (1) Nurse Supervisor noted and one (1) nurse on night shift instead of two (2), with one (1) Nurse Supervisor noted. The Certified Nurse Aide schedule had one (1) aide during the night shift instead of four (4). On 12/26/2025, the nursing schedule had one (1) nursing staff during the night shift instead of two (2), with one (1) Nurse Supervisor noted. The Certified Nurse Aide schedule had zero (0) aides during the night shift. On 12/27/2025, the nursing schedule had three (3) nursing staff during the night shift but one (1) scheduled to leave at 2 AM instead of (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	7 AM instead of two (2) for the entire shift, with one (1) Nurse Supervisor noted. The Certified Nurse Aide schedule had four (4) aides on day shift instead of six (6), two (2) aides on evening shift instead of six (6), and two (2) aides during the night shift instead of four (4). On 12/28/2025, the nursing schedule had three (3) nursing staff during the day shift instead of four (4), and zero (0) nurses on night shift, with one (1) Nurse Supervisor noted. The Certified Nurse Aide schedule had four (4) aides on day shift instead of six (6), three (3) aides on evening shift instead of six (6), and two (2) aides during the night shift instead of four (4). On 12/29/2025, the nursing schedule had three (3) nursing staff during the day shift instead of four (4), two (2) nurses on evening shift instead of four (4), and no nurses on night shift, with one (1) Nurse Supervisor noted. The Certified Nurse Aide schedule had five (5) aides during the day shift instead of six (6), five (5) aides on evening shift instead of six (6), and one (1) aide during the night shift instead of four (4). On 12/30/2025, the nursing schedule had two (2) nursing staff during the day shift instead of four (4), three (3) nurses on evening shift instead of four (4), and zero (0) nurses on night shift, with one (1) Nurse Supervisor noted. The Certified Nurse Aide schedule had five (5) aides during the evening shift instead of six (6), and three (3) aides for night shift instead of four (4). On 12/31/2025, the nursing schedule had three (3) nursing staff during the evening shift instead of four (4). The Certified Nurse Aide schedule had one (1) aide during the night shift instead of four (4). On 1/01/2026, the nursing schedule had three (3) nursing staff during the evening shift instead of four (4), and zero (0) nurses on night shift, with one (1) Nurse Supervisor noted. The Certified Nurse Aide schedule had five (5) aides during the day shift instead of six (6), and three (3) aides on evening shift instead of six (6). On 1/02/2026, the nursing schedule had three (3) nursing staff during the evening shift instead of four (4), and zero (0) nurses on night shift, with one (1) Nurse Supervisor noted. The Certified Nurse Aide schedule had five (5) aides during the evening shift instead of six (6). On 1/03/2026, the nursing schedule had one (1) nurse on night shift instead of two (2), with one (1) Nurse Supervisor noted.On 1/04/2026, the nursing schedule had one (1) nursing staff during the night shift instead of two (2). The Certified Nurse Aide schedule had one (1) aide on night shift instead of four (4). On 1/05/2026, the nursing schedule had one (1) nursing staff during the night shift instead of two (2), with one (1) Nurse Supervisor noted. The Certified Nurse Aide schedule had five (5) aides during the day shift instead of six (6), and four (4) aides on evening shift instead of six (6), and two (2) aides on night shift instead of four (4). On 1/06/2026, the nursing schedule had one (1) nursing staff during the night shift instead of two (2), with one (1) Nurse Supervisor noted. The Certified Nurse Aide schedule had five (5) aides during the day shift instead of six (6). On 1/07/2026, the nursing schedule had one (1) nursing staff during the night shift instead of two (2). The Certified Nurse Aide schedule had five (5) aides during the evening shift instead of six (6). On 1/08/2026, the nursing schedule had zero (0) nursing staff during the night shift, with one (1) Nurse Supervisor noted. The Certified Nurse Aide schedule had three (3) aides during the evening shift instead of six (6). On 1/09/2026, the nursing schedule had zero (0) nursing staff during the night shift, with one (1) Nurse Supervisor noted. The Certified Nurse Aide schedule had three (3) aides during the day shift instead of six (6), and three (3) aides on evening shift instead of six (6). On 1/10/2026, the nursing schedule had zero (0) nursing staff during the night shift, with one (1) Nurse Supervisor noted. The Certified Nurse Aide schedule had four (4) aides during the day shift instead of six (6), and four (4) aides on evening shift instead of six (6). On 1/11/2026, the nursing schedule had zero (0) nursing staff during the night shift, with one (1) Nurse Supervisor noted. The Certified Nurse Aide schedule had four (4) aides during the day shift instead of six (6), and four (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	(4) aides on evening shift instead of six (6). On 1/12/2026, the nursing schedule had two (2) nurses during the evening shift instead of four (4), and zero (0) nursing staff during the night shift, with one (1) Nurse Supervisor noted.On 1/13/2026, the nursing schedule had three (3) nursing staff during the day shift instead of four (4). The Certified Nurse Aide schedule had three (3) aides during the day shift instead of six (6). On 1/14/2026, the nursing schedule had three (3) nursing staff during the day shift instead of four (4), and one (1) nursing staff during the night shift instead of two (2), with one (1) Nurse Supervisor noted. The Certified Nurse Aide schedule had five (5) aides during the day shift instead of six (6). On 1/15/2026, the nursing schedule had three (3) nursing staff during the evening shift instead of four (4), and one (1) nursing staff during the night shift instead of two (2), with one (1) Nurse Supervisor noted.On 1/16/2026, the nursing schedule had zero (0) nursing staff during the night shift, with one (1) Nurse Supervisor noted. The Certified Nurse Aide schedule had four (4) aides during the day shift instead of six (6), and five (5) aides on evening shift instead of six (6). On 1/17/2026, the nursing schedule had three (3) nursing staff during the day shift instead of four (4), two (2) nurses on evening shift instead of four (4) and zero (0) nursing staff during the night shift.On 1/18/2026, the nursing schedule had three (3) nursing staff during the day shift instead of four (4), two (2) nurses on evening shift instead of four (4), and one (1) nursing staff during the night shift instead of two (2). The Certified Nurse Aide schedule had five (5) aides during the