STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335721	A. Building B. Wing	02/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Green Rehab & Skilled Nursing	3023 Route 430 Greenhurst, NY 14742

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** Based on interviews, observations, and record review conducted during a survey the facility did not ensure there was sufficient staff on a 24-hour basis to attain or maintain the highest practicable physical, mental and psychosocial well-being for residents in the facility. Residents #1, 2, 5, 7, 22, 37, 43, 60, 71, 76, 79 and 85 involved. The findings are: The Facility Assessment with a completed date of 02/16/2026, and a QAA (Quality Assessment and Assurance)/QAPI (Quality Assurance and Performance Improvement) review completed 8/26/2025 documented the facility has a secure dementia care unit (41 beds), long-term care unit compromised of 42 beds and another 51 bed that admits primarily short- term rehab. At least 65 percent of the facility's residents needed some assistance with dressing and bathing, 88 percent of residents needed some assistance with transfers, 93 percent needed some assistance with toileting, and 30 percent of residents needed some assistance with eating. The facility will ensure that there is sufficient and competent nursing 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. The facility will make decisions on required staffing based on resident census, resident acuity/needs, facility odors, complaints, call-lights, and staff's ability to complete assignments. The assessment included a facility staffing plan that would be based on resident needs. The total number of licensed practical nurses providing direct care needed/average of eight (8)-11; nurse aides 15-24; other nursing personnel one (1) - two (2) unit managers, and one (1) Minimum Data Set Nurse per day. The facility is licensed for 134 beds and has a daily average census of 111 residents. The policy and procedure titled Emergency Staffing Strategies with a revised date of 01/06/2024, documented bonuses and incentives may be offered, as appropriate, to enlist available and/or able staff, and that staffing agencies would be contacted for possible staffing assistance. The undated policy and procedure titled Call Bell Policy documented all staff were responsible for answering call bells, and to answer the call bell promptly when sounded. Staff are not to turn off the call bell unless they are able to provide assistance. Review of the Payroll Based Journal staffing report for Quarter 4 July 2025 - September 2025 revealed the facility had a one-star rating for staffing and triggered for low staffing levels on weekends. The facility resident census at the time of survey entrance on 02/23/2026 was 115. The undated document titled Heritage [NAME] Minimal Staffing Numbers, provided by the Facility Scheduler documented at a minimum they required: Nurses: 1st shift = four (Lake (1) Park (1) [NAME] (2)) 2nd shift = four (Lake (1) Park (1) [NAME] (2)) 3rd shift = three (Lake (1) Park (1) [NAME] (1))Certified Nurse Aides: 1st shift = six (Lake (2) Park (2) [NAME] (2))2nd shift = six (Lake (2) Park (2) [NAME] (2))3rd shift = three (Lake (1) Park (1) [NAME] (1)) Review of the facility daily staffing sheets dated 01/22/2026- 02/11/2026 revealed the Director of Nursing was counted in the facility's numbers to meet their minimum staffing numbers for direct care to the residents.During a telephone interview on 02/23/2026 at 9:59 AM, the Ombudsman stated they had received resident complaints regarding staffing issues. There were reported concerns of long call bell wait times, staff turnover, and resident appointments having to be (continued on next page)

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

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

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	cancelled because there was not enough staff to go out on transport with the residents. During a dining observation on 02/23/2026 at 11:50 AM, a meal cart was delivered to the [NAME] Unit by a kitchen staff member. Staff did not start passing trays until 11:59 AM. During an interview on 02/24/2026 at 9:14 AM, Resident #37 stated the coffee was lukewarm because there were not enough staff to pass trays. During an interview on 02/23/2026 1:47 PM, Resident #7 stated the facility did not have enough staff because they had to wait almost three (3) hours for their call light to be answered. Resident #7 stated they usually made their own bed because staff did not get to it in a timely manner. During an interview on 02/23/2026 1:34 PM, Resident #5 stated they have waited over an hour to go to the bathroom and ended up having to go in their brief, which was not right. Staff had told them they did not