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 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 (continued on next page)

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	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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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews conducted during a survey, the facility did not ensure it provided effective housekeeping and maintenance services, and the environment was maintained for two (2) of two (2) units observed. Specifically, the facility did not ensure that resident rooms were clean and in good repair. This isˆevidencedˆby:ˆˆDuring facility observations on 2/11/2026, 2/12/2026, and 2/19/2026 it was noted: rooms [ROOM NUMBER] air conditioner/heater units were not flush with the wall creating large gaps. In room [ROOM NUMBER], the outside yard was viewable through the gap. rooms [ROOM NUMBERS] had broken privacy curtains and broken window curtain rods causing the drapery to hang incorrectly. room [ROOM NUMBER] had stained bed linens. room [ROOM NUMBER] air conditioner/heater unit had a broken grate. room [ROOM NUMBER] door was unable to close completely and would get stuck against molding. ˆInterview:ˆˆDuring an interview on 01/29/2026 at 1:41 PM, Certified Nurse Aide #1 stated that they should report any maintenance concerns they see to the Maintenance Department.During an interview on 2/12/2026 at 10:03 AM, Family Member #6 stated they had cleaned Resident #80 entire room, located on second floor, then the facility moved the resident to room [ROOM NUMBER]. The floor was noted to be sticky during the interview, and Family Member #6 stated it always was. During an interview on 2/13/2026 at 9:29 AM, Assistant Administrator #1 stated that there were multiple external forces that ran the building. Assistant Administrator #1 stated they had the authority to order some things, but major purchases needed to be authorized other people, such as the Director of Procurement. During an interview on 2/17/2026 at 2:15 PM, Director of Maintenance #1 stated that they had been sealing the gaps (around the air conditioner/heater) units when they found them. When the issues observed on survey were pointed out, Director of Maintenance #1 stated that they would take care of them as soon as possible.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 been identifying issues where they wanted things to change and had a major update planned for the building. New York Codes, Rules, and Regulations Title 10 S415.5(h)(4)

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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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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 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	were not always notified of incidents/accidents that were reportable to the New York State Department of Health. 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 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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). 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 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 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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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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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 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	then suspended 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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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **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 written notification was sent to the resident, resident representative, and a representative of the Office of the State Long-Term Care Ombudsman of the resident's transfer or discharge and the reasons for the move for three (3) (Resident #'s 75, 86, and 87) of three (3) residents reviewed. Specifically, (a.) for Resident #'s 75, 86, and 87 there was no documented evidence that the resident, representative, or Ombudsman received a transfer/discharge notice upon discharging from the facility; and (b.) transfer/discharge notices were not provided to the resident, resident representative, or the Ombudsman when a resident discharged home or when admitted to the hospital since December 2025.This is evidenced by: 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 (an assessment tool) dated 12/31/2025, documented the resident had moderate cognitive impairment, was able to make themselves understood and understand others.A nursing progress note dated 11/11/2025 at 7:40 PM, documented per family request, Resident #75 was transferred to the hospital by emergency medical services at 4:00 PM due to pain and distended abdomenThere was no documented evidence that a transfer/discharge notice was completed for Resident #75, provided to the resident and/or resident representative, and sent to the Ombudsman. Resident #86 Resident #86 was admitted to the facility with diagnoses of metabolic encephalopathy (a broad term for acute or subacute brain dysfunction caused by chemical imbalances, systemic illness, or organ failure), Parkinson's disease (a movement disorder of the nervous system that worsens over time), and peritoneal abscess (a localized infected collection of pus, bacteria, and debris confined within the abdominal cavity). The Minimum Data Set, dated [DATE], documented the resident was understood, able to understand others, and had moderate cognitive impairments.A social work progress note dated 12/23/2025 at 4:43 PM, written by Assistant Administrator #1, documented a detailed conversation held with Resident #86's family regarding their desire to have the resident discharge against medical advice. The family had no concerns with the care provided at the facility, and they just wanted Resident #86 to be in their home environment. The progress note further documented that family was aware of the meaning of against medical advice and signed the appropriate paperwork.There was no documented evidence that a transfer/discharge notice was completed for Resident #86, provided to the resident and/or resident representative, and sent to the Ombudsman.An email from Ombudsman #1 dated 2/19/2026 at 9:49 AM, documented they had not received discharge notifications from the facility for the months of December 2025 and January 2026. It documented that they received discharge notifications for October and November 2025 on 12/12/2025. They had not received Resident #86's discharge notification.During an interview on 2/19/2026 at 11:12 AM, Assistant Administrator #1 stated the facility had not sent any discharge notifications to the Ombudsman since before Christmas 2025. They stated the former Social Worker sent discharge lists to the Ombudsman, but since there currently was no Social Worker, it was not getting done. They further stated the facility currently had an advertisement to hire a Social Worker. 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], (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	documented the resident was independent with making decisions regarding tasks of daily living.A nursing progress note dated 1/14/2026 at 7:12 AM, written by Licensed Practical Nurse #12 documented Resident #87 stated they fell and refractured their hip. It further documented, Resident #87's family called 911 to take the resident to the hospital.During an interview on 2/18/2026 at 1:36 PM, Family Member #5 stated they called 911 to have Resident #87 sent back to the hospital because the resident reported they had a fall.There was no documented evidence that a transfer/discharge notice was completed for Resident #87, provided to the resident and/or resident representative, and sent to the Ombudsman.During an interview on 2/25/2026 at 11:04 AM, Director of Nursing #1 stated they had been working at the facility for a little over a week. They stated they were not surprised that discharge notifications had not been sent to the Ombudsman.During an interview on 2/25/2026 at 12:25 PM, Administrator #1 stated they sent discharge notifications to the Ombudsman. They stated the discharge paperwork was sent with the resident when they were sent to the hospital. 10 New York Codes, Rules and Regulation 415.3 (i)(1)(iii)(a-c)

