STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335697	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eddy Village Green	421 W Columbia Street Cohoes, NY 12047

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 - Some	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** 48413 Based on observation and interviews conducted during the recertification survey, the facility did not ensure that each resident was treated with dignity and respect, cared for in a manner, and in an environment that promotes maintenance or enhancement of their quality of life for three (3) (Resident #s 110, 136 and 145) of 36 residents reviewed for dignity. Specifically, (a.) Resident #110 was administered medications in a common area with other residents and individuals present without resident's permission; (b.) Certified Nurse Aide stood over the dining room table instead of sitting with resident, while assisting Resident #136 with their meal; (c.) Resident #145 was served meals at dining room table with the use of plastic utensils. This is evidenced by: The facility's Policy and Procedure titled Resident Rights, effective 5/28/2024, documented it is the policy to ensure residents have the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. Social Work staff, in accordance with facility, New York State Department of Health, and CMS regulations, will act as the designated advocates for resident rights. New York State Manual or Nursing Home Resident Rights, 2022, documented, right to be valued as an individual, to be treated with consideration, dignity and respect in full recognition of your self-worth. o Be cared for in a manner that enhances your quality of life, free from humiliation. Privacy: Personal privacy during care and treatment. o Confidentiality concerning your personal and medical information. https://www.health.ny.gov/facilities/nursing/rights/docs/rights_booklet.pdf Resident #110 Resident #110 was admitted to the facility with a diagnoses of Parkinson's Disease (movement disorder of the nervous system that worsens over time), type 2 diabetes mellitus (when the body cannot use insulin correctly and sugar builds up in the blood), and major depressive disorder (a common and serious mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest or pleasure in activities). The Minimum Data Set (an assessment tool) dated 10/13/2024 documented that the resident could be understood, was understand by others, and was mildly cognitively impaired. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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 - Some	During an observation on 3/28/2025 at 10:59 AM, Licensed Practical Nurse #4 administered a cup of prescribed medication to resident while resident was sitting in living room. In addition, Licensed Practical Nurse held conversation with Resident regarding the medications received. Two other residents were present. During an interview on 3/28/2025 at 11:05 AM, Licensed Practical Nurse #4 stated Resident #110 always took their medication in the living room, and it was okay. Therefore, they did not ask resident's permission to administer the medication in the common area. Licensed Practical Nurse #4 stated they should have asked permission since the Department of Health was observing the medication pass. Resident #136 Resident #136 was admitted to the facility with diagnoses of neurocognitive disorder with Lewy Bodies (a progressive brain disorder characterized by the accumulation of Lewy bodies, protein clumps in the brain cells, leading to cognitive decline), adjustment disorder with mixed anxiety and depressed mood (short-term mental and behavioral condition that occurs when someone has an unhealthy or excessive reaction to a stressful event or life change within 3 months), and moderate protein-calorie malnutrition (a condition resulting from insufficient intake of protein and/or energy (calories) leading to weight loss or failure to gain weight). The Minimum Data Set, dated dated dated [DATE] documented Resident had severe cognitive impairment, and usually could make themselves understood and usually understand others. During an observation on 3/26/2025 at 12:26 PM, Shahbaz (Certified Nursing Aide) #9 was standing up next to Resident #136 while the resident was seated in their wheelchair at the dining table. Shahbaz #9 was feeding the resident their lunch meal. Shahbaz #9 remained standing up until they were done assisting the resident with finishing their lunch. During an interview on 3/26/2025 at 12:26 PM, Shahbaz # 9 stated they normally sat next to residents while feeding them but because there were no chairs around for them to sit in, they stood up while feeding Resident #136. They stated they were taught to sit next to the residents when feeding them so they could observe how they were eating, but they were standing as there were no chairs available for them to sit in when feeding the resident. During an interview on 4/02/2025 at 10:09 AM, Registered Nurse #4 stated when Shahbaz is feeding a resident, they should be sitting down next to them and conversing with the resident. They should not be standing up while feeding the resident because it was a dignity concern. They stated sometimes they had to remind Shahbaz they should be sitting down while feeding residents. They stated this was the resident's home and they should be treated like they were in their home and Shahbaz should not be standing up while feeding residents. During an interview on 4/03/2025 at 12:06 PM, Director of Nursing #1 stated Shahbaz should sit down next to a resident when they are feeding the resident. There were little stools in the houses that the Shahbaz could sit on when they aided with meals. The Shahbaz should sit next to the resident when feeding them because it was a dignity concern. They did not want the resident to feel rushed or pressured through the meal and this may occur if the Shahbaz were standing over them when eating. They stated meals should be enjoyable. 48615 (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #145 Resident #145 was admitted with the diagnoses of unspecified dementia (a decline in mental ability severe enough to interfere with daily life), morbid obesity (a severe form of obesity characterized by a significantly high body mass index), and major depressive disorder (a common and serious mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest or pleasure in activities). The Minimum Data Set, dated dated dated [DATE] documented that the resident sometimes could be understood and sometimes understand others and was severely cognitively impaired. During an observation on 3/26/2025 at 12:25 PM, seven residents, including Resident #145, were given plastic utensils for their meals. During a record review on 3/26/2025 at 1:45 PM, Resident #145's Comprehensive Care Plan did not include the usage of plastic utensils at meals. 51317 During an interview on 4/01/2025 at 12:45 PM, Shahbaz #4 stated that plastic utensils may be used for safety reasons and should be in the comprehensive care plan. During an interview on 4/02/2024 at 11:35 AM, Registered Nurse #1 stated that the use of plastic utensils should be included in the comprehensive care plan for each resident who used them 10 New York Codes, Rules, and Regulations 415.3(c)(1)(i)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate.

51317

Based on observation, record review, and interview conducted during the recertification survey, the facility did not ensure residents could safely self-administer medication when clinically appropriate for one (1) (Resident #84) of one (1) resident reviewed for medication administration. Specifically, Resident #84 was observed with a medicine cup of pills while eating breakfast in the dining area on 3/26/2025 and independently taking the pills. There was no documented evidence that Resident #84 was assessed to determine their ability to safely self-administer medications, or physician orders for self-administration of medications.

This is evidenced by:

Resident #84 was admitted to the facility with diagnoses of hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles) following cerebral infarction (occurs when blood flow to the brain is disrupted, leading to tissue death due to lack of oxygen and nutrients) affecting a dominant side, atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), and osteoporosis (a condition in which bones become weak and brittle). The Minimum Data Set (an assessment tool) dated 2/15/2025, documented the resident usually made themselves understood, usually understand others, and had moderate cognitive impairment

The facility policy, Self-Administration of Medications, dated 6/19/2023, documented it was the facility's policy to honor a resident's request to self-administer medication unless the interdisciplinary team determined the practice was unsafe. As part of the admission process, the nurse would determine if a resident wished to self-administer medications. If they did, the resident would be evaluated for self-administration of medications and the assessment would be completed and reviewed by the interdisciplinary team. If the assessment concluded the resident was able to self-administer medications, a written order would be obtained from the attending physician. The residents ability to self-administer medications would be reviewed on any readmissions, quarterly, and with significant changes.

During an observation on 3/26/2025 at 10:23 AM, Resident #84 was sitting in the dining area by themselves at the table eating their breakfast. There was a plastic medicine cup with their morning medications to the side of their plate. Resident #84 poured the pills onto their plate and took them with yogurt. There was no nurse supervising Resident #84 while they independently took their medications.

There was no documented evidence in Resident #84's medical record that they could self-administer their medications.