have enough help to get to them in time. During an interview on 02/24/2026 at 9:24 AM, Resident #22 stated there were not enough staff to help the residents with their needs. Resident #22 stated their call bell wait times were long, but when they finally answered, the staff were good. During the Resident Council meeting on 02/24/2026 at 10:04 AM, Residents #1, 43, 60, 79 and 85 were present. The residents stated they had monthly meetings, and staffing was a topic that was always discussed. The group all agreed that there were not enough certified nurse aides in the building. Resident #1 stated that they knew when a resident had to be transferred with a machine that two staff members were supposed to do it. They stated that at times staff would perform that transfer with only one staff member. Resident #1 also stated at times there were not enough staff to assist residents with eating, and they would help the residents sitting next to them. During an interview on 02/24/2026 at 10:48 AM, Resident #2 stated the facility did not have enough aides to go around and it was frustrating. They stated the staff would deliver their meals late and at times their call light could ring for an hour before they showed up to answer it. During a an interview on 02/25/2026 at 1:21 PM, the Food Service Director stated they get some resident complaints of food being cold, so they recently started doing more test trays. They stated they felt the issue was that there were not enough staff on the units to pass the trays timely. They stated the carts were usually delivered on time, but the staff might be providing care and unable to start passing them immediately. During an interview on 2/25/2026 at 10:14 AM, Licensed Practical Nurse #5 stated they had to start with one aide that morning from 6:00 AM until 7:30 AM. If a resident required two staff assist, they had to stop what they were doing and help the certified nurse aide. They stated that it happened more often than it should. There were usually only two (2) certified nurse aides and there were a lot of staff call offs. Licensed Practical Nurse #5 stated they usually stayed late to get their work done. During an observation and interview on 02/26/2026 from 10:05 to 10:39 AM, Resident #71's call light was observed to be activated for 10 minutes at 10:05 AM. Resident #71 was on the toilet, waiting for staff to return to get them off the toilet with the mechanical lift. At 10:39, Licensed Practical Nurse #4 and Certified Nurse Aide #2 entered the room with the lift. They provided toileting hygiene and assisted Resident #71 into their wheelchair. Certified Nurse Aide #2 stated it was difficult to get to all the residents timely with only two (2) Aides on the unit. During an interview on 02/26/2026 at 11:00 AM, [NAME] #1 stated they have reported trays often sat for extended periods of time before being delivered to residents by the unit staff. They recalled one time the [NAME] Unit had not yet served a breakfast cart until 10:25 AM which had been delivered at 8:25 AM. During an interview on 02/26/2026 at 12:35 PM, the family of Resident #76 stated they had not been happy with their family member's care recently. They stated the call bell wait times were too long. The staff will answer the bell but do not always come back when they said they would. During an interview on 02/26/2026 at 12:41 PM, Certified Nurse Aide #3 stated it was difficult to get their work done when they only had two (2) aides on the unit, which was almost every time they worked. They stated that they usually got everything done, but they knew the waiting times were long, and sometimes they were unable to get everyone their scheduled showers. During an interview on 02/26/2026 at 12:45 PM, Certified Nurse Aide #2 stated they always stayed late to complete their work and documentation. During an interview on 02/26/2026 at 4:35 PM, the family of Resident #5 stated their biggest concern was not (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	having enough help to get their family to the bathroom in time; so, they had to go in their incontinence brief. They also stated the food was always cold. They have been there at lunch many times and have watched the trays sit in the cart for a long time before getting passed to the residents. During an interview on 02/272026 at 9:10 AM, the facility Scheduler stated there were times when there were not enough staff to work, but they would keep trying to get other staff to come in. They did not feel the facility minimum numbers were enough for providing good care to the residents, but the staff did their best and worked very hard. They could not say that staff called off because they were tired of working short staffed, but there were more call offs when the schedule was short. The facility