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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 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 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews conducted during a survey, the facility did not ensure that comprehensive care plans were revised and updated according to professional standards for four (4) (Resident #s 1, 11, 75, and 85) of 22 residents reviewed. Specifically, (a.) for Resident #1, the comprehensive care plan was not updated with new interventions after Resident #1 fell; (b.) for Resident #11, the comprehensive care plan was not updated to reflect the urinary tract infections; (c.) for Resident #75, the comprehensive care plan was not updated to reflect the hospitalization on 11/11/2025,1/09/2026, and 2/17/2026 for repeated issues with constipation; and (d.) for Resident #85, the comprehensive care plan was not updated to reflect the resident's admission to the hospital for urinary tract infection and urosepsis.This isˆevidencedˆby:ˆ A facility policy titled Care Planning Process, date revised 8/2018, documented that an individualized comprehensive care plan would include measurable objectives and timetables to meet the resident's medical, nursing, mental, and psychological needs was developed for each resident. Further documented, in pertinent part, that (11) Assessments of residents were ongoing, and care plans were revised as information about the resident and the resident's condition changed; (12) The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans: (a) When there has been a significant change in the resident's condition. (b) When the desired outcome is not met (c) When the resident has been readmitted to the facility from a hospital stay; and (d) At least quarterly. Resident #1 Resident #1 was admitted to the facility with the diagnoses of encephalopathy (a disease in which the functioning of the brain was affected by some agent or condition), unspecified, acute respiratory failure with hypoxia (life-threatening medical emergency where the lungs could not adequately oxygenate the blood), and pneumonitis due to inhalation of food and vomit (lung inflammation caused by inhaling food, vomit, or saliva into the airways, leading to infection). The Minimum Data Set (an assessment tool), dated 1/30/2026, documented that the resident was able to understand others, be understood and was cognitively intact. The comprehensive care plan for at Risk for Injury related to falls, dated initiated 1/29/2026 documented Resident #1 fell on 2/08/2026 at 12:30 PM and 7:00 PM. Had one new intervention added on 2/08/2026 that documented no description provided. There were no other documented inventions updated, changed or added and no description provided was not expounded on. 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 (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. There was no documented evidence that a care plan for abuse or at risk for abuse was updated or revised after Resident #75 was identified as the victim of a resident-to-resident altercation that occurred in June 2025. Resident #85 Resident #85 was admitted to the facility with the diagnoses of chronic kidney disease (a long-term progressive loss of kidney function), stage 3 unspecified, age-related osteoporosis without current pathological fracture (a loss of bone density associated with age progression), unspecified dementia, severe (a progressive neurological disease-causing memory loss). The Minimum Data Set, dated [DATE], documented that the resident was usually able to understand others, was usually understood, and was so significantly cognitively impaired, they were unable to complete the exam. On 9/28/2025, Resident #85 was admitted to the hospital with urosepsis (a systemic shut down of major organ function), related to a urinary tract infection and re-admitted to the facility on [DATE] for comfort care. Resident #85's comprehensive care plan did not have documented evidence of revised care plan to include area related to risk of urinary tract infection prevention or recent hospitalization for urosepsis. During an interview on 2/24/2026 at 10:18 AM, Licensed Practical Nurse #4 stated that care plans were updated by Registered Nurse #2. Prior to Registered Nurse #2, whoever was the Director of Nursing or any Registered Nurse in the building would be able to update the care plan. Additionally, the people in charge of the care area requiring the update could update their section. During an interview on 2/24/2026 at 10:31 AM, Licensed Practical Nurse # 8 stated that care plans were updated through the unit managers, or the staff would consult with the director of the care area needing an update like rehabilitation. During an interview on 2/24/2026 at 11:52 AM, Acting Director of Nursing #1 stated that they had been updating care plans. Registered Nurse #2 was in charge of it and there were some other people that were able to update them. During an interview on 2/25/2026 at 11:04 AM, Director of Nursing #1 stated care planning was a significant issue in the facility due to not having enough staff. They also stated the facility would be interviewing for an Assistant Director of Nursing. During an interview on 2/25/2026 at 12:25 PM, Administrator #1 stated a care plan was used to make sure the resident was safe and was a blueprint of how to care for a resident. Care plans should be individualized. If there was something that the staff didn't do, it would be something that they would work toward in the future. Administrator #1 additionally stated that everyone could make mistakes, (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	and they were fixable. 10 New York Code of Rules and Regulations 415.4(a)(2-7)

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide activities to meet all resident's needs. Based on observation, record review and interviews conducted during a recertification survey, the facility did not ensure, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities for one (1) (Resident #14) out of three (3) residents reviewed. Specifically, Resident #14 was not offered meaningful activities that included their interests and preferences to maintain their highest practicable quality of life. This is evidenced by: The facility policy and procedure titled Activity Program Policy (undated and unsigned) documented facility would provide an individualized, ongoing activity program designed to meet the physical, mental, psychosocial, behavioral, and cognitive needs of all residents. Facility shall provide a structured person center program available 7 days a week, ensuring meaningful engagement for all residents.Demetia/Cognitively impaired residents programming will incorporate dementia-capable principles, including structured routine, sensory stimulation, reminiscence therapy, validation techniques, redirection strategies, and failure free activities. Residents who are unable to tolerate group settings will receive individual one-to-one therapy Facility shall maintain monthly Calanders, attendance logs, one-to-one visit documentation, and refusal trackingResident #14 was admitted to the facility with diagnoses of metabolic encephalopathy (diffuse brain disfunction), Alzheimer's disease unspecified (progressive mental deterioration), and muscle weakness. The Minimum Data Set (an assessment tool) dated 02/10/2026, documented the resident could usually be understood, sometimes understand others, and was severely cognitively impaired.During an observation on 02/11/2026 at 11:30 AM, Resident #14 was sitting in their wheelchair on the first floor Rehabilitation unit nursing station with no music playing or personal interactions.During an observation on 02/13/2026 at 10:55 AM, Resident #14 was sitting in their wheelchair on the first floor Rehabilitation unit nursing station with a drink on bedside table and no music playing or personal interactions.During an observation on 02/24/2026 at 2:25 PM, Resident #14 was sitting in their wheelchair outside of the first floor Rehabilitation unit nursing station with no music playing or personal interactions.There was no documented evidence of activities attendance logs provided.Care Plan revised 12/01/2025 titled Activities preferences documented preferences were to listen to music and kept informed about the news. Goal was to passively participate in group activities and one-to-one (1:1) visits. Interventions included to provide transportation to group activities.Progress notes dated 11/23/2025-02/24/2026 did not have documented evidence of one-to-one visits provided by activities.During an interview on 02/12/2026 at 3:53 PM, Ombudsman #1 stated the activities might not be meaningful for all residents.During an interview on 2/19/2026 at 9:23 AM, Licensed Practical Nurse #3 stated Resident #14 did not really participate in Bingo or group activities. They would go when movies were offered. They did not know if one-to-one (1:1) visits were happening with Resident #14.During an interview on 02/19/2026 at 2:47 PM, Licensed Practical Nurse #7 stated activities were done daily in the facility. They stated Resident #14 received one-to-one (1:1) time with nursing staff only, not activities. They stated Resident #14 spent time near the nursing station, and their family came in frequently to visit.During an interview on 02/24/2026 at 11:55 AM, Activities Director #1 stated they just started working in the facility on 02/23/2026, was unsure who had the position prior and were left no information regarding activities that had been done or were to be done in the facility. They stated they were organizing the activity office and did not have access to electronic medical records to start reviewing residents for their preferences and needs for activities. Activities Director #1 stated they believed activities were communicated with a calendar at that time and were unsure if one-to-one (1:1) activities were being done, as there was no current documentation in the activities office. They stated that day's activities listed were not something they considered activities; Chronical Pass, Independent Activities, Bible study, Hydration cart were listed on that day's calendar.During an interview on 2/24/2026 at 4:21PM, Licensed Practical Nurse #2 stated activities suck whether they (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	had someone for activities in the building or not. They did not know who the new manager was. They stated difficult residents were excluded from group activities. One activity was to make sand candles and the male residents on their unit did not want to do that. The activity aides were not trained to deal with any kind of residents. They stated an example would be of a particular resident was supposed to use the iPad to call their family member on Mondays which had only happened about three (3) times. During an interview on 2/26/2026 at 10:10 AM, Administrator #1 stated the changeover in management staff may be part of the problem within the facility. They needed better procedures, education, and logging of information. 10 New York Codes, Rules, and Regulations 415.12(h)(1)(2)