day shift instead of six (6), and two (2) aides for night shift instead of four (4). On 1/19/2026, the nursing schedule had one (1) nursing staff during the night shift instead of two (2), with one (1) Nurse Supervisor noted. The Certified Nurse Aide schedule had five (5) aides during the day shift instead of six (6), five (5) aides on evening shift instead of six (6), and two (2) aides on night shift instead of four (4). On 1/20/2026, the Certified Nurse Aide schedule had three (3) aides during the day shift instead of six (6). On 1/21/2026, the nursing schedule had one (1) nursing staff during the night shift instead of two (2), with one (1) Nurse Supervisor noted. The Certified Nurse Aide schedule had four (4) aides during the day shift. On 1/22/2026, the nursing schedule had three (3) nursing staff during the day shift instead of four (4), two (2) nurses on evening shift instead of four (4), and one (1) nursing staff during the night shift instead of two (2), with one (1) Nurse Supervisor noted.On 1/23/2026, the nursing schedule had two (2) nursing staff during the day shift instead of four (4), two (2) nurses on evening shift instead of four (4), and one (1) nursing staff during the night shift instead of two (2), with (1) Nurse Supervisor noted. The Certified Nurse Aide schedule had three (3) aides during the day shift instead of six (6). On 1/24/2026, the nursing schedule had one (1) nursing staff during the evening shift instead of four (4), and one (1) nursing staff during the night shift instead of two (2), with one (1) Nurse Supervisor noted for both shifts.On 1/25/2026, the nursing schedule had one (1) nursing staff during the night shift instead of two (2), with one (1) Nurse Supervisor noted. The Certified Nurse Aide schedule had three (3) aides during the day shift instead of six (6), two (2) aides on evening shift instead of six (6), and 0 aides for night shift. On 1/27/2026, the nursing schedule had two (2) nursing staff during the evening shift instead of four (4), and one (1) nursing staff during the night shift instead of two (2), with one (1) Nurse Supervisor noted. The Certified Nurse Aide schedule had three (3) aides during the day shift instead of six (6). On 1/28/2026, the nursing schedule had one (1) nursing staff during the night shift instead of two (2), with one (1) Nurse Supervisor noted. On 1/29/2026, the nursing schedule had zero (0) nursing staff during the night shift, with one (1) Nurse Supervisor noted. The Certified Nurse Aide schedule had five (5) aides during the day shift instead of six (6). On 1/31/2026, the nursing schedule had one (1) nursing staff during the night shift instead of (continued on next page)

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	335693	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	two (2).On 2/01/2026, the Certified Nurse Aide schedule had two (2) aides during the night shift instead of four (4). On 2/03/2026, the nursing schedule had one (1) nursing staff during the night shift instead of two (2), with one (1) Nurse Supervisor noted.On 2/04/2026, the nursing schedule had three (3) nursing staff during the day shift instead of four (4), and one (1) nursing staff during the night shift instead of two (2), with one (1) Nurse Supervisor noted. The Certified Nurse Aide schedule had five (5) aides during the day shift instead of six (6). On 2/10/2026, the Certified Nurse Aide schedule had five (5) aides during the evening shift instead of six (6). On 2/13/2026, the nursing schedule had three (3) nursing staff during the evening shift instead of four (4). The Certified Nurse Aide schedule had two (2) aides for night shift instead of four (4).On 2/14/2026, the Certified Nurse Aide schedule had three (3) aides during the night shift instead of four (4). On 2/15/2026, the Certified Nurse Aide schedule had three (3) aides during the night shift instead of four (4).On 2/20/2026, the nursing schedule had one (1) nurse for night shift instead of two (2).On 2/21/2026, the Certified Nurse Aide schedule had three (3) aides for evening shift instead of four (4).On 2/22/2026, the Certified Nurse Aide schedule had five (5) aides during the evening shift instead of six (6), and two (2) during the night shift instead of four (4).On 2/23/2026, the Certified Nurse Aide schedule had five (5) aides during the day shift instead of six (6). On 2/24/2026, the nursing schedule had three (3) nursing staff during the evening shift instead of four (4). During an interview on 2/11/2026 at 11:00 AM, Resident #72 stated staffing was an issue and there was very high staff turnover. Resident #72 stated that sometimes they were scared to ask for pain medication because the staff were so busy. Resident #72 stated they shower once a week and would like more showers, but staff would get mad if they asked for more because there were not enough staff.During an interview on 2/11/2026 at 11:25 AM, Resident #1 stated that they were very suspicious of staff. They believed the facility was short staffed like every nursing home. Getting help to get set up to clean up was hit or miss and sometimes they had to wait a long time to get pain medication.During an interview on 2/11/2026 at 1:26 PM, Resident #43 stated that the facility was short staffed too often. Sometimes staff came in the morning and the bed would be soaked from overnight because no one was there to change them. Resident #43 stated they knew when they needed to go to the bathroom or be changed, they would ring their call bell, and no one would come. Staffing was short on the night shift, and it did not matter whether it was weekday or weekend. Resident #43 stated that it usually took 1/2 hour or more for staff to answer their call bell, but it happened more at night.During an interview on 2/11/2026 at 1:46 PM, Resident #4 stated that there were not enough staff, especially on the overnight shift. Resident #4 also stated that they did not always get their medications on time because of staffing issues. During an interview on 2/12/2026 at 9:15 AM, Resident #67 stated that the facility was short staffed, but the staff were nice.During an interview on 2/12/2026 at 10:03 AM, Resident #80 stated that there were not enough staff to get things done and they had to wait a long time for help. During an interview on 2/12/2026 at 10:35 AM, Resident #50 stated that the facility could use more staff.During an interview on 2/12/2026 at 3:53 PM, Ombudsman #1 stated that staffing, particularly dietary, was lacking. One day on an undated weekend, breakfast was not served until 11 AM and needed to be made by maintenance because all the kitchen staff called out. Ombudsman #1 stated that the facility staffing was inconsistent.During an interview on 2/13/2026 at 9:29 AM, Assistant Administrator #1 stated that some of the staffing issues were related to staff that did not want to work. Assistant Administrator #1 stated that they wanted staff to want to work in long-term care and they believed that improvements had been made, and they had fired the people that were not a good fit for the facility. Over the last two months they have been using more agency. Assistant Administrator #1 stated they were (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	hoping to hire some of the agency's people that liked the facility. They were also considering trying to have the facility used as a clinical rotation for the nursing schools in the area. people that liked the facility. They were also considering trying to have the facility used as a clinical rotation for the nursing schools in the area.During an interview on 2/17/2026 at 11:14 AM, Certified Nurse Aide #16 stated that sometimes it was tough to get to all the residents in their assignment. It could be especially hard on the 3 PM - 11 PM shift when some residents become more confused. Certified Nurse Aide #16 stated that sometimes they had to finish their documentation an hour after their shift ends because there was not enough time during the shift. During an interview on 2/18/2026 at 9:57 AM, Staffing Coordinator #1 stated that they were in charge of staffing as of 2/12/2026. They were asked to help because they had knowledge and experience in staffing. Staffing Coordinator #1 stated that they pulled their numbers for the units from the facility assessment. Per unit, day shift was supposed to have three (3) Certified Nurse Aides and two (2) nurses, evening shift was three (3) aides and two (2) nurses, night shift was two (2) nurses and one (1) aide. They stated they were aware that there should be a Registered Nurse in the building for eight (8) consecutive hours every day, but they aimed to have a Registered Nurse for all three (3) shifts.Staffing Coordinator #1 stated that three (3) Certified Nurse Aides per unit was reasonable and appropriate. Four (4) aides would be great. There were days where call outs and no call/no shows would derail the staffing, but it was not as bad as they had seen in other places. Staffing Coordinator #1 believed that the staff turnover and lack of leadership caused some communication issues within the facility, and they were anticipating improvement since key positions had been filled.During an interview on 2/20/2026 at 10:46 AM, Licensed Practical Nurse #2 stated that they usually have two (2) aides on days but sometimes had three (3) or four (4). They stated they should have four (4) aides. On evenings, they usually had two (2) aides on evenings, sometimes three (3). Licensed Practical Nurse #2 stated they should have three (3) aides. On nights they had one (1) aide for each floor and one (1) Licensed Practical Nurse for both floors. If they had a supervisor, they would usually do medication passes. There were times when the supervisor was the only Licensed Practical Nurse and would have to do medication passes and be the supervisor.During an interview on 2/17/2026 at 10:36 AM, Dietary Aide #1 stated that staffing in the dietary department was normally limited and needed more staff specifically on weekends, with typically only one to two (1-2) cooks and four to six (4-6) dietary aides on weekdays.During an interview on 2/25/2026 at 11:04 AM, Director of Nursing #1 stated that the facility needed to use agency at this point. Director of Nursing #1 stated they had talked to Administrator #1 about referral bonuses. Director of Nursing #1 stated that the facility was not very big and should be able to be staffed, it was a slow process to get staff in.During an interview on 2/25/2026 at 10:10 AM, Administrator #1 stated that they would like to avoid staff turnover, but they let go of people that were not helping to move the facility forward. Administrator #1 stated they had openings on employment websites, offered sign on bonuses, and had booths at job fairs. Administrator #1 stated that they would schedule interviews, and the people would not show up, or the people would get through orientation and then not show up for their shifts. Administrator #1 stated that they had tried to work with local colleges but had not been very successful and was discussing offering referral bonuses for staff that would bring in other staff. Administrator #1 stated they believed that residents were being cared for, and that education and poor documentation were the main issues that needed to be addressed. 10 New York Codes, Rules and Regulation 415.13(a)(1)(i-iii)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on record review and interviews during a survey, the facility did not ensure licensed nurses and Certified Nurse Aides had the specific competencies and skills necessary to care for residents need. Specifically, based on the facility assessment of required education, (a.) education records reviewed for Certified Nurse Aides #1, 5 and 15 were incomplete; (b.) Licensed Practical Nurses #s1 and 12 education were incomplete; and (c.) there was no official person overseeing education for the facility.This is evidenced by: The Facility Assessment, dated 1/2026, documented under Staff training /education and competencies, the following topics, in addition to others, will be presented to staff: Communication, Resident Rights and facility responsibilities, Emergency planning, Person centered care, Dementia and behavioral management, substance abuse identification, trauma informed care/Post Traumatic Stress Disorder, proper body mechanics, Abuse, neglect, and exploitation, Infection control, Culture change, Required in-service training for nurse aides. In-service training must:o Be enough to ensure the continuing competence of nurse aides must be no less than 12 hours per year.o Include dementia management training and resident abuse prevention training.o Address areas of weakness as determined in nurse aides' performance reviews and facility assessment and may address the special needs of residents as determined by the facility staff.o For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. Identification of resident changes in condition, Cultural competency The following competencies and others will be offered to staff as necessary: Person-centered care Activities of daily living Disaster planning and procedures Infection control Medication administration Measurements: blood pressure, orthostatic blood pressure, body temperature, urinary output, etc. Resident assessment and examinations or Observations Caring for persons with Alzheimer's or another dementia Specialized care Caring for residents with mental and psychosocial disordersPolicies and procedures for the provision of care to our residents