Scheduler stated they were not currently utilizing agency staff. During an interview on 02/27/2026 at 9:55 AM, Activities Aide #1 stated the facility had less staff on the weekends. Activities Aide #1 stated there have been many times that residents missed an activity because there was no one to get them ready. They would go to their rooms for 1:1 if that happened. During an interview on 02/27/2026 at 10:24 AM, Registered Nurse Unit Manager #2 stated their unit typically had an average daily census of 39 residents and typical staffing consisted of two nurses and two or three aides on the day shift; two nurses and two aides on the evening shift; and one nurse and one aide on the night shift. They stated with those staffing numbers, the residents on the unit had their basic needs met but nothing beyond that. Registered Nurse #2 stated there was not a lot of extra time for social interaction with the residents and they felt their unit could use additional staff. They stated the resident wait time for care was long and the unit had multiple two assist transfers that added to an additional longer wait time for the residents. During a telephone interview on 02/27/2026 at 11:06 AM, Certified Nurse Aide #5 stated they worked 10:00 PM to 10:00 AM and usually they were the only aide on their unit. They stated they had got their work done but they knew the call light wait times were long. Certified Nurse Aide #5 stated they often had to get the nurse or an aide from another unit to help them, and they always stayed late to get their documentation done. During an interview on 02/27/20 at 11:07 AM, Licensed Practical Nurse #1 stated they worked on the day shift but would also pick up a lot of extra time on the evening shift. They stated they could not get all of their duties completed in an 8-hour shift but always stayed over their scheduled shift to ensure their work was done. Licensed Practical Nurse #1 stated they usually worked with just one aide in their hallway. They stated one aide working in a hallway was not enough staff and they spent a lot of their own shift helping get residents dressed, assist with feeding, assisted with transfers and toileting. They stated those types of duties took time away from their nursing duties. Licensed Practical Nurse #1 stated at times the aides cannot complete charting, showers, afternoon toileting and putting the residents back to bed in the afternoons. During an interview on 02/27/2026 at 11:49 AM, the [NAME] President Skilled Nursing Facilities Operations stated they were aware some residents had concerns with call bell wait times. They stated they tried to address each resident's specific concern. They were aware that staff complained about working short staffed, and they did have issues with call offs. During an interview on 02/27/2026 at 12:48 PM, the Director of Nursing stated they were aware their minimum staffing was not ideal, and it was not their goal for scheduling. They stated the staff had to work very hard when there were only two (2) of them on a unit. The Director of Nursing stated they were aware of the concerns regarding long call bell wait times. They have educated all staff to respond to the call bell and try to find someone who was able to help. They have worked through resident and family grievances and try to address each resident/family concern individually. They make care plan updates to meet each residents' needs. Staffing is their number one concern. During interviews on 02/27/2026 at 10:45 AM and 2:24 PM, the Administrator stated they had received complaints about food temperatures and that temperature audits were conducted and discussed in morning meetings and at resident council. They knew there were times when staff did not pass food trays promptly; they observed delays of about 10 minutes and notified the nurse manager and assisted when needed. They expected trays to be passed immediately to avoid foodborne illness and to ensure residents receive hot meals. The Administrator stated they were aware of the staffing concerns and long (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	waiting times. Staffing was the top priority, and they discussed it every morning. They stated the minimum staffing numbers were not their goal. 10 New York Codes Rules Regulations 415.13(a)(b) (1) (i)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review conducted during a survey the facility did not ensure the Director of Nursing served as a charge nurse, only when the facility had an average daily occupancy of 60 or fewer residents. Specifically, the Director of Nursing worked as a charge nurse when the facility had a daily average census of greater than 60. The findings are:Review of the undated document titled Director of Nursing Job Description documented that within