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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 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 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 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) (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 (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 (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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 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 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 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 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 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 (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 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 (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, record review and interviews conducted during a survey, the facility did not ensure that drug records were in order, that an account of all controlled drugs was maintained and periodically reconciled in four (4) of four (4) narcotic books reviewed on Units one (1) and two (2), and that nurses were properly documenting narcotic administration. Specifically, (a) for the shift-to-shift staff signature form for controlled drugs, titled Controlled Drugs-Count Record, did not consistently include the signatures of staff members at each shift change, validating the correct narcotic count; (b) Licensed Practical Nurse #8 did not document the administration of narcotics to Resident #5 at the time of administration.This is evidenced by: An undated facility policy titled Controlled Substances, documented that the facility shall comply with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of Schedule II and other controlled substances. Additionally, nursing staff must count controlled medications at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They must document and report any discrepancies to the Director of Nursing Services.An undated facility policy titled Administering Medications, documented that the individual administering the medication must initial the resident's electronic medical administration record on the appropriate line after giving each medication and before administering the next medication.During observations on 2/18/2026 at 9:59 AM, it was noted that the narcotics administered by Licensed Practical Nurse #8 to Resident #5 in the morning had not been signed for yet. A physician order dated 2/05/2026 at 8:00 PM documented to give 1 tablet of lorazepam 0.5 milligrams by mouth two times a day for anxiety and agitation.The Medication Administration Record dated February 2026, documented that on 2/18/2026, Resident #5 received their 8:00 AM dose of lorazepam from Licensed Practical Nurse #8.During observations on 2/18/2026 at 9:20 AM, narcotic sheets on both carts of Unit one (1) and two (2) were noted to not be consistently signed by two nurses shift to shift. A review of the shift-to-shift reconciliation of narcotics forms on Unit one (1) front medication cart #1 for January and February 2026 documented missing signatures for the following dates: 1/04/2026 on-coming nurse signature for 11PM-7AM shift, 1/05/2026 off-going nurse on the 11PM-7AM shift, 1/05/2026 on-coming nurse 11PM-7AM shift, 1/06/2026 off-going nurse 11PM-7AM shift, 1/07/2026 both the on-coming and off-going nurses 3 PM-11PM shift, and on-coming nurse 11PM-7AM shift, 11/08/2026 off-going nurse 11PM-7AM shift, as well as both on-coming and off-going nurses 7AM-3PM, 1/10/2026 both the on-coming and off-going nurses for the 3PM-11PM shift, 1/11/2026both on-coming and off-going nurses on 3PM-11PM shift, 1/13/2026 both on-coming and off-going nurses on 7AM-3PM shift and 3PM-11PM shift, 1/14/2026 on-coming nurse 11PM-7AM shift, 1/15/2026 off-going nurse 11PM-7AM, 1/23/2026 both on-coming and off-going nurses 7AM-3PM shift, 1/24/2026, 1/25/2026, 1/26/2026, 1/27/2026, 1/28/2026 and 1/29/2026, 1/30/2026, 1/31/2026, 2/01/2026, 2/02/2026, 2/03/2026, 2/04/2026, and 2/06/2026 both off-going and on-coming nurses 11PM-7AM shift, 2/07/2026 off-going nurse 3PM-11PM shift, 2/08/2026 both on-coming and off going nurse for 3PM-11PM shift, 2/14/2026 and 2/15/2026 both off-going and on-coming nurses 11PM-7AM shift, and 2/17/2026 off-going nurse 11PM-7AM. Additionally, one nurse signature was as both the off-going and on-coming nurse for the following dated shifts, but were not documented to be working double shifts: 7AM-3PM and 3PM-11PM shifts on 1/02/2026, 1/05/2026, , 1/24/2026, and 1/26/2026, .A review of the shift-to-shift reconciliation of narcotics forms on Unit one (1) back medication cart #2 for February 2026 documented missing signatures for the following dates: 2/01/2026 on-coming nurse signature for 11PM-7AM shift, 2/02/2026 off-going nurse on the 11PM-7AM shift, 2/03/2026 on-coming nurse 11PM- 7AM shift, 2/04/2026 off-going nurse 11PM-7AM shift, 2/05/2026 on-going nurse 11PM-7AM shift, 2/06/2026 off-going 11PM-7AM shift, 2/14/2026 on-coming nurse 11PM-7AM shift, and 2/15/2026 off-going nurse 11PM-7AM. Additionally, one nurse signature was as both the off-going and (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
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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	on-coming nurse for the following dated shifts, but were not documented to be working double shifts: 7AM-3PM and 3PM-11PM shifts on 2/04/2026, 2/05/2026, 2/08/2026, 2/09/2026, 2/10/2026, 2/11/2026, 2/13/2026, and 2/17/2026.A review of the shift-to-shift reconciliation of narcotics forms on Unit two (2) front medication cart #1 for January 2026 documented missing signatures for the following dates: 1/01/2026 both on-coming and off-going nurse signature for 3PM-11PM and 11PM-7AM shifts, both on-coming and off-going nurse for 3PM-11PM shift on 1/05/2026, 1/06/2026 both on-coming and off-going nurse 7AM-3PM, 3PM-11PM and 11PM-7AM shifts, 1/08/2026 both on-coming and off-going nurse on 7AM-3PM shift, 1/05/2026 on-coming nurse 11PM-7AM shift, 1/13/2026 both on-coming and off-going nurse 3PM-11PM shift, 1/15/2026 on-coming nurse 11PM-7AM, 1/16/2026 off-going nurse 11PM-7AM, 1/18/2026 both on-coming and off-going nurses for 11PM-7AM, 7AM-3PM, and 3PM-11PM shifts, 1/19/2026 off-going nurse 11PM-7AM, both on-coming and off-going nurses for 7AM-3PM and 3PM-11PM, 1/20/2026 off-going nurse 7AM-3PM shift, 1/23/2026 both on-coming and off-going nurses for 7AM-3PM and 3PM-11PM shifts, 1/30/2026 both on-coming and off-going nurses for 3PM-11PM and the off-going nurse for 11PM-7AM, 1/31/2026 off-going nurse 11PM-7AM nurse and both on-coming and off-going nurse 7AM-3PM shift. Additionally, one nurse signature was as both the off-going and on-coming nurse for the following dated shifts but were not documented to be working double shifts: 7AM-3PM and 3PM-11PM shifts on 1/09/2026, and 1/24/2026. A review of the shift-to-shift reconciliation of narcotics forms on Unit two (2) back medication cart #2 for February 2026 documented missing signatures for the following dates: 2/02/2026 on-coming nurse signature for 7AM-3PM shift, 2/06/2026 off-going nurse on the 3PM-11PM shift, 2/08/2026 off-going nurse 3PM-11PM shift, 2/09/2026 off-going nurse 3PM-11PM, 2/10/2026 both on-coming and off-going nurse 3PM-11PM shift, 2/11/2026 on-coming nurse 11PM-7AM shift, 2/12/2026 off-going nurse 11PM-7AM shift, 2/16/2026 on-coming nurse 11PM-7AM, and 2/17/2026 off-going nurse 11PM-7AM shift. During an interview on 2/18/2026 at 9:23 AM, Licensed Practical Nurse #4 stated that the narcotic sheets should be signed by two nurses every shift when they switch off. When asked why they had not signed with another nurse on 2/17/2026, Licensed Practical Nurse #4 stated that the agency nurse who's name they did not know handed them the keys and ran out the door and would not come back to do the count. During an interview on 2/18/2026 at 9:45 AM, Licensed Practical Nurse #9 stated they kept their narcotic book in the medication storage room and took it out when they needed it.During an interview on 2/18/2026 at 9:59 AM Licensed Practical Nurse #8 stated that the facility process was to sign specific narcotic count sheets at the time of narcotic administration.During an interview on 2/25/2026 at 11:04 AM, Director of Nursing #1 stated that they expected that the nurse that handed off the keys and the nurse that took the keys needed to sign the narcotic sheets together. The narcotic count should be done every time the keys were passed.During an interview on 2/25/2026 at 12:25 PM, Administrator #1 stated that the narcotic sheets needed to be signed by 2 nurses at shift change. They could not speak to why it was not getting done. 10 New York Codes, Rules, and Regulations 415.18(b)(3)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on observation, resident and staff interviews, review of facility policies and procedures, staffing records, resident records, accident and incident reports, and the facility's maintenance records during a survey, it was determined the facility was not administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. The administration failed to ensure the facility was in compliance with the following regulatory requirements, which affected or had potential to affect all residents in the facility. These failed practices directly impacted 35 of 35 residents sampled (Resident #s 1, 2, 3, 4, 5, 8, 9, 10, 11, 12, 14, 19, 25, 29, 31, 32, 33, 34, 35, 43, 44, 49, 50, 52, 53, 61, 64, 67, 70 , 72, 75, 80, 82, 90). Specifically, the lack of effective oversight and planning on the part of facility administration had the potential to adversely affect the health and safety of all residents residing in the facility. This is evidenced by: Deficiencies related to ineffective administration:Please refer to F550 as it pertains to the facility's failure to resident's dignity.Please refer to F580 as it pertains to the facility's failure to notify providers and resident representatives about changes of condition.Please refer to F584 as it pertains to the facility's failure to provide a safe, clean, comfortable and homelike environment.Please refer to F600 as it pertains to the facility's failure to ensure residents were free from abuse and neglect.Please refer to F609 as it pertains to the facility's failure to ensure injuries from unknown sources were reported to the State Survey Agency.Please refer to F610 as it pertains to the facility's failure to ensure all allegations of abuse, neglect, exploitation or mistreatment were thoroughly investigated.Please refer to F628 as it pertains to the facility's failure to document and notify the appropriate entities of discharges and transfers. Please refer to F656 as it pertains to the facility's failure to develop and implement a comprehensive person-centered care plan for each resident.Please refer to F657 as it pertains to the facility's failure to review and revise a comprehensive person-centered care plan for each resident.Please refer to F679 as it pertains to the facility's failure to provide activities based on comprehensive assessment, care plan, and preferences of each resident.Please refer to F684 as it pertains to the facility's failure to ensure services provided met professional standards.Please refer to F695 as it pertains to the facility's failure to ensure respiratory care services provided met professional standards.Please refer to F711 as it pertains to the facility's failure to ensure that physician notes were entered and maintained accurately.Please refer to F725 as it pertains to the facility's failure to ensure sufficient staffing services provided met professional standards.Please refer to F726 as it pertains to the facility's failure to ensure competent nursing services provided met professional standards.Please refer to F755 as it pertains to the facility's failure to ensure that pharmaceutical services were provided to meet the needs of each resident.Please refer to 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.Please refer to F812 as it pertains to the facility's failure to store, prepare, distribute, and serve food met professional food service safety standards. Please refer to F837 as it refers to the facility's failure to ensure that a governing body or designated persons functioning as a governing body, was legally responsible for establishing and implementing policies regarding the management and operation of the facility.Please refer to 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.Please refer to F867 as it refers to the facility's failure to ensure that the Quality Assurance Process Improvement feedback, data systems and monitoring.Please refer to 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.Please refer to F908 as it refers to the facility's failure to ensure that maintaining all mechanical electrical and patient care equipment is in safe operating condition.Please refer to 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.Please refer (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	to 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.Please refer to F947 as it refers to the facility's failure to 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 per year.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 without seeing Administrator #1. Ombudsman #1 stated that Assistant Administrator #1 was administering the building and that the residents considered the Assistant Administrator #1 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 nine (9%) of the facility. At the time of taking over as Administrator, they had asked Medical Director #1 and the previous 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, Administrator #1 stated prior to becoming the administrator, they were at the facility every other week. Administrator #1 stated they were now 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.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 foundation was solid 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, and department heads would be monitored more closely. Administrator #1 stated 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(a)