will be reviewed periodically to ensure that the methods we were utilizing to render that care was in line with the current practices of our industry. Staff would be provided with the opportunity to attend seminars, and educational experience will be utilized in tailoring our policies and procedures to ensure we were providing the best and most up to date care to our residents. Certified Nurse Aide #1's education file from the facility did not contain evidence that all annual educations were completed after 1/09/2022, many years after Certified Nurse Aide #1 had been employed at the facility. Certified Nurse Aide #1's electronic education record indicated that less than 12 hours of annual education had been completed by the time of survey.Certified Nurse Aide #5's education file from the facility contained multiple in-service sign- in sheets and some posttests associated with education. It could not be determined if Certified Nurse Aide #5 had completed all required annual educations from the provided information. Certified Nurse Aide #5 electronic education record indicated that less than 12 hours of annual education had been completed by the time of survey.Certified Nurse Aide #15's education file from the facility did not contain evidence that annual education was completed except for a written statement of verbal education of staff involving an incident that occurred on 2/18/2026. The electronic health records provided by the facility did not contain any education topics for Certified Nurse Aide #15.Licensed Practical Nurse #1's education file from the facility did not have documented evidence that annual educations were completed since 2022, except for one posttest provided dated 2024 and part of an answer sheet from a test that had no title. Licensed Practical Nurse #1's electronic education records documented that only two (2) of the ten (10) education topics were completed for 2025.Licensed Practical Nurse #12's education file from the facility did not have documented evidence that annual (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	educations were completed since 2024. Licensed Practical Nurse #12's electronic education records documented that only one (1) of the six (6) education topics were completed for 2025.During an interview on 2/13/2026 at 9:29 AM, Assistant Administrator #1 stated that typically the nurse educator was the Assistant Director of Nursing. Registered Nurse #2 had been filling in for that roll since they arrived. Assistant Administrator #1 stated they did on the spot education when it was needed, and the management team in general did education when needed.During an interview on 2/19/2026 at 9:35 AM, Assistant Administrator #1 stated that Acting Director of Nursing #1 handled education. The prior Assistant Director of Nursing and Director of Nursing also worked on education. There was an electronic education system that the staff were supposed to be using. Ideally, online teaching would be set up monthly to piggyback on in-house education and be due by a particular date. There were some one (1) on one (1) educations and group in services where people signed in. With the change of staff, education did stop for a little while. The previous Assistant Director of Nursing should have been keeping a binder with the information, but when they left, Assistant Administrator #1 was not able to find any of the information. Staff should have been getting yearly education on things like precautions, safety, and resident rights.During an interview on 2/24/2026 at 10:18 AM, Licensed Practical Nurse #4 stated that education was on the computer, and they came around and did in- service talks. Licensed Practical Nurse #4 stated that they did not know how to get education on the computer.During an interview on 2/24/2026 at 10:25 AM, Licensed Practical Nurse #3 stated that they knew that they had overdue education on the electronic education system and stated they did not have enough time in the day to complete them. Licensed Practical Nurse #3 stated that they did handwashing and infection control in the last year but were not sure if they had any teaching on Quality Assurance Performance Improvement program.During an interview on 2/24/2026 at 10:30 AM, Licensed Practical Nurse #8 stated that education was printed sheets that the staff read and signed. There was also education on the electronic medical record, and there were classes. The last one Licensed Practical Nurse #8 remembered receiving was hand hygiene on the laptop.During an interview on 2/24/26 at 11:52 AM, Acting Director of Nursing #1 stated that they did not do education. Acting Director of Nursing #1 stated that there were monthly online educations, and before the previous Director of Nursing left, they would post reminders about educations near the time clock.During an interview on 2/24/2026 at 10:55 AM, Laundry Attendant #1 stated that they received education on housekeeping and laundry tasks. They had not received any house wide education, such as abuse and neglect.During an interview on 2/24/2026 at 11:02 AM, Certified Nurse Aide #10 stated that they had not received any education in the last year. They had education on abuse and neglect about 3 years ago. They stated they did not use an online platform for education that they were aware of. They read and signed sheets.During an interview on 2/24/2026 at 2:47 PM, Licensed Practical Nurse #7 stated that as the unit manager they were not responsible for assigning education and was unsure who was.During an interview on 2/24/2026 at 5:30 PM, Certified Nurse Aide #4 stated that they knew there was online education that they had not completed. Certified Nurse Aide #4 stated they had not had training for abuse, neglect, infection control, or behavior health training.During an interview on 2/24/2026 at 5:35 PM, Certified Nurse Aide #15 stated that they did abuse and neglect training a week ago and that there was online training, but they had not done it.During an interview on 2/24/2026 at 5:40 PM, Certified Nurse Aide #5 stated that they had no idea if there was Certified Nurse Aide education, had not done any since they were hired, including nothing for abuse, neglect, infection control, or dementia behavior training.During an interview on 2/25/2026 at 11:04 AM, Director of Nursing #1 stated that education was going to be their priority. Director of Nursing #1 stated they were aware that there were required annual education such (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	as abuse, identifying and reporting, infection control, dealing with challenging residents/dementia care, activities of daily living, body mechanics, sexual harassment, foley care, urinary tract infections, medication administration, wound care, and resident rights. Everyone should have gotten abuse, reporting, and resident rights education.During an interview on 2/25/2026 at 12:25 PM, Administrator #1 stated that they would work closely and as a team with Director of Nursing #1 and the use of the online education system would make things easier. Administrator #1 stated they had accessed the online education system and that the annual education that needed to be done would be done by the Assistant Director of Nursing when they were hired. The online education system tracked the aides' required hours of education and had gone into effect in August 2025. There were house wide educations that everyone needed to do such as fire safety, resident rights, abuse, and oxygen control. Administrator #1 stated they had a checklist and cheat sheets for the things staff needed to know. Dementia training was part of resident rights. Quality Assurance was not part of nursing education. 