There was no documented evidence of physician order for Resident #84 to self-administer their medication.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/28/2025 at 3:17 PM, Licensed Practical Nurse #5 stated they put Resident #84's medications in a plastic cup and left them for Resident #84 to take with their yogurt. They stated they would leave Resident #84 alone while they took their medication, and they would come back to check on Resident #84 to make sure they took all their medication. They further stated they were not aware that Resident #84 was not formally assessed to take their medication independently. During an interview on 4/02/2025 at 10:09 AM, Registered Nurse #4 stated if a resident self-administered medication, an assessment for self-administration should have been completed. Registered Nurse #4 stated they did not think Resident #84 had an assessment for self-administration of medications and this resident should not have medications left for them to take independently. During an interview on 4/03/2025 at 12:06 PM, Director of Nursing #1 stated if a resident wanted to self-administer medications, an assessment would be completed, and the interdisciplinary team would need to agree that the resident was able to self-administer their medications. They stated Resident #84 did not have an evaluation for self-administration of medication and their medication should not have been left in a medicine cup for them to take independently. 10 New York Codes, Rules, and Regulations 415.3(e)(1)(vi)

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 51317 Based on interviews and record review conducted during the recertification survey, the facility did not ensure that it made prompt efforts to resolve a grievance and to keep the resident appropriately apprised of progress towards resolution for one (1) (Resident #28) of 36 residents reviewed. Specifically, Resident #28 and their representative did not receive prompt resolution when a grievance was filed regarding missing hearing aids on 2/19/2025. The facility did not follow up with this grievance until 4/01/2025. This is evidenced by: Resident #28 was admitted to the facility with diagnoses of chronic obstructive pulmonary disease (an ongoing lung condition caused by damage to the lungs resulting in swelling and irritation inside the airways that limit airflow into and out of the lungs), hypertensive heart disease (a condition arising from prolonged high blood pressure), and dependence on supplemental oxygen. The Minimum Data Set (an assessment tool) dated 1/03/2025 documented that the resident could be understood, could understand others, and had moderately impaired cognition. Facility policy titled, Complaints and Grievances, effective 1/2016, documented the facility provided a method to promptly deal with complaints and recommendations made by residents, their next of kin and/or their designated representative. The Social Worker was the grievance official or the person responsible for addressing complaints. Residents who wished to make a complaint were scheduled to be seen by the Social Worker or designee or would have the responsibility of presenting the complaint in writing to the Social Worker. Social Services would advise the Administrator of all complaints within 2 days of receipt. A response would be made to the resident, next of kin, or designated representative within 21 days of the day the complaint was made. Grievance Complaint/Follow Up Form, documented a grievance was received on 2/19/2025 and filed by Family Member #1. The form documented Resident #28 was missing two of their hearing aids. Staff were able to locate one of them, but the other hearing aid was still missing. The grievance form documented Social Worker #2 completed the form and an email was sent to the Administrator on 2/19/2025. Follow up notes on this form documented the Administrator spoke with Family Member #1 on 4/01/2025 and stated Family Member #1 said the prior administrator had agreed to reimburse the lost hearing aid prior to their departure from the facility, but to date they have not received reimbursement. Follow up notes were signed by Administrator #1. During an interview on 3/25/2025 at 10:46 AM, Family Member #1 stated Resident #28's hearing aids were missing and they looked everywhere but were not able to find them. Family Member #1 stated they told a nurse about the missing hearing aids and filed a grievance with the Social Worker. They stated this happened a few weeks ago but was unsure of the date and had not received a resolution for the filed grievance. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/31/2025 at 1:47 PM, Shahbaz #8 (Certified Nurse Aide) stated Resident #28 had a hearing aid for each ear. If a hearing aid was missing, they would notify the nurse. Shahbaz #8 stated they could not recall if they notified the nurse that Resident #28's hearing aids were missing. They stated by the time they realized the hearing aids were missing, they thought the nurse already knew about it. During an interview on 3/31/2025 at 2:08 PM, Licensed Practical Nurse #5 stated they were not aware of Resident #28's missing hearing aids or what was done to attempt to find them. They stated they may have been off for a few days when the hearing aids went missing. If they knew they were missing, they would write a note and tell the nurse manager or the nursing supervisor. During an interview on 4/02/2025 at 10:09 AM, Registered Nurse #4 stated they had no knowledge of Resident #28's missing hearing aids. They stated they spoke with Family Member #1 on the afternoon of 4/01/2025 and this was when Registered Nurse #4 learned the hearing aids were missing. They stated Family Member #1 told them about the missing aids and that there was no follow up on the grievance. Registered Nurse #4 stated there have been a lot of changes with nurse managers and it could have gotten lost in the shuffle, but they would communicate and make sure there was follow through on this grievance. During an interview on 4/01/2025 at 11:13 AM, Social Worker #2 stated when they got a complaint from a family member, they filled out a grievance form and they notified the Administrator or the Director of Nursing. The Administrator was the grievance officer. They worked together to figure out how to move forward on the complaint and come to a conclusion. They stated Family Member #1 filled out a grievance form regarding Resident #28's missing hearing aid on 2/19/2025. Social Worker #2 gave this form to the former administrator. Social Worker #2 stated there was a disconnect with follow up on this grievance. During an interview on 4/03/2025 at 12:15 PM, Administrator #1 stated a family member, or a resident could report a grievance, and an investigation would be completed. If the incident was reportable, they would report it, but if it was not reportable, they would come up with a solution to resolve the grievance for the family member/resident. They would expect the grievance to be resolved within 21 days but if the grievance was regarding missing items, it could take longer. 10 New York Code Rules and Regulations 415.3(d)(1)(ii)

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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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43805 Based on observations, record review, and interviews conducted during the recertification survey, the facility did not ensure assessments were coordinated with the Pre-Admission Screening and Resident Review (PASARR) program under Medicaid for eight (8) (Resident #s 16, 22, 65, 70, 115, 130, 145, and 166) of 36 residents reviewed. Specifically, (a) Resident # ' s 22, 65, 70, and 145 received new diagnoses of mental illness and no Level I screening was done to determine if a Level II screen needed to be done and (b) Resident # ' s 16, 22, 115, 130, and 166 were admitted with diagnoses of mental illness and Level I screen was not accurately completed to indicate the need for Level II. This is evidenced by: 48413 The facility Policy and Procedure titled, Pre-Admission Screening and Resident Review (PASSAR), effective 9/10/2022, documented all individuals seeking admission would undergo a Pre-Admission Screening and Resident Review Level I screening prior to admission to determine if they have a mental illness or intellectual disability. Screening would be conducted in accordance with New York State Department of Health guidelines and Centers for Medicare and Medicaid Services regulations. Level II Evaluation: If the Level I screening indicates potential mental illness or intellectual disability, a Level II evaluation would be completed by a qualified mental health professional. The evaluation would assess the individual's needs, preferences, and the appropriateness of nursing facility placement. Resident #22 Resident #22 was admitted to the facility with diagnoses of dementia (loss of memory, language, problem-solving and other thinking abilities), anxiety (feeling of fear, dread, and uneasiness), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). The Minimum Data Set (an assessment tool) dated 11/15/2024, documented the resident had severe cognitive impairment, could be understood, and understand others. The Screen Form dated 12/29/2017, documented under Level I Review for Possible Mental Illness-question #23: Does this person have a serious mental illness - No. A Psychiatric consultation on 8/16/2022, documented medical history of major depressive disorder, anxiety disorder (repeated episodes of sudden feelings of intense anxiety and fear or terror), and post-traumatic stress disorder (a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event). 48615 Resident #130 Resident #130 was admitted to the facility with diagnosis of fracture of right femur neck (broken hip), fracture of left ulnar (broken forearm), and major depressive disorder. (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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Screen Form dated 7/24/2024, documented under Level I Review for Possible Mental Illness-question #23: Does this person have a serious mental illness - No. A Psychiatric consultation dated 9/05/2024, documented the following active diagnosis: adjustment disorder with mixed anxiety and depressed mood; psychotic disorder with hallucinations due to known physiological condition, and neurocognitive disorder with lewy bodies dementia. Recommendation: consider use of Galantamine for cognition and hallucinations. Continue Zoloft 100 milligrams daily for (depression/anxiety). Continue Remeron 7.5 milligrams at bedtime for Appetite Enhancement/helps with psychosis). 51317 Resident #166 Resident #166 was admitted to the facility with diagnoses of major depressive disorder, dementia, and hypertension (high blood pressure). The Minimum Data Set, dated dated dated [DATE] documented the resident was usually understood, could usually understand others, and was severely cognitively impaired. The Screen Form dated 10/22/2024 documented under Level I Review for Possible Mental Illness-question # 23: Does this person have a serious mental illness - No. During an interview on 4/01/2025 at 10:56 AM, Social Worker #3 stated the screen was completed prior to admission. They stated that a developmental disability, serious mental illness, or intellectual disability would warrant a Level II screen. They stated if a resident was diagnosed with a serious mental illness after admission, the facility should then complete a new screen then call an agency to come in and complete the Level II screen if warranted. During an interview on 4/01/2025 at 3:46 PM, Social Worker #1 stated resident #22 and resident #130 did not have any diagnosis that required a Level II screen. During an interview on 4/01/2025 at 11:06 AM, Social Worker #2 stated a Level II screen should be requested for conditions like bipolar disorder. During an interview on 4/03/2025 at 10:10 AM, Admissions Coordinator #1 stated prior to admission all resident medical and financial information was gathered, including the DOH-695 Screen. They stated the information was reviewed for completeness then given to nursing staff for admission; any subsequent changes requiring level II screen was followed up by social work. 10 New York Codes, Rules, and Regulations 415.11(e)