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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 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 (continued on next page)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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, 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 (continued on next page)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews conducted during a survey, the facility did not ensure a quality assessment and assurance committee developed and implemented appropriate plans of action to correct identified quality deficiencies. Additionally, the facility did not develop written policies and procedures for feedback, data collection systems, and monitoring, including adverse event monitoring. Specifically, (a) the facility had repeat deficiencies in the areas of comprehensive care planning and implementation (F656), evaluation and revision of comprehensive care plans (F657), and providing flu and/pneumococcal immunizations (F883), cited during the recertification survey, completed on 6/23/2023, were implemented as indicated by the same deficiencies being issued on the current survey; (b) policies and documents provided by the facility were noted to be undated, improperly titled, were missing information, had outdated information and/or were not signed; (c) key Quality Assurance Performance Improvement components were not being implemented such as having the required participants, documenting the topics reviewed, and missing information from required departments. The facility's inability to obtain feedback, use data, and take action to conduct structured, systematic investigations and analysis of underlying causes or contributing factors of problems affecting facility-wide processes has the potential to negatively impact quality of care, quality of life, and resident safety for all residents in the facility.This is evidenced by: A. Repeat deficiencies.Facility was cited for the following on recertification survey: 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.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. B. Policies and Documents Incomplete.The undated facility 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. The section 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 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 served The documented purpose was that the Quality Assurance Performance Improvement plan had been established to provide a planned, systemic, and ongoing quality improvement process designed to objectively monitor and evaluate the quality of resident care and to pursue opportunities for organizational improvement. Quality Assurance Performance Improvement is a process designed to systematically assess and improve important functions and work processes and their outcomes. Quality must be continuously evaluated and improved in order to meet the needs of our resident and community.The documented objectives (continued on next page)

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program for all new and existing staff members. Based on observation, record review and interviews conducted during a survey, the facility did not ensure that that it developed, implemented, and maintained an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. Specifically, for five (5) employees education records reviewed, one (1) employee received a comprehensive orientation with all the required educations. 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/PTSD, proper body mechanics, Abuse, neglect, and exploitation, Infection control, Culture change, Required in-service training for nurse aides. In-service training must: Be enough to ensure the continuing competence of nurse aides must be no less than 12 hours per year. Include dementia management training and resident abuse prevention training. 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. 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 disorders The Facility Assessment further specified that Certified Nurse Aides are required to complete a minimum of 12 hours of annual in-service training, including dementia care and abuse prevention education. Review of staff education records indicated inconsistent documentation of training completion.Review of staff education records showed incomplete and inconsistent documentation of the required training.Certified Nurse Aide #1's education file from the facility did not have documented evidence of annual training after January 2022. Electronic records indicated that less than 12 hours of annual education had been documented.Certified Nurse Aide #5's education file from the facility contained sign-in sheets and post-tests; however, the documentation did not clearly demonstrate completion of all annual training hours.Certified Nurse Aide #15's education file did not contain documentation indicating the aide had received annual education as required.Licensed Practical Nurse #1's education file from the facility contained partial documentation of annual education topics.Licensed Practical Nurse #12' education file did not contain documentation indicating the aide had received annual education as required.During an interview on 2/24/2026 at 10:18 AM, Licensed Practical Nurse #4 stated that education was available on the computer and that in-service talks were sometimes conducted but reported not knowing how to access education through the computer system.During an interview on 2/24/2026 at 10:25 AM, Licensed Practical Nurse #3 stated they were aware of overdue education assignments on the electronic system and reported difficulty finding time to complete them.During an interview on 2/24/2026 at 10:30 AM, Licensed Practical Nurse #8 stated education was sometimes provided through printed sheets that staff read and signed and recalled completing hand hygiene education on a laptop.During an interview on 2/24/2026 at 10:55 AM, Laundry Attendant #1 stated they had received education specific to housekeeping and laundry tasks but had not received facility-wide education such as abuse and neglect training.During an interview on 2/24/2026 at 11:02 AM, Certified Nurse Aide #10 stated they had not received education within the last year and recalled abuse and neglect training approximately three years ago.During an interview on 2/24/2026 (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 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	at 2:47 PM, Licensed Practical Nurse #7 stated that as a unit manager they were not responsible for assigning education and were unsure who was responsible.During an interview on 2/24/2026 at 5:30 PM, Certified Nurse Aide #4 stated they were aware there was online education that had not been completed.During an interview on 2/24/2026 at 5:35 PM, Certified Nurse Aide #15 stated they completed abuse and neglect education one week prior and were aware of additional online training that had not yet been completed.During an interview on 2/24/2026 at 5:40 PM, Certified Nurse Aide #5 stated they were unaware of Certified Nurse Aide education requirements and had not completed training since hire.During an interview on 2/25/2026 at 11:04 AM, Director of Nursing #1 stated that staff education would be a priority. Director of Nursing #1 stated they were aware of the required annual education topics included in the facility's staff training program. These topics included abuse prevention, identifying and reporting abuse, infection control, managing challenging residents and dementia care, activities of daily living, proper body mechanics, sexual harassment, Foley catheter care, urinary tract infection awareness, medication administration, wound care, and resident rights. Director of Nursing #1 further stated that staff were expected to receive education related to abuse prevention, reporting requirements, and resident rights as part of the facility's annual training program.During an interview on 2/25/2026 at 12:25 PM, Administrator #1 stated they would work closely with Director of Nursing #1 to support the facility's staff education program. Administrator #1 stated the facility utilized an online education system to assign and track staff education. Administrator #1 reported the system was implemented in August 2025 and was used to monitor required education hours for Certified Nurse Aides. Administrator #1 further stated that certain facility-wide education topics were required for all staff, including: fire safety, resident rights, abuse, and oxygen control. Administrator #1 stated the online system tracks staff education requirements and that the Assistant Director of Nursing would be responsible for coordinating education assignments when hired. Administrator #1 also stated the facility maintained education checklists and reference materials to assist staff in understanding required training topics. 10 New York Codes, Rules, and Regulations 415.26