10 New York Code of Rules and Regulations 415.26(c)(1)(iv)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation and interviews conducted during a survey, the facility did not ensure that food and drink were palatable, attractive, and at a safe and appetizing temperature. Specifically, for three (3) of three (3) meals reviewed (Breakfast meal 02/17/2026, Lunch meals on 2/13/2026 and 2/17/2026). Specifically, food was not served at a palatable and appetizing temperature during the breakfast meal 02/17/2026 and lunch meals on 02/13/2026 and 02/17/2026.This is evidenced by: Observation: During a meal tray sampling on 02/13/2026 at 1:06 PM, Resident #72's lunch tray was tested, and a replacement tray was provided with an extended wait time of 32 minutes from requesting. The lunch tray was tested for taste and temperature, and the results were as follows: coffee 119.3 degrees Fahrenheit, whole milk 49.1 degrees Fahrenheit, seafood casserole 125.5 degrees Fahrenheit, California blend vegetables 122.2 degrees Fahrenheit, and chocolate cake 68.5 degrees Fahrenheit. During a meal tray sampling on 02/17/2026 at 7:46 AM, Resident #67's breakfast tray was tested, and a replacement tray was provided. The breakfast tray was tested for taste and temperature, and the results were as follows: water for tea 144.1 degrees Fahrenheit, whole milk 53.2 degrees Fahrenheit, orange juice 56.1 degrees Fahrenheit, hot cereal 136.9 degrees Fahrenheit, sausage patty 102.0 degrees Fahrenheit, toasted bagel 85.6 degrees Fahrenheit, and two (2) cream cheese packets 41.1 and 41.5 degrees Fahrenheit.During a meal tray sampling on 02/17/2026 at 1:06 PM, Resident #8's lunch tray was tested, and a replacement tray was provided. The lunch tray was tested for taste and temperature, and the results were as follows: water for tea 140.7 degrees Fahrenheit (tea bag was missing from tray), apple juice 64.9 degrees Fahrenheit, cranberry juice 64.2 degrees Fahrenheit, Philly steak on bun with peppers, onions, and cheese sauce casserole 128.5 degrees Fahrenheit, mixed vegetables 124.9 degrees Fahrenheit, bow tie noodles 110 degrees Fahrenheit (noted to be underprepared with no sauce), cottage cheese 49 degrees Fahrenheit, and Assorted fruit 64.2 degrees Fahrenheit (canned oranges) which were sour to taste. Interviews:During an interview on 02/11/2026 at 11:00 AM, Resident #72 stated that food was horrible and delivered cold most of the time; sometimes it was warm.During an interview on 02/12/2026 at 10:03 AM, Family member #6 stated they thought the food in the facilty was gross.During an interview on 02/12/2026 at 12:44 PM, Resident #8 stated meals were always cold. They stated they were the last one on the list for food delivery.During an interview on 02/17/2026 at10:36 AM, Dietary Aide #1 stated their responsibilities included setting up trays (placing silverware, ensuring items match the meal ticket, and cleaning dishes). They stated each resident received a meal ticket, and as of recently, requested substitutions were being highlighted. Replacement meals normally take 3-4 minutes to make and get delivered to residents. Staffing was usually limited. On weekdays, there were typically one (1)-2 cooks and 4-6 dietary aides. In addition, they stated, the cook tested the temperature of food before it was delivered to the residents.During an interview on 02/20/2026 at 12:53 PM, Certified Nurse Aide #5 stated lunch was usually brought to the unit around 12:30 PM. They stated residents always complained about the food not matching the meal tickets. They stated that that morning a resident was missing oatmeal off their tray. They stated if a resident was missing or did not get an item on their tray they would call the kitchen or walk down there and grab it. Lunch was still not delivered to the unit at 12:55 PM.During an interview on 02/25/2026 at 12:25 PM, Administrator #1 stated they checked that the food arrived to the residents, and temperatures were taken randomly. 10 New York Code of Rules and Regulations 415.14(d)(1)(2)??

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review and interviews conducted during a survey, the facility did not ensure that storage and preparation of food was maintained according to professional standards. Specifically, incidents of potential for contamination of finished food, improperly functioning thermometers, and improperly stored food were identified throughout the kitchen.This is evidenced by: During the initial kitchen tour on 2/11/2026 from 10:24 AM to 11:00 AM and the follow-up visits on 2/19/2026 between 11:00 AM and 2:30 PM, the following observations were made:One (1) of four (4) thermometers tested for accurate calibration was outside of acceptable range. When tested in ice water bath, the thermometer displayed 37 degrees Fahrenheit.Improper storage of food was identified in the following areas:In the walk-in refrigerator open bags of peperoni and hot dogs were found undated.In the walk-in freezer open bags of chicken, green beans, sausage patties and egg patties were found undated.In dry storage room eight (8) bags of English muffins were observed on the shelves. Product label stated they were to be stored frozen. All bags were undated. Four (4) bags had identified mold on the English muffins within the bags.In second floor kitchenettes two (2) bowls of dry cereal were identified stored in the cabinets without dates or times labeled.In second floor kitchenettes five (5) bowls of dry cereal were identified stored in the cabinets without dates or times labeled.Potential for contamination of food products was identified as follows:Two (2) of five (5) kitchen staff were identified to not have required hair protection while working in the food preparation area.One bottle of drain cleaner was identified improperly stored in the food service area.Clean/dry