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F 0679

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide activities to meet all resident's needs.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 43805

Based on observation, record review and interview conducted during the recertification survey, the facility did not ensure ongoing provision of programs to support each resident and their choices of activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident for three (3) (Resident #s 16, 22, and 25) of 36 residents reviewed. Specifically, (a.) Resident #22 was unable to make their needs known, and there were several dates with no documented activities. (b.) For Resident #s 16 and 25, there were no consistent activities planned to meet the resident's needs and/or preferences.

This is evidenced by:

The facility Policy and Procedure titled, Activities, effective 10/15/2021, documented: (a) the Residential Services Activities Departments provided ongoing programs of activities designed to meet, in accordance with the comprehensive resident assessment, the interest and the physical, mental and psychosocial well-being of each resident; (b) activities programs encouraged the resident's voluntary choice of activities and participation by offering a variety of programs throughout the day and week. The programming promotes and maintains the resident's sense of usefulness to self and others; (c) the coordinator of each program ensured that there was a written plan for individual, group and independent activities in accordance with the resident's needs, interests and capabilities. The plan recognized the resident's mental and physical needs and interests, as well as education and experiences. The plan was developed and prepared with the resident and their designated representatives when it was appropriate and communicated to team members; (d) a monthly activities schedule based upon individual and group needs, interactions and capabilities was developed by the coordinator; (e) upon request, the coordinator provided the Executive Director with a monthly report of the type, frequency of, and number of residents who participated in the activity programs. They also ensured that the resident's clinical record contained a quarterly assessment to the resident's degree of participation in, response to, and benefit from the activities program.

Resident #22

Resident #22 was admitted to the facility with diagnoses of dementia (loss of memory, language, problem-solving and other thinking abilities), anxiety (feeling of fear, dread, and uneasiness), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). The Minimum Data Set, dated dated dated [DATE], documented the resident had severe cognitive impairments, could be understood, and understand others.

During observations on 3/26/2025 at 2:56 PM, 3/27/2025 at 10:00 AM, and 3/28/2025 at 11:30 AM, Resident #22 was noted to be the living room common area where a television was on. The resident was dozing on and off.

The Comprehensive Care Plan for Activities revised 2/11/2025, documented Resident #22 would be able to participate in activities of their choice and the resident would maintain the highest quality of life possible.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review revealed no documented evidence of activities for Resident #22 on the following dates in 2025: 1/03, 1/06, 1/08, 1/10, 1/13-1/17, 1/19-1/21, 1/23-1/25, 1/28-1/31, 2/05, 2/07, 2/08, 2/10-2/14, 2/19, 2/21, 2/22, 2/25-2/27, 3/03-3/08, 3/12-3/14, 3/19, 3/28, and 3/31/2025. Resident #25 Resident #25 was admitted to the facility with diagnoses of major depressive disorder, spinal stenosis (a narrowing of the space inside the backbone), and cardiac murmur (an extra, unusual sound heard during a heartbeat). The Minimum Data Set, dated dated dated [DATE] documented the resident was understood, could understand others, and was severely cognitively impaired. The Comprehensive Care Plan for Activities, last revised on 3/09/2025, documented the resident would continue to participate in groups and activities of choice. During an observation on 3/25/2025 at 12:16 PM, Resident #25 was in their room alone. During an observation on 3/31/2025 at 10:15 AM, Resident #25 was in their room alone with no activities or interaction. There were personal craft supplies available in the room, but they were not in reach of the resident. Resident #16 Resident #16 was admitted to the facility with diagnoses of dementia, major depressive disorder, and panic disorder (an anxiety disorder characterized by unexpected and repeated episodes of intense fear). The Minimum Data Set (an assessment tool) dated 3/15/2025, documented the resident had moderate cognitive impairment, could be understood, and understand others. The Comprehensive Care Plan for Activities, last revised on 3/09/2025, documented the resident would continue to participate in groups and activities of choice. During an observation on 3/25/2025 at 12:50 PM, Resident #16 was observed to be in their room with no staff interaction. During an observation on 3/31/2025 at 10:09 AM, Resident #16 was observed to be sitting at the dining table with no interaction or activities. Interviews: During an interview on 3/26/2025 at 12:30 PM, Ombudsman #1 stated residents had requested more activities to take place in the houses; they wanted more personalized activities that included exercise and outside trips. During an interview on 4/03/2025 at 10:14 AM, Shahbaz (Certified Nurse Aide) #1 stated that each house had activities and that the activities depended on the Shahbaz. They stated they tried to follow the activity calendar but not all staff did. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335697	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eddy Village Green	421 W Columbia Street Cohoes, NY 12047

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/31/2025 at 1:56 PM, Recreational Therapy Manager #1 stated when there were three (3) Shahbaz in the house, one should have been conducting the activity. They stated the following: The Activity Calendar was posted in the houses. Activity attendance roster was documented in electronic medical records. One-to-One activities were documented for each elder receiving 1:1 activities. Recreational Therapy Manager #1 stated a staff member from dietary held exercise groups in the houses, although it was not on a regular basis. They also stated there had been two outside trips within their 2-year tenure--One to the mall and the other to see Christmas Lights. They stated the major barrier to outside trips was securing a driver to drive the van. 48615 During an interview on 3/31/2025 at 3:18 PM, Administrator #1 stated they were reviewing current activity programs and working with Recreational Manager #1 and house staff to improve activities. They stated that they were recently made aware of needing a driver for outside trips and looking into obtaining more drivers; families had volunteered to assist in coordinating and conducting activities, such as paint and sip. They further stated that a dietary employee conducted an exercise program each month for each house. 10 New York Codes, Rules, and Regulations 415.5(f)(1)h