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct mandatory training, for all staff, on the facility?s Quality Assurance and Performance Improvement Program. Based on interview and record review during a recertification and Extended survey, the facility did not ensure that an effective training program for all new and existing staff was developed, implemented, and maintained based on the facility assessment. Specifically, for five (5) of five (5) employee files reviewed, the facility did not provide mandatory training that outlines and informs staff of the elements and goals of the facility's Quality Assurance Performance Improvement program as part of its Quality Assurance Performance Improvement program.This is evidenced by:Cross reference: F726 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/PTSD, 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 would be utilized in tailoring our policies and procedure to ensure we were providing to the best and most up to date care to our residents. The policy did not have documented evidence that training on the Quality Assurance Performance Improvement program would be provided to staff. The facility's Quality Assurance and Performance Improvement policy, undated, did not contain any documentation of a requirement that staff would be educated on the Quality Assurance and Performance Improvement policy.Certified Nurse Aide #1's education file from the facility did not contain documented evidence that all of the annual educations had been 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. Quality Assurance and Performance Improvement policy and procedures were not included in the list of required education.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. Quality Assurance and Performance Improvement policy and procedures were not included in the list of required education.Certified Nurse Aide #15's education file from the facility did not contain evidence that annual educations had been done except for a written statement of verbal education of staff involving an incident that occurred on 2/18/2026, and the electronic health records provided by the facility did not contain any education topics for Certified Nurse Aide #15. Quality Assurance and Performance Improvement policy and procedures were not included in the list of required (continued on next page)

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	education.Licensed Practical Nurse #1's education file from the facility did not contain documented evidence that annual educations had been done 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 two (2) of the ten (10) education topics were completed for 2025. Quality Assurance and Performance Improvement policy and procedures were not included in the list of required education.Licensed Practical Nurse #12's education file from the facility did not contain documented evidence that annual educations had been completed since 2024. Licensed Practical Nurse #12's electronic education records documented that one (1) of the six (6) education topics were completed for 2025. Quality Assurance and Performance Improvement policy and procedures were not included in the list of required education.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 since they arrived. Assistant Administrator #1 stated they did on the spot education when it was needed. 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 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 educations on things like precautions, safety, and resident rights.During an interview on 2/24/2026 at 10:25 AM, Licensed Practical Nurse #3 stated that they knew that they had overdue educations 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 2/25/2026 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 educations such 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. 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 went 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 Rules and Regulations 415.26

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F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor each resident's preferences, choices, values and beliefs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews conducted during the survey, the facility did not ensure that each resident received, and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. This was evident for three (3) of 35 residents sampled (Resident #s 75, 85, 87) and residents residing in the facility. Specifically, (a) for Resident #75, the facility did not monitor or medicate the resident, causing multiple admissions to the hospital for constipation; (b) for Resident #85, the facility delayed testing and treatment of a urinary tract infection causing the resident to go to the hospital with urosepsis; and (c) no meaningful activities were provided to the facility residents, resulting in lack of mental stimulation. This is evidenced by: Cross Reference:Please refer to F550 as it pertains to the facility's failure to resident dignity.Please refer to F580 as it pertains to the facility's failure to notify providers and resident representatives about changes of condition.Please refer to F584 as it pertains to the facility's failure to provide a safe, clean, comfortable and homelike environment.Please refer to F600 as it pertains to the facility's failure to ensure residents were free from abuse and neglect.Please refer to F656 as it pertains to the facility's failure to develop and implement a comprehensive person-centered care plan for each resident.Please refer to F679 as it pertains to the facility's failure to provide activities based on comprehensive assessment, care plan, and preferences of each resident.Please refer to F684 as it pertains to the facility's failure to ensure services provided met professional standards.A facility policy titled Quality of Life/Dignity, date last revised 12/2019, documented that each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. The policy further documented in pertinent parts, (5) Residents shall be assisted in attending the activities of their choice, including activities outside the facility. (9) Staff shall give verbal staff to staff communication (e.g. change of shift reports) shall be conducted outside the hearing range of residents and the public.Multiple observations were made of residents sitting in common areas. Activities posted on the activity calendar included daily Chronicle Pass (the facility resident paper), Hydration carts, Puzzles, and Coffee Carts.During an interview on 2/24/2026 at 4:21PM, Licensed Practical Nurse #2 stated activities stink whether they had someone for activities in the building or not. They did not know who the new manager was. They stated difficult residents were excluded from group activities. One activity was to make sand candles and the male residents on their unit did not want to do that. The activity aides were not trained to deal with any kind of residents. They stated an example would be of a particular resident was supposed to use the iPad to call their family member on Mondays which had only happened about three (3) times. 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 understood others.Resident #75 returned from the hospital on [DATE] after being treated for severe constipation. The facility did not ensure close monitoring of bowel movements, routine assessments when there was no bowel movement, administration of as needed bowel medications per physician orders and facility policy, and reporting of bowel status to the provider. As a result, the resident was sent to the hospital on 1/9/2026 and diagnosed with severe sepsis due to proctocolitis. The facility did not ensure notification to the provider when there was no bowel movement in greater than 24 hours, routine abdominal assessments, and administration of as needed bowel medications. As a result, the resident was sent to the hospital on 2/17/2026 and diagnosed with severe fecal impaction (continued on next page)