rags were stored at floor level in an overfilled small garbage can.The undated facilities Food Receiving and Storage policy states that all food stored in refrigerator or freezer will be covered labeled and dated.During interview, on 2/11/2026 at 10:46 AM, Food Service Director #1 stated they were aware that the unlabeled food in the walk-in refrigerator and freezer as well as in the unit kitchenettes were supposed to be dated and was unaware of why they were not at that time.During interview on 2/19/2026 at 2:15 PM, Food Service Director #1 stated they were unaware the English muffins were supposed to remain frozen, that someone else must have unpacked them since they usually did, and made sure they were dated. When the mold was pointed out all products were disposed of immediately. Food Service Director #1 also stated they were unaware as to why the drain cleaner was not in a properly secured area, and they were trying to move away from the dry rags to wipe down surfaces to single use disposable wipes. Food Service Director #1 stated they would keep a closer eye on the calibration of the thermometers and ensure that those in use were properly calibrated. 10 New York Codes, Rules, and Regulations 415.14(h)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. Based on observation, record review, and interviews during the recertification survey, it was determined the governing body did not establish and implement policies regarding the management and operation of the facility. The governing body did not maintain a consistent Administrator who was responsible for the management of the facility to ensure regulatory compliance. Specifically, multiple deficiencies were identified on the recertification survey including repeat deficiencies in the areas of safe/clean/comfortable/homelike environment(F584), develop/implement comprehensive care plan(F656), care plan timing and revision (F657), and Influenza and pneumococcal immunizations (F883).This is evidenced by: Facility was cited for the following on recertification survey:F550 as it pertains to the facility's failure to resident dignity.F580 as it pertains to the facility's failure to notify providers and resident representatives about changes of condition.F584 as it pertains to the facility's failure to provide a safe, clean, comfortable and homelike environment.F600 as it pertains to the facility's failure to ensure residents were free from abuse and neglect.F609 as it pertains to the facility's failure to ensure injuries from unknown sources were reported to the State Survey Agency.F610 as it pertains to the facility's failure to all allegations of abuse, neglect, exploitation or mistreatment were thoroughly investigated.F628 as it pertains to the facility's failure to document and notify the appropriate entities of discharges and transfers. F656 as it pertains to the facility's failure to develop and implement a comprehensive person-centered care plan for each resident.F657 as it pertains to the facility's failure to review and revise a comprehensive person-centered care plan for each resident.F679 as it pertains to the facility's failure to provide activities based on comprehensive assessment, care plan, and preferences of each resident.F684 as it pertains to the facility's failure to ensure services provided met professional standards.F695 as it pertains to the facility's failure to ensure respiratory care services provided met professional standards.F711 as it pertains to the facility's failure to ensure that physician notes were entered and maintained accurately.F725 as it pertains to the facility's failure to ensure sufficient staffing services provided met professional standards.F726 as it pertains to the facility's failure to ensure competent nursing services provided met professional standards.F755 as it pertains to the facility's failure to ensure that pharmaceutical services were provided to meet the needs of each resident.F804 as it pertains to the facility's failure to ensure that food and drink were palatable, attractive, and at a safe and appetizing temperature.F812 as it pertains to the facility's failure to store, prepare, distribute, and serve food met professional food service safety standards. F851 as it refers to the facility's failure to ensure that accurate staffing information based on payroll data was submitted to Centers for Medicaid/Medicare Services.F867 as it refers to the facility's failure to ensure that the Quality Assurance Process Improvement feedback, data systems and monitoring.F883 as it refers to the facility's failure to ensure that providing and/or documenting influenza and/or pneumococcal immunizations as required for residents.F908 as it refers to the facility's failure to ensure that maintaining all mechanical electrical and patient care equipment in a safe operating condition.F940 as it refers to the facility's failure to ensure that it developed, implemented, and maintained an effective training program for all new and existing staff.F944 as it refers to the facility's failure to ensure that it included as part of its Quality Assurance Performance Improvement program mandatory training that outlined and informed staff of the elements and goals of the facility's Quality Assurance Process and Improvement program.F947 as refers to the facility's failure to ensure that in-service training for nurse aides was sufficient to ensure the continuing competence (continued on next page)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	of nurse aides and be no less than 12 hours per year.The undated document titled, Quality Assurance Performance Improvement, documented it was the policy of this facility to establish and utilize specific systems for feedback, data collection, and monitoring inclusive of adverse events. The information would be utilized to fulfill the facility's responsibility and accountability for assessment and improvement in the quality of care and the services provided to resident's families and the community we serve. Under Feedback, Data Systems and Monitoring documented that Performance Improvement Projects (quality indicators) would be chosen based on those elements, which measured facility wide functions, involving high-volume, high risk and/or problem-prone activities. The Facility Assessment would be utilized in further determining quality indicators that were relative to the needs of the population served. The development of Performance Improvement Projects (indicators) would also be based upon feedback received from the following data sources. These considerations include but are not limited to: Direct observations of the Quality Assurance Performance Improvement Committee Input from residents, families, staff, and other customers Accident/Incident