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NAME OF PROVIDER OR SUPPLIER Eddy Village Green		STREET ADDRESS, CITY, STATE, ZIP CODE 421 W Columbia Street Cohoes, NY 12047	

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51317 Based on observation, record review, and interview conducted during the recertification and abbreviated (Case #NY00347510) survey, the facility did not ensure that each resident received adequate supervision and assistance devices to prevent accidents, and did not ensure that the resident environment remained as free of accident hazards as is possible. This was evident for one (1) (Residents #146) of the 36 residents reviewed, and for House #s 10, 16, and 21. Specifically, (a.) Resident #146, who had a prior incident of being found outside of the home unsupervised, was found to have an electronic monitoring device alarm on their walker that was not functioning as it should. There was no documented evidence that the electronic monitoring device was checked daily for placement and function to prevent further accidents. Additionally, (b.) alcoholic beverages within spaces and rooms of House #s 10, 16, and 21 were observed to be open and unattended. The facility did not identify the risk and the provision of supervision to prevent accidental consumption of alcohol that was accessible to residents, staff and visitors. This is evidenced by: (a) Resident #146 Resident #146 was admitted to the facility with the diagnoses of Alzheimer ' s disease (a type of dementia that affects memory, thinking, and behavior), type 2 diabetes mellitus (a chronic condition that happens when a person has persistently high blood sugar levels), and hypertension (high blood pressure, a condition in which the force of blood against the artery walls is too high). The Minimum Data Set (an assessment tool) dated 2/21/2025 documented that the resident was severely cognitively impaired, could be understood and understand others. Policy titled Elopement and Disruptive Wandering (Exit-Seeking), effective 2/24/2023, documented that it was the policy of the facility to identify those residents at risk for elopement and disruptive wandering behavior and to take the necessary steps to ensure their safety. If a resident was determined to be at risk for elopement, the following steps would be followed: wandering device would be placed on the resident. If the resident is wearing the device, it would trigger the alarm. Battery life would be monitored and addressed within the manufacturer's recommended timeframes. Each wander device would be checked weekly for proper functioning. The placement of the wander device for each resident would be checked at every shift. The comprehensive Care Plan with a focus on safety awareness deficit related to confusion/decreased memory, dementia, history of falls, and impulsive behavior documented on 7/06/2024. Resident #146 exited the house and was found at the end of the carport by a staff member. Resident #146 was directed back into the home. The sole of the shoe was searched, and the electronic monitoring device was not present. A new electronic monitoring device was placed on Resident #146 ' s walker. Intervention initiated 7/08/24, documented Wander alert bracelet: (check function each week) on walker. A physician's order with a start date of 12/20/2023 documented the need to check the battery for the electronic monitoring device weekly and change it if needed. Directions documented that the battery should be checked every day of the shift on Wednesday. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Medication Administration Record/Treatment Administration Record, which started on 12/20/2023, documented checking the battery for the electronic monitoring device electronic monitoring device weekly and changing it if needed each day shift, every Wednesday for safety. During March 2025, the battery was checked on 3/05/2025, 3/12/2025, 3/19/2025, and 3/26/2025. Task sheet with intervention listed, check the electronic monitoring device bracelet for placement every 12-hour shift while awake. If the alarm does not sound, or the watch is missing, notify the supervisor, Nurse Manager, or House Nurse to replace the watch (place on the walker in the red box). Walk the elder past the patio door to check the function by sound. The following dates and times were listed as times this task was documented, and it was completed: 3/18/2025- 8:13PM 3/19/2025 6:59 AM 3/25/2025 8:33 PM 3/26/2025 6:54 AM 4/01/2025 10:30 AM and 9:29 PM There was no documentation that this task was completed on 3/20/2025, 3/21/2025, 3/22/2025, 3/23/2025, 3/24/2025, 3/27/2025, 3/28/2025, 3/29/2025, 3/30/2025, and 3/31/2025. During an interview and an observation on 3/31/2025 at 2:39 PM, Shahbaz (Certified Nurse Aide) #9 stated Resident # 146 had an electronic monitoring device on their walker which was in a red plastic box attached to their walker by screws. If Resident #146 approached the doors that led outside the home, an alarm would sound. When they heard the alarm, they would check to see if the resident was attempting to exit the house. Shahbaz (Certified Nurse Aide) #9 walked with Resident #146 to the home's front door to demonstrate how the alarm was activated. Resident #146 was using their walker with the electronic monitoring device attached. When they approached the front door, an alarm did not go off, indicating Resident #146 had approached the front door. Licensed Practical Nurse #6 approached Shahbaz #9 and Resident #146 at the front door, and they all walked with Resident #146 and their walker to the side door of the home to test the alarm on the side door. When Licensed Practical Nurse #6 approached the side door with Resident #146, the alarm was not triggered and did not make a sound alerting them. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/31/2025 at 2:52 PM, Licensed Practical Nurse #6 stated the electronic monitoring device for Resident #146 was kept in the red box screwed on to their walker because they would remove the electronic monitoring device if it were on their body or in their shoe. Resident #146 could not remove the red box from their walker. They stated that if the alarm worked properly, it would sound when Resident #146 approached the front or side door with the walker. An alert was sent to the pagers the Shahbaz (Certified Nurse Aide) ' s used and to the cell phones the Licensed Practical Nurse and Registered Nurse used that indicated the electronic monitoring device alarm was set off. They stated that during this observation on 3/31/2025, the electronic monitoring device alarm did not go off, and the Shahbaz pager and nurse's cell phone did not receive an alert that the electronic monitoring device alarm was set off. They stated the electronic monitoring device and alarm/alert system did not work as they should have, and they would call the person responsible for maintenance to fix the electronic monitoring device. During an interview on 3/31/2025 at 4:02 PM, Director of Maintenance #1 stated they checked the battery in Resident #146 ' s electronic monitoring device after the above-described observation. They stated the battery was dead, and the electronic monitoring device was not working. They programmed a new electronic monitoring device and checked it to make sure it was working, and they said it was working as it was supposed to at this time. During an interview and observation on 4/01/2025 at 12:36 PM, Shahbaz (Certified Nurse Aide) #10 stated that if they heard an alarm sound, they would check the pager they wore and each door in the home to see what could have caused the alarm to go off. They said they check Resident #146 ' s electronic monitoring device daily to ensure it works. Shahbaz (Certified Nurse Aide) #10 took Resident #146 ' s walker to the front door. The door alarm went off, and Shahbaz (Certified Nurse Aide) #10 received a notification on their pager that the electronic monitoring device had set off the alarm. Shahbaz (Certified Nurse Aide) #10 approached the side door with Resident #146 ' s walker, and the alarm went off. Shahbaz (Certified Nurse Aide) #10 received a notification on their pager that the electronic monitoring device had set the alarm off. During an interview on 4/02/2025 at 10:09 AM, Registered Nurse #4 stated Resident #146 was able to wander out of the house one time, so they now have an electronic monitoring device in a locked box on their walker to alert staff if the resident was attempting to leave the house. Registered Nurse #4 said the electronic monitoring device was checked weekly to ensure it was functioning as it should be, and the placement of the electronic monitoring device was checked daily. Registered Nurse #4 stated they did not think checking the function of the electronic monitoring device once a week was enough and that it should be checked each 12-hour shift. They stated that if the alarm were to be set off, they would hear the alarm, and the doors would automatically lock. The Shahbaz (Certified Nurse Aide) received a notification on their pager, and the nurses received a notification on their phone that the alarm was set off. Registered Nurse #4 stated they heard the alarm did not go off for Resident #146 on 3/31/2025, and on 4/01/2025, staff checked every alarm for residents that had them to ensure they were working. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an Interview on 4/03/2025 at 12:06 PM, Director of Nursing #1 stated that if a resident wearing an electronic monitoring device were to approach an exit, the system would alarm with a beeping noise, and Shahbaz (Certified Nurse Aide) received a notification on their pager. The Shahbaz (Certified Nurse Aide) should respond to the noise and check on the residents, check the exits, and redirect the residents if necessary. They stated the nurses check the batteries in the electronic monitoring device once a week, but the batteries could stop working. The batteries could be working one minute and not the next. Director of Nursing #1 stated it was not difficult to check if Resident #146 ' s electronic monitoring device was working because a Shahbaz (Certified Nurse Aide) could take the walker and bring it to the door to see if it sets the alarm off. The resident did not need to be with them as they did this. When Director of Nursing #1 saw the gaps on the task sheet to check the electronic monitoring device placement every 12-hour shift while awake, they stated that the Shahbaz (Certified Nurse Aide) were not documenting that they completed this task consistently. Director of Nursing #1 could not say the electronic monitoring device was checked to ensure it was functioning correctly on the days that were not documented. 48413 (b) Resident environment During an observation in House #16 on 3/26/2025 at 10:46 AM, the kitchen pantry contained a box of [NAME] Oktoberfest beer with three (3) bottles, labeled with the Resident #54's name. In the pantry refrigerator, two (2) bottles of the same beer were on the door shelf with no label of the resident's name. The pantry was accessible to residents, staff and visitors. During an observation in House #10 on 3/26/2025 at 11:05 AM, the unlocked medication room contained one (1) bottle of wine and two (2) bottles of hard liquor on a shelf approximately 5 feet from the ground. During an observation on 3/28/2025 at 12:34 PM, House 21 Medication Room Door was wide open. Signage was posted on door that read, Please Keep Med Room Door Closed At All Times. Four (4) wine bottles were observed within the room. Licensed Practical Nurse #1 was observed walking from medication room to kitchen area while leaving medication room door open. They returned approximately 10 minutes later. In the interim, Certified Nurse Aide #2 went into medication room and retrieved supplies leaving door open. During an interview on 3/28/2025 at 12:44 PM, Licensed Practical Nurse #1 stated the Certified Nurse Aides and dietary staff had the access code to medication room. Record review revealed some residents had a physician order to be administered an alcoholic beverage. Record review of Resident #54's care plan documented Resident #54 enjoyed a beer occasionally; staff were to offer a beer to them when having Happy Hour. Record review of physician orders revealed Resident #54 was ordered as: may have a beer nightly at dinner and may have a beer daily. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/02/2025 at 2:38 PM, Registered Nurse #1 stated that nurses would give Resident #54 the alcoholic beverage when requested. They indicated that they were unsure where they would document when the nurse would give the resident their beer. Registered Nurse #1 stated there was no way of documenting when Resident #54 was given a beer due to how it was entered into the system. During an interview on 3/31/2025 at 2:43 PM, Director of Nursing #1 stated Certified Nurse Aides, dietary staff, and central supply staff had access to the medication room. They further stated the Nurse Manager would keep an eye on alcoholic beverages, and there was no tracking for how much alcohol was used/distributed. There was no documented evidence that the facility identified the accessible alcoholic beverages as an environmental hazard, assessed individual resident risk of an accident, tracked consumption of alcoholic beverages ordered by a physician when administered to a resident, or identified and implemented measures to mitigate the risk of unintended alcoholic consumption. During an interview on 3/31/2025 at 3:18 PM, Administrator #1 stated staff who were not certified to pass medication should not access the medication room. They stated that as of 3/31/2025, Shahbaz (Certified Nurse Aide) supplies were relocated to another area, and the access code to the mediation rooms were changed and given only to licensed staff who administer medication. During an observation on 4/01/2025 at 10:17 AM, House #19 Medication Room door was wide open and unattended. At the time of observation, Shahbaz (Certified Nurse Aide) #3 stated it was their mistake, but the door was usually open anyway. 10 New York Codes, Rules and Regulations 415.12(h)(1)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48615 Based on observations, record review, and interviews conducted during the recertification survey, the facility did not ensure residents who needed respiratory care were provided such care, consistent with professional standards of practice for two (2) (Resident #s 28 and 89) of three (3) residents reviewed. Specifically, (a.) Resident #28 order for continuous oxygen was not administered. The oxygen nasal cannula was placed on the resident, but the oxygen concentrator was off, therefore not delivering oxygen to the resident; (b.) Resident #89's order for 2 liters of oxygen were not followed consistently. This is evidenced by: The facility Policy and Procedure titled, Oxygen Management, effective 5/13/2024 documented, it was policy to administer oxygen per provider order in a safe manner. Responsibility of Licensed Nursing Staff: Procedure: (1) Review orders; (2) Identify resident and explain procedure; (3) Plug in power cord; (4) Keep concentrator at least 12 inches from walls, draperies and avoid confined spaces; (5) Connect humidifier (if needed); (6) Attach oxygen tubing from the humidifier bottle to oxygen outlet connector on the concentrator. If humidification is not being utilized place adaptor on the outlet connector and attach oxygen tubing directly to the adaptor; (7) Press power switch on; (8) Turn the flow meter to the prescribed flow rate setting. (9) Follow manufacturer's recommendations on filter changes or additional required maintenance. Resident #28 was admitted to the facility with diagnoses of chronic obstructive pulmonary disease (an ongoing lung condition caused by damage to the lungs resulting in swelling and irritation inside the airways that limit airflow into and out of the lungs), hypertensive heart disease (a condition arising from prolonged high blood pressure), and dependence on supplemental oxygen. The Minimum Data Set (an assessment tool) dated 1/03/2025, documented the resident had moderate cognitive impairments, could be understood, and understand others. The Comprehensive Care Plan with focus, Potential/Actual Impaired Breathing related to Chronic Obstructive Pulmonary Disease, effective 1/17/2023, last revised 1/01/2025, documented Resident #28 was to receive 2 liters of oxygen via nasal cannula continuously. May increase as needed. Physician order initiated 5/07/2024 and revised monthly, documented apply continuous oxygen 2 liters via nasal cannula; titrate as needed to keep oxygen saturation greater than 88 percent. During an observation and interview on 3/26/2025 at 10:46 AM, Resident #28 was in their room, seated in a recliner. They were wearing a nasal cannula that was attached to an oxygen concentrator (a device that draws air from the surrounding environment and delivers a concentrated, purified stream of oxygen). The oxygen concentrator was turned off. Resident #28 was not receiving continuous oxygen. Family Member #1 stated Resident #28 was brought back to their room after eating breakfast. When they ate breakfast in the dining area, Resident #28 used a portable oxygen tank attached to their wheelchair to supply oxygen, and when Resident #28 was in their room the concentrator was used to supply oxygen. Family Member #1 stated the concentrator was not turned on when Resident #28 was returned to their room. Family member #1 turned on Resident #28's oxygen concentrator. They stated Resident #28 was supposed to receive supplemental oxygen continuously. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/31/2025 at 1:47 PM. Shahbaz (Certified Nurse Aide) #8 stated Resident #28 always used supplemental oxygen. When they were in their room, Resident #28 used the concentrator to supply oxygen and during meals or activities they used a portable tank to supply the oxygen. During an interview on 3/31/2025 at 2:08 PM, Licensed Practical Nurse #5 stated Resident #28 should have received supplemental oxygen continuously. Residents may need to be checked on to make sure they were receiving supplemental oxygen. During an interview on 4/02/2025 at 10:09 AM, Registered Nurse #4 stated they were not sure if Resident #28 was to receive continuous oxygen, but if a resident had orders for continuous oxygen, they should have received oxygen at all times. Resident #89 Resident #89 was admitted to the facility with diagnoses of hemiplegia (paralysis on one side of the body) following a stroke (a loss of blood flow to part of the brain, which damages brain tissue), congestive heart failure (heart cannot pump blood well enough to meet your body's needs), and chronic obstructive pulmonary disease. The Minimum Data Set, dated dated dated [DATE], documented the resident was cognitively intact, could be understood, and understand others. The Comprehensive Care Plan for Cardiac Function initiated 10/24/2024, revised 1/18/2025, documented actual alteration in cardiac function, as manifested by cardiac arrhythmia, edema, unstable vital signs. Interventions include: (a) assess lung sounds as needed and report changes to Medical Doctor; (b.) oxygen as ordered. During an observation on 3/26/2025 at 12:14 PM, Resident #89 was at the dining room table, oxygen concentrator in place, set at 5 liter per minute via nasal cannula. During an observation on 4/01/2025 at 10:57 AM, Resident #89 was sitting in the recliner in their room, oxygen concentrator in place, set at 3 liters per minute via nasal cannula. The physician order dated 10/24/2024, renewed 3/01/2025 documented Oxygen 2 liters per minute via nasal cannula as needed. Notify medical doctor if increased flow rate and/or continued use as needed for shortness of breath. During an interview on 4/03/2025 at 11:30 AM, Director of Nursing #1 stated nursing staff were to check and follow oxygen orders as prescribed. The concentrator may be used in or out of the room. If the resident is on a lower flow, they may use a tank or a portable oxygen delivery system if away from the concentrator. Certified Nurse Aides could make sure the cannula is in and turn the machine on or off but could not adjust flow of oxygen. 51317 During an interview on 4/03/2025 at 12:06 PM, Director of Nursing #1 stated if a resident had orders to receive continuous oxygen, they should have oxygen on all the time. Director of Nursing #1 stated if a resident was wearing a nasal cannula attached to an oxygen concentrator, but the concentrator was turned off, the resident was not receiving supplemental oxygen. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10 New York Codes, Rules, and Regulations 415.12(k)(6)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48413 Based on observation, record review, and interviews conducted during a recertification and abbreviated survey (Case #NY00368845), 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, (1) an analysis of the actual staffing schedule showed that on multiple occasions from 3/25/2025 through 4/02/2025, the facility was below the minimum levels required; (2) staff reported a lack of sufficient staffing; and (3) residents reported during interviews that the facility was short-staffed at times, and this resulted in call bells not being answered timely and long wait times for care to be provided. This is evidenced by: Upon entrance to the facility on [DATE], there were 170 residents residing in 16 housing units. The Facility Assessment, last reviewed on 7/31/2024, documented that the facility's bed capacity was 190. The section titled Staffing Plan documented the following: The day shift required 1 Registered Nurse for four houses, 2 Licensed Practical Nurses for two houses, and 3 Shahbaz (Certified Nurse Aide) per house. The evening shift required 1 Registered Nurse for the facility, 2 Licensed Practical Nurses for two houses, and 2 Shahbaz per house. The night shift requires one Registered Nurse for the facility, two Licensed Practical Nurses for two houses, and one Shahbaz per house. A review of staffing sheets provided by the facility from 1/19/2025 through 3/22/2025 documented that they did not meet their assessed minimum staffing on most day shifts, for the following: On 1/20/2025, during the day shift, all houses had 2.5 Shahbaz providers except for houses 7, 10, and 16, which had 1.5 Shahbaz each; houses 12 and 19, which had two Shahbaz each. On 1/28/2025, during the day shift, all houses had 2.5 Shahbaz except for house 1, which had 1.5 Shahbaz; houses 3, 10, and 12, which had two Shahbaz each. On 2/05/2025, during the day shift, all houses had 2.5 Shahbaz providers except for house 6, which had 1.5 Shahbaz. On 2/13/2025, during the day shift, all houses had 2.5 Shahbaz providers except houses 1, 2, 4, 10, and 12, which had two Shahbaz each. On 2/21/2025, during the day shift, all houses had 2.5 Shahbaz providers except for houses 1 and 4, which each had 1 Shahbaz; house 7, which had 2 Shahbaz. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Eddy Village Green		STREET ADDRESS, CITY, STATE, ZIP CODE: 421 W Columbia Street Cohoes, NY 12047	