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F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that required fecal disimpaction under anesthesia.Resident #85:Resident #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 2 Diabetes Mellitus with hyperglycemia (when the body cannot use insulin correctly and the sugar builds up in the blood), and hypersensitive chronic kidney disease with Stage 1 through stage 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 understood others.Nurse Practitioner note dated 9/18/2025 with date of service 9/19/2025 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 (urine test).Provider orders dated 9/27/2025 documented, obtain urine analysis and culture and sensitivity. Completed 9/27/2025 at 7:30 PM.Nursing Note dated 9/28/2025 at 3:48 AM, documented resident sent to emergency room at 3:35 AM, urine from straight catheterization obtained was dark red. Resident was lethargic and was not answering questions. Nurse Practitioner #1 was made aware and ordered resident to be sent to emergency room. Resident emergency contact and Director of Nursing made aware.Hospital Discharge summary dated [DATE], document admission diagnosis of septic shock and discharge diagnosis of resolved septic shock secondary to urinary tract infection.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.ˆAn Incident and Accident form dated 1/13/2026, documented 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 documented 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. A Nursing 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 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 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 there was inconsistency with quality of care in the facility.During an interview on 2/25/2026 at 9:29 AM, Medical Director #1 stated that the facility couldn't control the lab timing, just how fast they could get the urine to the lab. Medical Director #1 stated that they oversaw the nurse practitioner and wasn't overly involved unless it was complicated and they needed help. Medical Director #1 stated they reviewed notes when they needed to follow up with a resident, if something unexpected happened or if it was requested by owner. Medical Director #1 also stated that they were not always in the loop or called for every incident or (continued on next page)

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F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	accident and asking them to comment on a resident-to-resident incident would be like asking them what they ate seven (7) months ago. Medical Director #1 stated they hadn't signed any incident and accident reports in the last few months and also stated they signed off on them.During an interview on 2/25/2026 at 11:04 AM Director of Nursing #1 stated they attributed a lot of the issues found on survey as a lack of staff education and the need for staff.During an interview on 2/25/2026 at 12:25 PM Administrator #1 stated that they tried to address everything that was brought to them as soon as they could. Administrator #1 stated that they knew incidents and accidents were an issue and needed a new system, was surprised to learn that notification of resident changes was an issue, the facility staff needed to follow the regulations, and the 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 415.5

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews conducted during the a survey, the facility did not ensure that physician notes were entered and maintained accurately according to professional standards for ten (10) (Residents #4, 13, 31, 33, 34, 53, 72, 75, 80, and 90) of ten (10) residents reviewed. Specifically, (a.) on 8/12/2025, Residents #4, 13, 31, 33, 34, 53, 72, 75, 80, and 90 dated 08/12/2025 had the same provider encounter note by Medical Director #1 entered into their electronic medical records erroneously;, (b.) Resident #13 had a provider visit encounter by Medical Director #1 in their electronic medical record for Resident #33 dated 12/17/2025 erroneously that was not signed until 01/04/2026; and (c.) Resident #75 had a provider encounter note dated 11/13/2025 was not signed by Nurse Practitioner #1 until 01/12/2026.This is evidenced by: The facility provided a policy titled Medical Provider Policy (undated and unsigned) that outlined the responsibilities of all providers.^^The policy medical services are providedˆinˆaccordanceˆwithˆstate regulations, standards of practice,ˆand federal guidelines: such asˆmaintainˆappropriate license, practice within their scope of practice,ˆand maintainˆtimelyˆaccurateˆdocumentation. (A)Resident #13Resident #13 was admitted to the facility with diagnoses of Wernicke's encephalopathy (a brain and memory disorder), Schizoaffective disorder, Bipolar type (mental health disorder with depression, mania, and psychotic symptoms), and adult failure to thrive (a multifactorial decline in physiological, psychological, and social functions leading to unintentional weight loss, decreased appetite, and overall functional impairment). The Minimum Data Set (an assessment tool) dated 01/29/2026, documented they could be understood, understand others, and was cognitively intact.ˆProvider encounter note dated 08/12/2025 by Medical Director #1 documented, a routine visit. The resident was described as resting comfortable in their room, typically attends meals in the dining room, and participated in facility social activities. Examination comprehensive review of symptoms documented no abnormalities. The nursing staff had reported a witnessed fall where resident slid off their chair, assessment was performed by a nurse with no apparent injuries. Monitoring continues in accordance with policy to mitigate injury risk. Plan was to continue monitoring resident's acute and chronic conditions, as part of ongoing long-term care.Provider encounter note dated 12/17/2025 by Medical Director #1 documented, late entry visit note for Resident # 33. The visit was conducted for monthly physician evaluation and detailed a complete physician assessment was documented. The encounter was signed by Medical Director #1 on 01/04/2026. 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 (theˆgradual decline in physical function and strength that occurs with aging). The Minimum Data Set, dated [DATE], documented the resident was understood, able to understand others, and was severely cognitive impaired. Provider encounter note dated 08/12/2025 by Medical Director #1 documented, a routine visit. The resident was described as resting comfortable in their room, typically attends meals in the dining room, and participated in facility social activities. Examination comprehensive review of symptoms documented no abnormalities. The nursing staff had reported a witnessed fall where resident slid off their chair, assessment was performed by a nurse with no apparent injuries. Monitoring continues in accordance with policy to mitigate injury risk. Plan was to continue monitoring resident's acute and chronic conditions, as part of ongoing long-term care. Resident #75Resident #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 (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	constipation (slow movement of waste through the digestive system). The Minimum Data Set, dated [DATE], documented the resident could be understood, understand others, and was moderately cognitive impaired.Provider encounter note dated 08/12/2025 by Medical Director #1 documented, a routine visit. The resident was described as resting comfortable in their room, typically attends meals in the dining room, and participated in facility social activities. Examination comprehensive review of symptoms documented no abnormalities. The nursing staff had reported a witnessed fall where resident slid off their chair, assessment was performed by a nurse with no apparent injuries. Monitoring continues in accordance with policy to mitigate injury risk. Plan was to continue monitoring resident's acute and chronic conditions, as part of ongoing long-term care. (B)Provider encounter note dated 11/13/2025 by Nurse Practitioner #1, documented Resident #1 was evaluated on 11/13/2025 following return from the Emergency Department. The note was signed by Nurse Practitioner #1 on 01/12/2026.Provider encounter note dated 12/17/2025 by Medical Director #1 documented, late entry visit note for Resident # 33. The visit was conducted for monthly physician evaluation and detailed a complete physician assessment was documented. The encounter was signed by Medical Director #1 on 01/04/2026. Interviews:During an interview on 02/13/2026 at 3:30 PM, Assistant Administrator #1 stated while fulfilling a record request for surveyor they identified about 30 resident's electronic medical records with an erroneous physician encounter note for a fall by Medical Director #1. They were unsure which resident had the fall and was assessed. They stated they were in the process of contacting Medical Director #1 to review their notes and update the electronic medical records accordingly.During an interview on 02/19/2026 at 12:00 PM, Assistant Administrator #1 was informed by surveyor Resident #13 had a visit encounter for Resident #33 on 12/12/2025 by Medical Director #1. They stated Medical Director was not careful when uploading documents to charts and they would contact Medical Director #1 to void the entry in Resident #13's electronic health record and place correctly in Resident #33's electronic health record.During an interview on 02/19/2026 at 1:15 PM, Nurse Practitioner #1 stated erroneous dated 12/17/2025 provider encounter note in Resident #13 electronic medical record had been voided, Medical Director #1 still had to update Resident #33's electronic medical record.During an interview on 02/25/2026 at 9:29 AM, Medical Director #1 stated they stated they would expect documentation to entered quickly. They would expect a routine note to be entered into the electronic medical record within 3 days. They documented resident admission assessments and then followed the resident once a month and wrote a note.During an interview on 02/25/2026 at 12:25 PM, Administrator #1 stated Medical Director #1 was not their employee. They were aware documentation was an issue. They would be working with Director of Nursing #1 to put a new process in place. 10 New York Codes, Rules, and Regulations 415.12(h)(1)(2)