reports Infection Control reports Consultant Services/reports Monthly Department Head meetings QI/QM, acronym not defined, reports; Facility Indicator Profile Report DentalFacility-wide indicators may include such areas as: Staff turnover, recruitment, and retention efforts Safety issues (related to residents and employees, visitors) Resident Grievances Other areas as identified based upon outcomes and feedback from those servedThe documented objectives were:1. Establish, maintain, support, and document evidence of an ongoing QAPI program that included effective mechanisms for monitoring and evaluating resident care and for appropriate response to findings.2. Assist individual departments in improving care and identifying problems through the use of ongoing performance improvement projects. This was to be done by focusing on identification, analysis and resolution of problems that affected the residents of the facility.3. Evaluate the results of action taken by individual departments and maximize the efficient use of resources available within the facility.4. Centralize and expand the scope of present quality improvement activities into a more comprehensive program.5. Direct improvement efforts at processes, not individuals.The documented Design and Scope was that Quality Assurance Performance Improvement activities would be integrated and coordinated among departments within the facility; they would be designed to minimize duplication of effort; and would be cost-effective. AllThe document referenced above ended at All and the last two pages of the document supplied by the facility was a Quality Assurance and Performance Improvement test.During an interview on 2/12/2026 at 3:53 PM, Ombudsman #1 stated that they were at the facility weekly except for the last two weeks and they did not see the Administrator. Ombudsman #1 stated that they would go a month or more with seeing Administrator #1. Ombudsman #1 stated that Assistant Administrator #1 was administering the building and that the residents considered the Assistant Administrator the actual Administrator.During an interview on 2/13/2026 at 9:29 AM, Assistant Administrator #1 stated that Administrator #1 was at the facility periodically but always accessible and they talked multiple times a day. During an interview on 2/25/26 at 10:10 AM Administrator #1 stated that they became Administrator in August 2025 when the previous Administrator told them on a Friday that they would not be returning on the following Monday. Administrator #1 stated they had no choice but to put their name on the building as they owned 9% of the facility. At the time of taking over as Administrator, they had asked the Medical Director and Director of Nursing if there were any major infection control concerns, to which they said no. Administrator #1 stated that Director of Nursing #1 was going to be the answer to many of the issues identified during survey. Administrator #1 stated that they were already working on a new formula on how to track issues. Administrator #1 stated that when the previous Administrator was running the building, (continued on next page)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administrator #1 was at the facility every other week. Now Administrator #1 was at the facility from Sunday through Thursday, every week. Administrator #1 acknowledged that residents might not know they were the Administrator. Administrator #1 stated they had been identifying issues where they wanted things to change. Administrator #1 stated they did not recall ever doing a Performance Improvement Project or Plan with any individuals in the facility.During an interview on 2/25/2026 at 11:04 AM Director of Nursing #1 stated in the week that they had been in the building, they believed the bones were good but the facility needed revamping. Director of Nursing #1 stated they were actively interviewing for a local administrator.During an interview on 2/25/2026 at 12:25 PM Administrator #1 stated that they have tried to address issues that were brought to them as soon as they could. They were not aware of some of the issues that had been brought to light during survey. Administrator #1 stated they needed some new processes. Administrator #1 stated that all issues should be and going forward would be discussed in morning meeting and afternoon wrap up. Administrator #1 stated that department heads would be monitored more closely and that they would look at regulations to ensure compliance with things they did not know the regulations on. 10 New York Code of Rules and Regulations 415.26(b)(3)(1)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation and interviews conducted during a recertification survey, the facility did not maintain all mechanical, electrical, and patient care equipment in safe operating condition. Specifically, the self-closing device on the Walk-in freezer was not functioning as intended.This is evidenced by: During observations on 2/17/2026 at 11:00 AM as part of inspection of the walk-in freezer, the self-closing mechanism on the main entry door was inoperable and not pulling the door closed to ensure a tight seal.During an interview on 2/17/2026 at 2:00 PM, Food Service Director #1 stated that the company was just there several days ago and left several items in disrepair and they would contact them and have it addressed. 10 New York Codes, Rules, and Regulations 415.5(e)(1)(2)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on record review and interviews conducted during a survey, the facility did not ensure that in-service training for nurse aides was sufficient to ensure the continuing competence of nurse aides and be no less than 12 hours annually to include dementia care and abuse. This was identified for 11 of 14 Certified Nurse Aides (Certified Nurse Aides #'s 1, 3, 4, 5, 7, 8, 9, 10, 11, 12, and 14) reviewed for nurse aide training. Specifically, the facility was unable to provide evidence that Certified Nurse Aide #s 1, 3, 4, 5, 7, 8, 9, 10, 11, 12, and 14 were provided 12 hours of mandatory annual training.This is evidenced by: The facility assessment, dated 1/2026, documented that the following topics, in addition to others, would be presented to staff: Communication, Resident's Rights and Facility Responsibilities, Emergency Planning, Person-Centered Care, Dementia and Behavioral Management, Substance Abuse Identification, Trauma Informed Care, Proper Body Mechanics, Abuse, Neglect and Exploitation, Infection Control, and Culture Change. Additionally documented was that required in-service training for nurse aides must be enough to ensure the continuing competence of nurse aide but must be no less than 12 hours per year, including dementia management training and resident abuse prevention training, address