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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 - Some	On 2/24/2025, during the day shift, all houses had 2.5 Shahbaz providers except for houses 5 and 22, which each had 1.5 Shahbaz; houses 1, 2, 3, 4, and 7, which had 2 Shahbaz. On 3/05/2025, during the day shift, all houses had 2.5 Shahbaz providers except for houses 1 and 12, which each had 1.5 Shahbaz; house 2, which had 2 Shahbaz; and houses 7, 21, and 24, which each had 3 Shahbaz. On 3/14/2025, during the day shift, all houses had 2.5 Shahbaz providers except for house 24, which had 2 Shahbaz; and houses 2, 7, 10, and 21, which each had 3 Shahbaz. On 3/19/2025, during the day shift, all houses had 2.5 Shahbaz providers except for house 5, which had 1 Shahbaz; houses 2, 8, and 12, which each had 2 Shahbaz. During an interview on 3/25/2025 at 10:35 AM, Resident #70 stated that the staff were sometimes late in providing care. They stated that it could take up to an hour for staff to assist in the bathroom. They also stated that the staff stated that they were always busy and unable to do certain tasks because they were busy taking care of 12 residents. During an interview on 3/25/2025 at 3:01 PM, Resident #91 stated that they were consistently short-staffed in the morning, and breakfast was usually delayed. During an interview on 3/27/2025 at 12:04 PM, Resident #19 stated that they had waited a long time to get assistance. They also stated that the call bell system did not work well, and staff sometimes ignored it. During a surveyor-led group resident meeting on 3/27/2025 at 11:35 AM, the nine (9) residents in attendance all reported insufficient staffing to meet their needs. They often had to wait after they activated their call light. They stated that the call light system was unreliable, and staff do not hear it. They stated that staff would turn off their call light and told them they would return to provide requested care, and sometimes never returned. They stated that mealtimes were when they did not get the assistance needed, as everyone was busy trying to get the residents' meals, moved, and cleaned up afterwards. During an interview on 4/01/2025 at 12:35 PM, Shahbaz (Certified Nurse Aide) #7 stated that they were often short-staffed, residents would have to wait for care, and they had no time for anything extra. During an interview on 4/02/2025 at 2:09 PM, Registered Nurse #1 stated that staffing was not great. During an interview on 4/03/2025 at 10:54 PM, Scheduler #1 stated that they had been the scheduler since December of 2024, and the schedule calls for 2.5 Shahbaz (Certified Nurse Aides) per day per house. They stated that there were two (2) Shahbaz scheduled for the 7:00 AM to 3:00 PM shift and one (1) Shahbaz from the 8:00 AM to 1:00 PM shift. They stated that the 8:00 AM shift was tough to fill and would drop that shift if needed, and work at their minimum staffing level of two (2) Shahbaz for the house. They stated that if able, they would move individuals around the campus to achieve the minimum staffing if there were call-outs. They stated that they have had to use more agency personnel lately due to staffing issues. (continued on next page)

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	335697	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eddy Village Green	421 W Columbia Street Cohoes, NY 12047