the framework of the objectives and policies established by the Corporation, and the New York State Department of Health regulations, the Director of Nursing is responsible for planning, directing, and coordinating nursing services. Under the supervision of the Administrator, the Director of Nursing exercises authority, responsibility and accountability for the functions, activities and training of the nursing service staff. Participates as a member of the facility management team in planning, policy formulation, and administrative decision making with particular reference to the role, function, and operation of the facility's nursing services. Is responsible for the overall management of resident care 24 hours a day, seven (7) days a week. Additionally, the Director of Nursing ensures a sufficient number of qualified supervisory and supportive nursing personnel are assigned for each tour of duty to meet the resident's needs and nursing standard of care. The State Operations Manual dated 07/23/2025, documented a Charge Nurse is a licensed nurse with specific responsibilities designated by the facility that may include staff supervision, emergency coordinator, physician liaison, as well as direct resident care.The documents titled Census Summary Reports by Location for January 23, 2026- February 23, 2026, documented the following:01/28/2026 the resident census was 11302/05/2026 the resident census was 11502/11/2026 the resident census was 116 The facility census at the time of survey entrance on 02/23/2026 was 115 out of 135 available beds.The undated document titled Heritage [NAME] Minimal Staffing Numbers, provided by the Facility Scheduler documented they required two (2) nurses on [NAME] Unit for the 6:00 AM - 2:00 PM, and 2:00 PM - 10:00 PM shifts.Review of the facility daily staffing sheets dated 01/22/2026- 02/11/2026 revealed the Director of Nursing was counted in the facility's numbers to meet their minimum staffing numbers for direct care to the residents.02/05/2026 2:00 PM- 10:00 PM shift:Wood Unit- Director of Nursing worked 6:00 PM- 10:00 PM, acting as the second nurse on the unit. 02/11/2026 2:00 PM- 10:00 PM shift:Wood Unit- Director of Nursing worked 6:00 PM- 10:00 PM, acting as the second nurse on the unit. From 9:21 PM until 10:00 PM the Director of Nursing was the only nurse on the unit. During an interview on 02/27/2026 at 9:10 AM, the Facility Scheduler stated they tried not to have the Director of Nursing act as a staff nurse for the facility very often. They only did it when they were instructed to do so by the Director of Nursing or the Administrator. The Facility Scheduler was not aware that the Director of Nursing was not supposed to act outside their role as the Director of Nursing. They stated there were days that there were not enough staff, they tried their best to find coverage, but occasionally the Director of Nursing would help out. The Facility Scheduler stated the minimum staffing numbers were not ideal numbers of staff. It was very difficult for the staff to get all their work done and provide good care to all the residents. During an interview on 02/27/2026 at 12:48 PM, the Director of Nursing stated they were not aware of the exact regulation regarding the Director of Nursing acting as a charge nurse, they just thought it was frowned upon. They knew that the staff needed help, and they felt obligated to help them. They stated they would act as a certified nurse aide, a housekeeper or a medication nurse, whatever they needed at the time. They stated they were always available as the Director of Nursing while they were acting in a different role. During an interview on 02/27/2026 at 2:24 PM, the Administrator stated the minimum staffing numbers were not what their goal was. They always tried to have adequate staff, but they were also willing to help if their staff and residents needed them. 10 New York Codes Rules Regulations 415.13(b)(1)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review conducted during the Standard survey completed on 02/27/2026, the facility did not ensure: they assessed all residents for risk of entrapment from bed rails prior to installation, or provide documentation that preventive maintenance was conducted for all bed rails for three (3) (Residents #5,14, and 118) of three (3) residents reviewed. Specifically, the quarter side rails were loose and not secure (Resident's #5 and #14); and there was no documented evidence of routine preventative maintenance (Resident #5, 14, & 118). In addition, the quarter side rails were installed in error and not reflected on the care plan (Resident #5 and #118). The findings are: The policy and procedure titled Side Rail Use revised 10/2021 documented the intent of this policy and procedure is to provide a safe bed