areas of weakness as determined in nurse aides' performance reviews and facility assessment. The following competencies and others would be offered to staff as necessary: Person-Centered Care, Activities of Daily Living, Disaster Planning and Procedures, Infection Control-Hand Hygiene, Isolation, and Standard Precautions, Measurements such as blood pressure, temperature, Caring for Persons with Alzheimer's or another dementia, and Caring for Residents with Mental and Psychosocial Disorders. Facility provided education records and in-service sign-in-sheets documented the following: Certified Nurse Aide #1, who was hired 1/22/2013, completed seven (7) of the 11 required electronic education topics totaling four (4) of 7.5 hours and had attended 5 in-service trainings in 2025. Certified Nurse Aide #3, who was hired 8/21/2017, completed three (3) of the 11 required electronic education topics totaling two and half (2.5) of seven and half (7.5) hours and had attended one (1) in-service training in 2025. Certified Nurse Aide #4, who was hired 8/21/2017, completed six (6) of the 11 required electronic education topics totaling four (4) of seven and half (7.5) hours and had attended one (1) in-service training in 2025. Certified Nurse Aide #5, who was hired 1/21/2020, completed six (6) of the 11 required electronic education topics totaling four (4) of seven and half (7.5) hours and attended zero (0) in-service trainings in 2025. Certified Nurse Aide #7, who was hired 12/06/2024, completed three (3) of the eight (8) required electronic education topics totaling three (3) of eight (8) hours and had attended 0 in-service trainings in 2025. Certified Nurse Aide #8, who was hired 9/13/2000, completed three (30 of the 11 required electronic education topics totaling two and half (2.5) of seven and half (7.5) hours and had attended zero (0) in-service trainings in 2025. Certified Nurse Aide #9, who was hired 10/10/1984, completed four (4) of the 11 required electronic education topics totaling two and half (2.5) of seven and half (7.5) hours and had attended one (1) in-service trainings in 2025. Certified Nurse Aide #10, who was hired 8/21/2017, completed nine (9) of the 14 required electronic education topics totaling six (6) of nine and half (9.50 hours and had attended one (1) in-service trainings in 2025. Certified Nurse Aide #11, who was hired 11/12/2024, completed three (3) of the ten (10) required electronic education topics totaling two and half (2.5) of seven (7) hours and had attended two (2) in-service trainings in 2025. Certified Nurse Aide #12, who was hired 9/18/2024, completed three (3) of the eight (8) required electronic education topics totaling two and half (2.5) of six (6) hours and attended zero (0) in-service trainings in 2025. Certified Nurse Aide #14, who was hired 7/25/2002, completed six (6) of the 11 required electronic education topics totaling four (4) of seven (continued on next page)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and half (7.5) hours and attended one (1) in-service trainings in 2025. During an interview on 2/13/2026 at 9:29 AM, Assistant Administrator #1 stated that typically the nurse educator was the job of Assistant Director of Nursing #1. Registered Nurse #2 had been filling in since their arrival. Assistant Administrator #1 stated they did on-the-spot education when it was needed and the management team in general did education when it was needed. During an interview on 2/19/2026 at 9:23 AM Licensed Practical Nurse #3 stated online educations were done through an electronic education system. Acting Director of Nursing #1 used to handle education but Registered Nurse #2 was handling it going forward. During an interview on 2/19/2026 at 9:35 AM, Assistant Administrator #1stated that the Assistant Director of Nursing handled education. The prior Assistant Director of Nursing and the Director of Nursing also worked on education. Ideally, online teaching would be set up monthly to piggyback on in-house education and would be due by specific date. With the change of staff, education stopped for a little while. The previous Assistant Director of Nursing, who became the Director of Nursing, was doing education. Ideally, they would have kept a binder with the education information, but when they left, Assistant Administrator #1 was not able to find any of the information. During an interview on 2/24/2026 at 10:18 AM, Licensed Practical Nurse #4 stated that education was done on the computer, and staff came around and did in- service talks. Licensed Practical Nurse #4 stated that they did not know how to get education on the computer. During an interview on 2/24/2025 at 10:25 AM, Licensed Practical Nurse #3 stated that they knew they had some electronic education that was overdue. They knew they had done handwashing and infection control in the last year. During an interview on 2/24/26 at 11:52 AM, Acting Director of Nursing #1 stated they did not do education. There were monthly online teachings. Before the previous Assistant Director of Nursing left, they would post reminders about education, but there was no electronic triggering reminders set up through the electronic system. During an interview on 2/25/2026 at 10:10 AM, Administrator #1 stated that the changeover in management staff may be part of the problem. They needed better procedures, education and logging of information. During an interview on 2/25/2026 at 11:04 AM, Director of Nursing #1 stated the education process needed structure. Education would go on the Assistant Director of Nursing's role. Director of Nursing #1 stated that they were aware that Certified Nurse Aides needed to maintain education hours each year and thought that it was 20 hours a year.During an interview on 2/25/2025 at 12:25 PM, Administrator #1 stated that they would work with Director of Nursing #1 as a team. The annual education that needed completion would be done by Assistant Director of Nursing when they were hired. The electronic education system tracked the aides' required hours of education, but they did not think that it alerted staff to what was due. Administrator #1 stated that they had cheat sheets of codes, phone trees, emergency processes and other things staff needed to know. Administrator #1 stated that they knew that there were certain mandatory educations that needed to be done yearly and named abuse training and resident rights. Administrator #1 believed that dementia training was part of the resident rights teaching.During an interview on 2/25/26 at 6:03 PM, Assistant Administrator #1 stated that the last formal nurse educator in the building was the Assistant Director of Nursing who left at the end of August 2025. 10 New York Codes, Rules and Regulations 415.26(c)(1)(iv)