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	51317 During an interview on 4/03/2025 at 10:54 PM, Nurse Educator #1, stated they also completed scheduling and agreed with Scheduler #1 regarding the facility staffing level and minimum staffing. Nurse Educator #1 was shown the facility assessment and staffing plan, which stated that the staffing calls for a minimum of three (3) Shahbaz per resident house. They stated that they were unsure when the facility assessment was updated but indicated that it should not have been three (3) Shahbaz. Nurse Educator #1 was shown that the facility assessment was updated on 7/31/2024 by Administrator #2. 10 New York Code Rules and Regulations 415.13(a)(1)(i-iii)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. 48413 Based on observations and interview conducted during the recertification survey, it was determined that the facility did not post nurse staffing information in an area accessible to all residents and visitors, as required by the posting requirements. Specifically, the posting of daily nurse staffing levels for staff working in the facility on each shift was displayed on one (1) resident unit, and not accessible to residents and visitors on the other resident units of the facility. This is evidenced by: During an observation from 3/25/2025 through 4/03/2025, the doorway to the administration suite was labeled with a sign documenting that no one was allowed in the building except staff. During an observation on 4/03/2025, at 11:10 AM, the daily nurse staffing postings were located on the wall by the reception desk in the administration building, which was not readily visible or accessible to all residents and visitors. There was no nurse staffing levels posted at any of the 16 residential units where residents and visitors from other units would walk through. During an interview on 4/03/2025 at 11:15 AM, Director of Nursing #1 stated that the nurse staffing postings were not posted in the residential houses, and they would expect residents and visitors to go to the administration building to see the staff posting it if they wanted to. 10 New York Codes, Rules, and Regulations 415.13

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 48615

Based on observation, record review, and interviews conducted during the recertification survey, the facility did not ensure drugs and biologicals were labeled and stored in accordance with professional standards of practice for two (2) (House 21 and House 24) of 8 medication carts reviewed, and 8 (Houses 1, 2, 3, 4, 19, 21, 22, 24) of 8 medication rooms reviewed. Specifically, (a.) opened medications had no open and or expiration dates; (b.) one active medication had expired; (c.) medication rooms were left open and unattended; (d.) unlicensed staff had key/access code to medication rooms.

This is evidenced by:

The facility's Policy and Procedure Titled, Medication Administration effective [DATE] documented, each patient/resident/elder would receive medications according to provider orders and accepted professional standards. Under General Considerations, Responsibility and Procedure: The nurse is responsible for: #3: NOTE carefully the name, dose, amount of administration and expiration date. Be sure the frequency and time schedules correspond. Multidose Medications: 1. Medications with shortened expiration dates should have date opened noted. 2. Once any medication or biological package is opened, the facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. 3. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened. a. Facility staff may record the calculated expiration date based on date opened on the medication container.

The facility's Policy and Procedure 5.3 titled Storage and Expiration Dating of Medications and Biologicals, revised dated [DATE], documented General Storage Procedures: 1. Facility should ensure that only authorized facility staff, as defined by facility, should have possession of the keys, access cards, electronic codes, or combinations which open medication storage areas. Authorized staff may include nursing supervisors, charge nurses, licensed nurses, and other personnel authorized to administer medications in compliance with applicable law. 5. Facility should ensure all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors.

During an observation on [DATE] at 12:34 PM, House 21 Medication Room Door was wide open. Signage was posted on door that read, Please Keep Med Room Door Closed At All Times. Licensed Practical Nurse #1 was observed walking from medication room to kitchen area while leaving medication room door open. They returned approximately 10 minutes later. In the interim, Shahbaz (Certified Nurse Aide) #2 went into medication room and retrieved supplies leaving door open.

During an interview on [DATE] at 12:44 PM, Licensed Practical Nurse #1 stated the Shahbaz (Certified Nurse Aides) had the access code to medication room because some of their patient care supplies, such as soap, toothpaste, deodorant, combs, etcetera are kept in the medication room. Dietary staff also had access code to enter medication room to deliver tube feeding supplies.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on [DATE] at 12:55 PM, House 21 medication cabinet contained 1 Basaglar Kwik insulin pen with no open and or expiration date. It was placed in a bag dated [DATE]; 1 bottle of Carbamide Peroxide ear drops with no open and or expiration dates. 1 expired albuterol sulfate hydrofluoroalkane (HFA) inhaler dated [DATE]. During an observation on [DATE] at 1:20 PM, House #24 medication cabinet contained the following with no open and or expiration dates: 1 polyvinyl alcohol ophthalmic 1.4 percent eye drops; 1 Novolog insulin pen, and 1 fluticasone inhaler with no open and or expiration dates. During an observation on [DATE] at 3:15 PM, House #21 Medication Room contained the following stock medications: Calcium 600 milligram tablets; multivitamins; Benadryl liquid; Senna plus tablets; Guaifenesin cough syrup; Aspirin 81 milligram tablets; Tylenol 325 and 500 milligram capsules; Efferdent; Mucinex tablets; Ferrous Sulfate 325 milligrams; Ibuprofen 200 milligram tablets; Melatonin tablets; Vitamin B12 500 and 1000 micrograms; Glucose Gel; Hemorrhoid cream; Ben Gay Ointment. MiraLAX powder; Artificial Tears Eye Drops; Debrox Ear Drops; Deep Sea Nasal Spray; 4% Lidocaine Patches. The unlocked medication room refrigerator contained a six-back beer for resident use as prescribed. On top of the medication room filing cabinet there were 3 bottles of wine. During an observation on [DATE] at 3:30 PM, Medication Rooms in House 1, 2, 3, 4, 19, 21, 22, and 24 contained stock mediations as above and supplies that Shahbaz (Certified Nurse Aide) use for resident care. During an interview on [DATE] at 2:43 PM, Director of Nursing #1 stated nurse should date medication upon opening with open and expiration dates. Shahbaz (Certified Nurse Aides) had access to the medication room so that they could obtain necessary supplies for patient care. Dietary staff deliver tube feeds, central supply delivers stock medication and other stocks. Both had access to medication room. Families provided alcohol beverages unless there was a special event. In that case the facility will order alcoholic beverages to serve. The Nurse Manager kept an eye on alcoholic beverages. There was no tracking for how much alcohol was used. During an interview on [DATE] at 03:18 PM, Administrator #1 stated staff who were not certified to pass medication should not access the medication room. As of today, the Certified Nurse Aide supplies were relocated to another area, and the access code to the mediation rooms were changed and given only to licensed staff who administer medication. During an observation on [DATE] at 10:17 AM, House #19 Medication Room was wide open and unattended. At the time of observation, Certified Nurse Aide #3 stated it was their mistake, but the door was usually open anyway. 10 New York Codes, Rules, and Regulations 415.18(d)