environment through assessment and planning of each resident's needs. Side Rail Safety Assessments shall be completed upon admission. Residents who are care planned to use side rails shall be assessed quarterly and with each significant change as long as they use side rails. The Registered Nurse shall list options or alternative equipment interventions to be taken to the Interdisciplinary Team Care Plan meeting for discussion and implementation. A Registered Nurse shall complete a care plan for residents assessed and found to be safe for using side rails. In the event resident(s) opt to utilize bed rail (s), the bed rails will only be used if the bed & bed rail system passes an entrapment- assessment to be completed by the maintenance department. The Registered Nurse, in conjunction with the Interdisciplinary Care Plan Team, may discontinue side rail use when it is determined the risk outweighs the benefit. 1.Resident #5 had diagnoses including wedge fractures (a compression fracture of the spine, where the front part of the vertebra collapses, creating a wedge-shaped deformity), difficulty walking, and cognitive communication deficit (impairment involving underlying issues like memory, attention, organization, and executive function). The Minimum Data Set (a resident assessment tool), dated 01/14/2026, documented Resident #5 was cognitively intact, always understood & always understands others. Resident #5 required supervision by staff for bed mobility, and bed rails were not used. The comprehensive care plan dated 01/14/2025, documented Resident #5 had impaired functional status related to wedge compression fractures. They required partial/moderate assistance from staff for transfers; they were independent for bed mobility and had no bed rails. Review of the Use and Care Manual for the Encore series (Bed Manual), Resident Care Bed, revealed the bed required preventive maintenance every six (6) months. The facility should check the action of the side rails; the rails should move freely through their range, latch fully when raised, and not be excessively wobbly when raised.The Side rail assessment dated [DATE], documented Resident #5 was a high risk for injury. No side rails noted to bed. Risks reviewed with verbal understanding by the resident. The Side rail assessment, dated 05/02/2025, documented no side rails. The Side rail assessment, dated 01/26/2026, documented no side rails, risks of use and nonuse explained with understanding. During an observation and interview on 02/23/2026 at 1:41 PM, Resident #5 was in their recliner next to their bed. Their bed had gray plastic side rails on both sides of the upper portion of the bed (approximately 12 inches wide by 18 inches tall). Both rails were loose and wobbly. The bed also had a red foam padded area beneath the mattress covering the metal frame. During additional observations on 02/25/2026 at 10:11 AM, and 02/26/2026 at 9:59 AM, Resident #5's bed had the two gray upper side rails, and they were loose and wobbly. Resident #5 stated they used the bed rails to get into bed at night. They stated they never hurt themselves on the side rails.During an interview on 02/26/2026 at 11:02 AM, Registered Nurse #2, Unit Manager stated the side rail assessments were completed by a Registered Nurse, sometimes with the help of therapy. They stated that if the side rail assessment said no rails, it could be because the resident did not want them or because they were unsafe. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Occasionally the side rails are already on the bed and they have to do the assessment to make sure the resident is safe. Registered Nurse #2 stated they did not know what maintenance tested with the side rails, but they thought they measured for the risk of entrapment. They stated the side rail assessments should be completed quarterly. Registered Nurse #2 stated that Resident #5 did not have side rails, and if they did, they did not know who put them on. During an interview on 02/26/2026 at 4:35 PM, Resident #5's daughter stated that Resident #5's bed was the same one they had when they first came to the facility, and the side rails had been on the bed the whole time. During an interview on 02/26/2026 at 4:35 PM, Resident #5 stated they had not seen anyone check on the side rails. During an interview on 02/27/2026 at 12:33 PM, the Director of Nursing stated the side rail assessment was done to assess the risk of entrapment and to determine whether the resident was able to use them. They stated side rails were used to help residents with mobility, but with cognitively impaired residents they were risky because they had poor safety awareness. The Director of Nursing stated if the side rail assessment documented no side rails, the resident should not have side rails. They stated that Resident #5 should not have the side rails, and someone should have noticed they were there and not on their care plan. The Director of Nursing stated that Certified Nurse aides and Licensed Practical Nurses had to sign off on the care plan every day. They should have noticed the side rails were not supposed to be there. The Director of Nursing stated that unit managers were supposed to do quarterly side rail audits. 