

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335721	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/15/2025
NAME OF PROVIDER OR SUPPLIER Heritage Green Rehab & Skilled Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 3023 Route 430 Greenhurst, NY 14742	
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)		
<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>Based on interview and record review conducted during a Complaint investigation (#NY00364661-530180), the facility did not ensure that a resident has the right to refuse treatment for one (1) (Resident #1) of six (6) residents reviewed for immunizations. Specifically, Resident #1 was administered the COVID-19 vaccine without consent. The finding is: The policy and procedure titled Standing Order for Provision of Influenza, Pneumococcal, and COVID-19 Vaccine, revised 01/06/2024 documented all residents will be screened upon admission to the facility to evaluate COVID-19 immunization status. Consent or declination of the COVID-19 vaccination will be obtained within seven (7) days of admission and documented in the medical record. Residents or responsible parties have the right to refuse any vaccination at any time, education and refusals will be documented in the medical record. The policy and procedure titled Medication Administration revision/reviewed dated 12/09/2024 documented to check the resident wristband or bracelet or badge before administering the medication to make accurate resident identification. Resident #1 had diagnoses that included dementia, depression, and hypertension. The Minimum Data Set (a resident assessment tool) dated 09/24/2024 documented the resident was cognitively intact. The undated COVID-19 Booster Immunization Screening and Consent Form, signed by Resident #1, documented the resident declined to receive the vaccine. The Interdisciplinary Note dated 09/27/2024 at 2:42 PM authored by Licensed Practical Nurse #2 documented vaccination was given to right arm, small red dot, slightly swollen and tender. The Medication Error Report dated 09/26/2024 documented Licensed Practical Nurse #1 failed to follow resident's rights of medication administration when they failed to identify the correct resident. During a telephone interview on 08/13/2025 at 10:08 AM, Licensed Practical Nurse #1 stated they did not check Resident #1's wristband, to ensure correct, prior to administering the COVID-19 vaccination. During a telephone interview on 08/13/2025 at 12:02 PM, Registered Nurse #1 Infection Preventionist stated they provide the education and obtain consents/declinations for the COVID-19 vaccination. Identifying the correct resident was one of the basic medication administration rights. Registered Nurse #1 Infection Preventionist stated Resident #1 received the COVID-19 vaccination, after signing a declination, which was a violation of Resident #1's rights. During an interview on 08/13/2025 at 12:18 PM, the Director of Nursing stated Resident #1 received the COVID-19 vaccination in error. Licensed Practical Nurse #1 did not verify the correct resident prior to the administration of the vaccination. The administration of the COVID-19 vaccination to Resident #1 violated their rights because the resident had signed a declination not to receive the vaccine. 10 NYCRR 415.3(f)(1)(ii)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 335721	Facility ID: 335721 If continuation sheet Page 1 of 3

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Based on observation, interview, and record review conducted during a Complaint investigation (NY00384369-530162, NY00384458-530191, NY00385240-530194) completed on 08/15/2025, the facility did not ensure sufficient nursing staff to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing of each resident. Specifically, the facility did not ensure there was sufficient nurse staffing to meet the needs of the resident in accordance with their preferences and plans of care. The finding is: Review of the Dear Administrator letter 23-11 dated 06/30/23 sent to the nursing home administrators informing them that starting 04/01/2022 nursing homes were required to have an average daily staffing of 3.5 hours of care per resident per day with 2.2 hours for Certified Nurse Aides and 1.1 hours for Licensed Practical Nurses or Registered Nurses. The Facility Assessment, review dated 04/28/2025, documented the assessment is required by the nursing home Requirements of Participation to identify and analyze the facility's resident population and identify the personnel, physical plant, environmental and emergency response resources needed to competently care for the residents during the day-to-day operations and emergencies, including nights and weekends. The facility is licensed for 134 beds with an average daily census of 111. The facility will ensure that there is sufficient and competent staff to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. Additionally, the Facility Assessment documented the following total number needed or average or range of nursing staff including days, evenings, nights, and weekends:- Licensed nurses providing direct care 8-11- Nurse Aides 18-24 The undated handwritten Emergency Staffing Policy Plan Initiated documented the facility required one Registered Nurse on any shift per day; three Licensed Practical Nurses on first and second shift, and two Licensed Practical Nurses on third shift; five Certified Nurse Aides on first and second shift, and two Certified Nurse Aides on third shift. Review of the All Patches Detailed report of nursing staff directly responsible for nursing care documented the following:- 06/09/2025 - resident census 117; Licensed Practical Nurse and Registered Nurse hours 100.25 or .75 hours per resident per day; Certified Nurse Aide hours 115.5 or 1.0 hours per resident per day. Based on the census there was not the required number of Licensed Nurse or Certified Nurse Aide hours per day.- 08/09/2025 - resident census 109; Licensed Practical Nurse and Registered Nurse hours 56.75 hours or .5 hours per resident per day; Certified Nurse Aide hours 116.5 hours or 1.0 hours per resident per day. Based on the census there was not the required number of Licensed Nurse or Certified Nurse Aide hours per day.- 08/10/2025 - resident census 109; Licensed Practical Nurse and Registered Nurse hours 78.5 or .75 hours per resident per day; Certified Nurse Aide hours 110.5 hours or 1.0 per resident per day. Based on the census there was not the required number of Licensed Nurse or Certified Nurse Aide hours per day. The Aspen Complaints/Incidents Tracking System (ACTS) complaint #NY00384458, Internet Quality Improvement & Evaluation System (IQIES) complaint #530191, documented the complainant reported 06/09/2025 Resident #1 had not gotten out of bed for three (3) days, had been wearing the same clothes for three (3) days, and incontinent brief appeared to be from days earlier. During a telephone interview on 08/14/2025 at 10:00 AM, Licensed Practical Nurse #1 stated they recalled the complainant reporting the condition of Resident #1 on 06/09/2025. Licensed Practical Nurse #1 stated it had appeared that Resident #1 had minimal Care care over the past few days, the resident and their bed were soiled, the bottom sheet was wet and had dried stains. Licensed Practical Nurse #1 stated there wasn't enough staff to properly care for the residents. During an interview on 08/13/2025 at 1:28 PM, Resident #2 stated they filed a grievance with the facility and things have gotten a little better. Usually, they get into bed about 11:30 PM which they are fine with, sometimes 12:00 AM but it was better than 2:30 AM. Resident #2 stated all they ask of the staff was to give them a time frame as when they will be in to put them to bed. Sometimes they have to wait long to be changed or use the bed pan, about 45 minutes. Resident #2 stated they know the staff are busy due to the facility being short staffed. During an interview/observation on 08/15/2025 at 9:04 AM, Resident #3 stated they had waited over an hour that morning for assistance to the restroom because they were a two (2) assist with a mechanical lift and there were only two (2) Certified Nurse Aides on the unit, one (1) for each hall. Resident #3 stated they were unable to wait for staff assistance and soiled their brief making a mess in the bathroom when they were finally assisted. The toilet in the bathroom was observed to have feces on the seat. During an interview/observation on 08/15/2025 at 9:11 AM the call light system at the nurse's desk indicated Resident #5's call light had been ringing for eight (8)</p>		