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48413 Based on observation, record review, and interviews conducted during the recertification survey, the facility did not ensure food was stored in accordance with professional standards for food service safety for four (4) of 16 resident central kitchens. Specifically, (a.) bulk food items were not labeled for their contents; (b.) bulk food items and outside items were not date-labeled after opening or labeled with an expiration date; (c.) appliances were not cleaned and had dirt, grime, and unknown substances within them; and (d.) chicken was improperly being thawed. This is evidenced by: An undated policy titled Food Safety Labeling Procedure documented that all food or beverage items stored, opened, prepared, or leftover in our kitchens/storage areas and/or delivered to areas such as Nursing Stations or pantries would be clearly identified by the item name/product, the production or opened date, and the use-by date. A document titled Important Foodservice and Sanitation Guidelines described that any prepared food that was opened or stored must be labeled and dated for discard within three days. Any beverage or dairy product must be labeled with its opening date. Items must be discarded within seven days of being opened or by the manufacturer's use-by date, whichever comes first. Any condiment-type item that must be refrigerated after opening must be labeled with the opened date, and items must be discarded within 30 days of being opened. House #5 During an observation on [DATE] at 10:27 AM, uncooked chicken was in a Ziploc bag placed in a metal bowl in the kitchen sink, with water from the faucet running over it. The bag was labeled ,d+[DATE] dinner. At 11:23 AM, the same bag of chicken was observed in the metal bowl filled with water in the same sink. The bag of chicken was sitting in the bowl filled with water, and the faucet was turned off. During observations on [DATE] from 10:35 AM to 12:35 PM, the following was noted within the main kitchen area for Houses #10, 12, 14, and 16: House # 10 A) Eight (8) items did not have labels describing what they were or what they contained: Frozen French fries located within a freezer Frozen scones located within a freezer Frozen cookies located within a freezer Frozen sausage patties located within a freezer (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Frozen fish fillets located within a freezer Frozen peas located within a freezer Frozen dinner rolls located within a freezer Frozen broccoli located within a freezer B) Two (2) items lacked a label or writing of when they were opened: A bag of Ruffles chips Package of cookies C) The appliances had the following findings: Seals on the freezer and refrigerator were covered with dirt and grime The freezer had old fallen labels dating back to 2019 The freezer bottom had substance on the bottom of the freezer The interior of the oven had unknown substances on the glass doorway The microwave oven was covered with an unknown substance within the appliance House # 12 A) Eight (8) items did not have labels describing what they were or what they contained: Frozen waffle fries located within a freezer Frozen hot dogs located within a freezer Frozen hamburgers located within a freezer Two (2) packages of frozen sausage patties located within a freezer Four (4) packages of frozen sausage patties located within a freezer Frozen fish fillets labeled as sausage located within a freezer Frozen corn located within a freezer Frozen cinnamon rolls labeled as dinner rolls located within a freezer Frozen broccoli located within a freezer (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Frozen berry mix located within a freezer B) Two (2) items lacked a label or writing of when they were opened: Two (2) packages of wheat bread Package of cookies C) The appliances had the following findings: Seals on the freezer and refrigerator were covered with dirt and grime The freezer had old fallen labels dating back to 2021 The freezer bottom had substance on the bottom of the freezer The interior of the oven had unknown substances on the glass doorway The microwave oven was covered with an unknown substance within the appliance House #14 A) Eight (8) items did not have labels describing what they were or what they contained: Frozen French fries located within a freezer Frozen scones located within a freezer Frozen cookies located within a freezer Frozen sausage patties located within a freezer Frozen fish fillets located within a freezer Frozen peas located within a freezer Frozen dinner rolls located within a freezer Frozen broccoli located within a freezer B) Four (4) items lacked a label or writing of when they were opened: A bag of Ruffles chips Package of cookies Package of Cinnamon Toast Crunch bars (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Package of Oatmeal Bars C) The appliances had the following findings: Seals on the freezer and refrigerator were covered with dirt and grime The freezer had old fallen labels dating back to 2019 The freezer bottom had substance on the bottom of the freezer. The interior of the oven had unknown substances on the glass doorway The microwave oven was covered with an unknown substance within the appliance House #16 A) Eight (8) items did not have labels describing what they were or what they contained: Frozen hamburgers located within a freezer Frozen scones located within a freezer Frozen cookies located within a freezer Frozen sausage links located within a freezer Frozen fish fillets located within a freezer Frozen corn located within a freezer Frozen dinner rolls located within a freezer Frozen broccoli located within a freezer B) Two (2) items lacked a label or writing of when they were opened: Two (2) packages of wheat bread Package of cookies C) The appliances had the following findings: Seals on the freezer and refrigerator were covered with dirt and grime The freezer had old fallen labels dating back to 2019 The freezer bottom had substance on the bottom of the freezer (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The interior of the oven had unknown substances on the glass doorway The microwave oven was covered with an unknown substance within the appliance Interviews: During an interview on [DATE] at 10:44 AM, Shahbaz (Certified Nurse Aide) #4 stated that staff should have properly labeled and discarded the expired item. They stated that the labels did not always stick in the freezer and fell off. During an interview on [DATE] at 10:54 AM, Shahbaz #5 stated all staff needed to be more diligent in labeling and tracking item dates and labeled when identified. During an interview on [DATE] at 11:49 AM, Shahbaz #1 stated that all Certified Nurse Aides were responsible for looking at items and determining if they needed to be discarded by the date. During an interview on [DATE] at 11:08 AM, Registered Nurse #1 stated that food and kitchen activities were ultimately the staff's responsibility. All staff in the kitchen area should have checked the items regularly for resident safety. Registered Nurse #1 stated that it was the daily routine of the Shahbaz (Certified Nurse Aides) to maintain the cleanliness of the kitchen areas. They stated that there was a daily cleanliness checklist for them to follow. They further stated that they would periodically meet with the food service division to review the items found. During an interview on [DATE] at 2:15 PM, Director of Nursing #1 stated that the Food Service Director oversaw the food at the facility. However, it was a joint staff effort to check the food and food items daily for potential expiration dates. They further stated that the facility's distribution manager and Shahbaz (Certified Nurse Aides) were to check the items regularly, with them opened and labeled per policy. 10 New York Codes of Rules and Regulations 415.14(h)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48413 Based on observation, record review, and interview conducted during the recertification survey, the facility did not maintain medical records in accordance with accepted professional standards and practices, as accurately documented and completed for one (1) (Resident #54) of the 36 residents reviewed. Specifically, for Resident #54, the physician's ordered alcohol administration was not documented in the Medical Administration Record. This is evidenced by: Resident #54 was admitted to the facility with diagnoses of Friedreich Ataxia (a progressive neurodegenerative disorder that primarily affects the nervous system, causing impaired muscle coordination), gastro-esophageal reflux disease (occurs when stomach contents persistently flow back into the esophagus, causing symptoms like heartburn), and essential hypertension (a condition characterized by persistently high blood pressure without an identifiable underlying cause). The Minimum Data Set (an assessment tool) dated 2/14/2025 documented that the resident could be understood and usually understand others and had intact cognition for daily living decisions. During an observation in House #16 on 3/26/2025 at 10:46 AM, the kitchen pantry contained a box of [NAME] Oktoberfest beer with three (3) bottles, labeled with the Resident #54's name. In the pantry refrigerator, there were two (2) bottles of the same beer on the door shelf with no label of the resident's name on them. During a record review of Resident #54's care plan on 3/28/2025, it was documented that Resident #54 enjoyed a beer on occasion, and staff were to offer this to them during Happy Hour. During a record review of physician orders on 3/28/2025, it was documented that Resident #54 may have a beer nightly at dinner and may have a beer daily. Record review of the March 2025 Medication Administration Record and Treatment Administration Record revealed no documentation of when Resident #54 was given an alcoholic beverage. Record review revealed no documented evidence on a process for staff to document in the medical record when a resident was given an alcoholic beverage. Record review revealed no documented evidence of policies regarding resident consumption of alcoholic beverages. During an interview on 4/02/2025 at 2:38 PM, Registered Nurse #1 stated that nurses were to give the resident the alcoholic beverage when they requested it. They indicated that they were unsure where they would document when the nurse gave the resident their beer. Registered Nurse #1 looked at the physician's orders and agreed that there was an order for the resident to receive a beer. They stated that there was no way of documenting when Resident #54 was given a beer due to the way it was entered into the system. Registered Nurse #1 stated that there should be something in the electronic records to track and record when the resident was given the beverage. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10 New York Code of Rules and Regulations 483.70 (h)(2)(ii)