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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 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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(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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on record review and interview conducted during a recertification survey, the facility did not ensure residents and/or their designated representative were fully informed of their right to an expedited review of a service termination for one (1) resident (Resident #52) of three (3) residents reviewed. Specifically, Resident #52, who remained in the facility after receiving covered services, was not provided with timely notification of at least two (2)-day notification of the termination of Medicare Part A services with completion of the required Notice of Medicare Non-coverage and Advance Beneficiary notice of Non-coverage form prior to the of the termination of Medicare Part A services.This is evidenced by: Facility policy titled NOMNC & ABN (Notice of Medicare Non-Coverage and Advance Beneficiary Notice of Non-Coverage) (undated) documented the facility shall issue a Notice of Medicare Non-Coverage and/or an Advance Beneficiary Notice of Non-Coverage in accordance with Medicare requirements when skilled Medicare Part A services are ending or a service is expected to be denied by Medicare. Residents and/or their representatives shall receive clear, timely notice and information regarding appeal rights and potential financial liability. The Notice of Medicare Non-Coverage must be delivered at least two (2) calendar days before the last covered day of skilled services. Signature acknowledging receipt must be obtained. If refused, document refusal. The Advance Beneficiary Notice must be issued prior to providing the non-covered service. The resident must select an option and sign acknowledging potential financial responsibility. During a record review of Resident #52's Notice of Medicare Non-Coverage, it was documented that the effective date coverage of their current skilled services would end on 9/06/2025. There was no signature with the date from the resident or their representative on this form. Additional information on this form documented Activing Director of Nursing #1 spoke with Family Member #52 and gave them the name and phone number for the facility business office. The form was signed by Acting Director of Nursing #1 on 9/15/2025. During a record review of Resident #52's Advance Beneficiary Notice of Non-Coverage, it was documented beginning on 9/07/2025, they may have to pay out of pocket for care if they did not have other insurance that may cover the cost. There was no signature with the date from the resident or their representative on this form. Additional information handwritten on this form documented Acting Director of Nursing #1 spoke with spouse, gave them phone number and contact for the facility business office. The form was signed by Acting Director of Nursing #1 and dated 9/15/2025. During an interview on 2/12/2026 at 3:21 PM, Acting Director of Nursing #1 stated the Notice of Medicare Non-Coverage and Advance Beneficiary Notice of Non-Coverage were signed by a resident or their representative when skilled services for a traditional Medicare Part A resident was finished and the resident was staying in the facility. They stated that they were responsible for providing the notices and obtaining the signatures, and that the forms were typically completed two (2) days before the resident's last covered day. Acting Director of Nursing #1 stated there was no documentation in Resident #52's medical record which stated they spoke with Resident #52's spouse before 9/15/2025 regarding these forms and the spouse should have been notified about signing these forms by 09/04/2025. When they realized these forms for Resident #52 were not completed, they reached out to the spouse for completion on 9/15/2025. 10 New York Codes, Rules, and Regulations 415.3 (g)

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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 (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	(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. 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. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 #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 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident 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 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 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, record review and interviews conducted during a recertification survey, the facility did not ensure that resident received respiratory care according to professional standards for one (1) (Resident #43) of three (3) residents reviewed. Specifically, Resident #43's continuous positive airway pressure machine (aka CPAP, used to treat sleep apnea) was not administered on 01/11/2026, 01/12/2026, 01/23/2026, 02/06/2026, or 02/12/2026, and their continuous positive airway pressure machine was not maintained on 01/11/2026, 01/12/2026, 01/23/2026, 02/01/2026, or 02/12/2026.This is evidenced by: Policy and procedure titled, continuous positive airway pressure machine/Bilevel positive airway pressure support, revised 01/2026 documented:Purpose To provide spontaneous breathing resident with continuous positive airway pressure To improve arterial oxygenation in resident with obstructive sleep apnea To promote residents comfort and safetyPreparation Only qualified and appropriately trained nurse or respiratory therapist should administer continuous positive airway pressure Review physicians orders to determine flow and pressure for the machine Review manufactures instructions for setup and delivery for machineSteps in the procedure Explain procedure and ask permission to continue Explain possible side effects and instruct resident to report Set mode as prescribed Attach oxygen oximeter and monitor oxygen levelsGeneral Guidelines for Cleaning Specific cleaning instructions to be obtained from manufacture Machine cleaning, wipe with warm soapy water weekly and as needed Humidifier cleaning, use clean distilled water for chamber cleaning only. Clean weekly and air dry, to disinfect place humidifier in vinegar and water 1:1 solution. Soak for 30 minutes and rinse thoroughly Mask and tubing, clean daily placing in warm soapy water soaking for 5 minutes. Rinse with warm water and allow air to dry between usesDocumentation General assessment prior to procedure Time continuous positive airway pressure was started and duration of therapy Mode and settings for continuous positive airway pressure How resident tolerate procedure Oxygen saturation during procedure Resident #43 was admitted to the facility with diagnoses of obstructive sleep apnea (a sleep-related breathing disorder), diabetes mellitus type two (2) with hyperglycemia (when the body cannot use insulin correctly and the sugar builds up in the blood), and hemiplegia and hemiparesis following cerebral infarction affecting left non dominant side (paralysis or weakness on one side of the body). The Minimum Data Set (an assessment tool) dated 10/01/2025, documented the resident could usually be understood and could usually understand others with intact cognition. In separate observations on 02/11/2026 at 1:26 PM, 02/17/2026 at 10:20 AM, 02/19/2026 at 12:50 PM, and on 02/24/2026 at 2:25 PM, Resident #43 was in their room, and their continuous positive airway pressure machine was observed on their nightstand with tubing and mask attached. Tubing and mask were dry and not covered with a protective bag. Review of comprehensive care plan reviewed 01/15/2026 revealed no documented evidence of a Respiratory care plan. Review of orders dated 10/18/2025 documented: Clean tubing every morning Empty water chamber and air dry every AM Fill Continuous positive airway pressure machine chamber with distilled water prior to turning on machine Clean mask daily Apply Continuous positive airway pressure and turn machine on at bedtime, Continuous positive airway pressure setting 12-20 centimeters water. There was no documented evidence of a provider order for removal of Continuous positive airway pressure machine daily.There was no documented evidence of a provider order for oxygenation monitoring.There was no documented evidence of staff education or training for use of CPAP devices.Review of the electronic Treatment Administration Record dated 01/01/2026-01/31/2026 revealed no documented evidence of filling the Continuous positive airway pressure water chamber on 01/11/2026, 01/12/2026, or 01/23/2026, nor of placing the Continuous positive airway pressure device on Resident #43 on 01/11/2026, 01/12/2026, or 01/23/2026 at bedtime.Review of the electronic Treatment Administration record dated 02/01/2026-02/16/2026 revealed no documented evidence of:- Cleaning Continuous positive airway pressure mask on 02/01/2026 or 02/06/2026.- Cleaning Continuous positive airway pressure tubing 02/01/2026 or (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	02/06/2026.- Placement of Continuous positive airway pressure on 02/06/2026 or 02/12/2026.- Emptying Continuous positive airway pressure water chamber on 02/02/2026.- Filling Continuous positive airway pressure water chamber on 02/01/2026 or 02/12/2026. During an Interview on 02/11/2026 at 1:26 PM, Resident #43 stated they needed continuous positive airway pressure on when they slept because if they did not have it on, they would stop breathing 20-40 times per minute. They stated they had no feeling in their hands, so they could not get the mask on by themself. They could get it in place on their head but not fastened. They stated staff only put continuous positive airway pressure on them about 50 percent of the time. They stated they asked staff to put it on at night, sometimes nurses were busy with their medication passes. They stated it must be a nurse who would place the continuous positive airway pressure on, at least that was the policy. They stated if staff were too busy to get to them before they fell asleep, the nurse had to wake them up to put the continuous positive airway pressure on and that would disrupt the whole rest of their night. They stated continuous positive airway pressure was on them last night, 02/10/2026, but the previous night (02/09/2026) the nurse got to them at midnight, and they had already fallen asleep. They stated that sometimes if they fell asleep before continuous positive airway pressure was on, they woke up and panicked because they could not get air. During an interview on 02/17/2026 at 10:33 AM, Licensed Practical Nurse #7 stated that continuous positive airway pressure daily removal should be documented in electronic medication or treatment record. Orders should be placed for removal of continuous positive airway pressure. They stated if there were no orders then a note should be placed as a progress note. During an interview on 02/24/2026 at 2:31 PM, Licensed Practical Nurse #3 stated to clean a continuous positive airway pressure device they rinse mask and tubing with water and leave to air dry. They stated there were orders in place for Resident #43 continuous positive airway pressure daily cleaning for the 7 AM to 3 PM (daytime) shift. During an interview on 02/24/2026 at 2:35 PM, Licensed Practical Nurse #4 stated to clean a continuous positive airway pressure they would unplug device, rinse mask, let mask air dry, then place in zip lock bag. 10 New York Codes, Rules, and Regulations 415.12(K)(6)