2.Resident #14 had diagnoses including Fournier Gangrene (flesh eating disease of the genital), diabetes mellitus and morbid obesity. The Minimum Data Set, dated [DATE], documented the resident was cognitively intact, understood and understands. Resident #14 was dependent on staff for rolling left to right for bed mobility and side rails were not used. Review of the Comfort Q Series Beds Parts and Maintenance Manual dated 09/00 documented that every facility should incorporate a good preventative maintenance program. Equipment should be checked periodically to catch problems. The comprehensive care plan dated 01/29/2026 documented Resident #14 was independent with bed mobility and had two upper side rails. The document titled Side rail assessment dated [DATE], Registered Nurse #1 Unit Manager documented at 2:01PM that Resident #14 utilized one (1) staff member for bed mobility and Resident #14 had two upper side rails. The risks of entrapment with use/non-use were discussed with resident/family with a verbal understanding expressed. During an observation and interview on 02/24/2026 at 9:43 AM and 02/25/2026 at 11:17 AM Resident #14 had two (2) gray quarter side rails up on both sides of their bed. Resident #14 stated they used the side rails for bed mobility. The side rails were loose and wobbly from them yanking them when turning over in bed. Resident #14 then stated they had been there for three (3) years, and no one had checked the side rails to ensure they were secured. Resident #14 never asked to have them tightened. During an observation and interview on 02/26/2026 at 11:33 AM Certified Nurse Aide #6 observed Resident $14's side rails, shook them, and stated they were loose. Certified Nurse Aide #6 stated Registered Nurse #1 Unit Manager checked the rails every three (3) months to make sure they were steady, and residents still required them. 3.Resident #118 had diagnoses including dementia, pneumonia, and anxiety. The Minimum Data Set, dated [DATE], documented Resident #118 had moderate cognitive impairment, sometimes understood and sometimes understands. Resident #118 was independent for rolling left to right for bed mobility and side rails were not used. The comprehensive care plan dated 03/12/2025 documented Resident #118 was independent with bed mobility with no side rails. Review of the Side rail assessment dated [DATE] at 2:33 PM, revealed Registered Nurse #1 Unit Manager documented that Resident #118 was independent for bed mobility and Resident #118 had no side rails. The risks of entrapment with use/non-use were discussed with resident/family with a verbal understanding expressed. During observations on 02/24/2026 at 9:17 AM, 9:45 AM and on 02/25/2026 at 11:30 AM Resident #118 was asleep in bed. There was one (1) quarter side rail up on the left side of the bed. The quarter rail on the right side of the bed was in the down position. The Maintenance Supervisor provided a binder and a folder that included what they identified as preventative maintenance logs and bed system (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	measurement device test results worksheets on 02/25/2026. The binder contained logs that were dated for the years 2024 and 2025. The logs included the unit where the bed was located, room number of the bed, model number of the bed and manufacturer and serial number of the bed. There was no documented routine preventative maintenance for the side rails and there were no logs for the year 2026. The folder contained the most current documentation of bed system measurement device test results worksheets that were dated 2023. There were no additional worksheets. During an interview on 02/26/2026 at 9:26 AM the Maintenance Supervisor stated there were three (3) styles of beds and that maintenance was responsible for checking the beds for entrapment. Entrapment was measured based on the style and specific type of bed, not resident specific and they had no current records of entrapment checks. The side rails were visually checked every six (6) months, and they had no documentation of routine inspections of the side rails. They were notified if a rail was loose or not secure by the nursing staff by E maintenance (a program used for communication) and they had no notifications for loose side rails. During observation and interview on 02/26/2026 at 11:57 AM, Facility