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on record review and interviews conducted during the recertification survey, the facility did not ensure that accurate staffing information based on payroll data was correctly submitted to Centers for Medicare & Medicaid Services. Specifically, during Fiscal Quarter 4 (July 2025 through September 2025), payroll data submitted to Centers for Medicare & Medicaid Services indicated that less than eight (8) hours of consecutive Registered Nurses were available in the facility on 7/19/2025, 7/23/2025, 7/25/2025, 7/28/2025, 7/29/2025, 7/30/2025, 8/02/2025, 8/03/2025, 8/09/2025, 8/10/2025, 8/16/2025, 8/31/2025, 9/01/2025, and 9/13/2025. Inspection of timecards and internal facility reports documented that submitted data did not capture hours worked by Director of Nursing #1.This is evidenced by: The Centers for Medicare & Medicaid Services Electronic Staffing Data Submission Payroll-Based Journal, Long Term Care Facility Policy Manual version 2.7 dated 06/2025 documented Section 6106 of the Affordable Care Act requires facilities to electronically submit direct care staffing information (including agency and contract staff) based on payroll and other auditable data. Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to Centers for Medicare & Medicaid Services complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by Centers for Medicare & Medicaid Services.The Centers for Medicare and Medicaid Services Payroll Based Journal Staffing Data Report documented there was no Registered Nurses for a consecutive eight (8) hours on every day submitted by the facility for the fiscal year Quarter 4 2025 (July 1 - September 30). There was no Registered Nurse hours documented on 7/19/2025, 7/23/2025, 7/25/2025, 7/29/2025, 7/30/2025, 8/02/2025, 8/10/2025, 8/16/2025, 8/31/2025, and 9/01/2025. There were less than eight (8) hours of Registered Nurse hours documented on 7/28/2026, 8/03/2025, 8/09/2025, and 9/13/2025.During an interview on 2/18/2026 at 10:28 AM, Human Resources Director #1 stated that they took their position in August of 2025, and did not submit the data to Centers for Medicare & Medicaid Services. They stated they verified the staff punch cards and submitted that information to Director of Payroll #1.During an interview on 2/18/2026 at 11:17 AM, Human Resources Director #1 reviewed a facility report of timecard punches for Fiscal Quarter #4 and compared the punch card information to the Job Title Report. All dates noted to not be eight (8) hours were missing hours by Director of Nurse #1.Record review of timecard punches revealed Director of Nurse #1 was present in the building on the dates noted above.During an interview on 2/18/2026 at 11:33 AM, Director of Payroll #1 stated that they submitted the payroll data through the portal. They submitted it in a zip file and got confirmation of its acceptance. They stated they could not think of a reason that it wouldn't capture the hours of Director of Nursing #1. Director of Payroll #1 stated they pulled the report at the end of the month from the system but did not review the timecards.During an interview on 2/25/2026 at 12:25 PM, Administrator #1 stated that issue with the Job Title Report had to be an issue on the side of Centers for Medicare and Medicaid Services. Administrator #1 did not believe there was an issue with the submission of the information but would ask Director of Payroll #1 to look at it. 10 New York Code Rules and Regulations 400.2

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview during a survey, the facility did not ensure each resident was offered pneumococcal and influenza immunizations and received education regarding the benefits and potential side effects of the immunizations for one (1) (Residents #25) of four (4) residents reviewed. Specifically, there was no documented evidence Resident #25 was offered, declined, or educated on the pneumococcal or influenza immunizations, and did not complete the tuberculosis testing required as required.This is evidenced by:A facility policy titled admission policy and dated 8/2018, documented in pertinent part that when a resident was admitted to the nursing unit, the Nurse must record data (as each may apply) in appropriate place in the record (paper) or electronic health record. The recorded information listed included (p.) notation of any signs or symptoms of an infectious or communicable disease; (q.) Immunization history, immunization required and tuberculosis testing. Resident #25 Resident #25 was admitted to the facility with the diagnoses of periprosthetic fracture, around internal prosthetic hip joint (a break in the bone occurring adjacent to an orthopedic implant, most commonly following hip or knee replacement), hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (weakness of one side of the body, usually caused by brain damage from stroke), and unspecified fall. The [NAME] Data Set (an assessment tool), dated 1/27/2026, documented that Resident #25 was usually able to understand others and be understood, and was significantly cognitively impaired.A review of Resident #25's immunizations in the electronic health record documented that Resident #25 received dose #1 of the Mantoux Tuberculin skin test on 10/23/2025 and had a negative result. Dose #2 of Mantoux Tuberculin skin test was administered 11/01/2025 and the results documented were pending. There was no documented evidence that Resident #25 had been offered a yearly influenza vaccine or the required pneumococcal vaccine prior to or since admission on [DATE].There was no documented evidence that the resident/resident representative received education, was offered the vaccinations, or declined the pneumococcal and influenza vaccines.During an interview on 2/24/2026 at 10:47 AM. Administrator #1, also serving as Infection Preventionist, stated that immunizations for residents were tracked through a report in the electronic health record. If someone was missing an immunization, Administrator #1 would ask the nurse to look through the record to see if it was received prior to admission. There were some residents that refused immunizations. Administrator #1 stated that if a resident had refused the immunization, there should be documentation that the resident refused. When asked if there was a declination form, Administrator #1 stated they were unsure, but there should be education given to the resident about the risks of refusal. It should have been documented in the electronic medical record. Administrator #1 stated they did not know where they would find the information.During a follow up interview on 2/25/26 at 10:10 AM, Administrator #1 stated that the immunizations given prior to admission would have been uploaded to the miscellaneous tab in the electronic medical record. Administrator #1 stated that they asked a nurse and found out the answer. 10 New York Code Rules and Regulations 415.19 (a) (1-3)

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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 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 (continued on next page)

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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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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)