Technician #1 measured the quarter side rails at twenty-one and 3/4 inches by 10inches by 1/4 inches. They stated they checked the beds monthly for broken parts, wires or defects and physically pulled up on the side rails to make sure they were secure. The Facility Technician #1 shook Resident #14 side rails and stated they were loose, but the side rails were not going anywhere as it would be impossible for the rails to snap or break off and cause injury. Preventative maintenance was done every six (6) months, but they did not document specifically on the side rails. During an interview on 02/27/2026at 8:15 AM, Registered Nurse #1 Unit Manager stated maintenance was responsible to install or take side rails off and measure for entrapment. They expected the staff to notify them of Resident #14's loose side rails. They would have contacted maintenance to tighten them. When the side rails were loose and wobbly they could snap during bed mobility, fall off and cause a fall out of bed. Resident #118's care plan said no devices for bed mobility, and they discovered on 02/26/2026 the side rail should not have been up. They would have expected the aides to let them know that Resident #118's rail was up by checking the care plan. Resident #118 could have sustained a skin tear or had a fall related to the side rail being up. During an interview on 02/27/2026 at 9:20 AM, Physical Therapist #1 stated Registered Nurse #1 Unit Manager was responsible for completing side rail assessments and updating care plans. Loose side rails put Resident #14 at risk of getting caught or having a fall. Routine inspections would ensure the side rails were secure on a routine basis and could prevent injury. During an interview on 02/27/2026 at 1:55 PM, the Director of Nursing stated Registered Nurse #1 Unit Manager did the side rail assessments. Physical therapy determined if side rails were safe for Resident #14 and maintenance determined that the side rails were compliant and did not pose an entrapment risk. The Director of Nursing expected maintenance to keep track of preventative maintenance of the side rails that should be done per the equipment manual and could not explain the lack of documentation. Someone should have noticed Resident #118's rail was up and reported it to the Unit Manager. Registered Nurse #1 Unit Manager should have caught that the side rail was up when doing Resident #118's quarterly assessment. Having the side rail posed an injury risk for Resident #118 as they could have bumped their arm, caused bruising or a skin tear. If Resident #118 was not as mobile as they are the side rail in the up position could have caused falls and there would be the risk for entrapment. During an interview on 02/27/2026 at 2:11 PM, the Administrator stated the Unit Managers were responsible for the side rail assessments. Maintenance installed the side rails after an entrapment risk was done. Maintenance should have been documenting preventative maintenance routinely with consistency and should have incorporated specifics of the beds in addition to the side rails to all be part of one routine preventative maintenance program. 10 NYCRR 415.12(h)(1)

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	335721	A. Building B. Wing	02/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Green Rehab & Skilled Nursing	3023 Route 430 Greenhurst, NY 14742

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, record review, and interviews during a survey, the facility did not ensure that services provided or arranged by the facility met the current professional standards of quality for one (Resident #82) of one resident reviewed. Specifically, Resident #82's medications were not administered as per the physician's order, medications were left on resident's overbed table, and nursing staff documented that the medications were administered in the Medication Administration Record. The findings are. Refer to F 761 scope and severity = D The policy and procedure titled Medication Administration dated 10/17/2019 documented only licensed nurses shall prepare and administer medications. The designated licensed nurse shall prepare medications immediately prior to administration; be certain that the resident takes the prescribed medication in their presence; and never leave any medication in the resident's possession or at the bedside unless the physician orders in writing, state to do so. Each medication given is to be recorded on the resident's medication record. The policy and procedure titled Self-Administration of Medications dated 11/03/2015 documented when a resident chooses to accept the responsibility for self-administration of drugs the interdisciplinary team will assess the resident's cognitive, physical, and visual ability to carry out this responsibility; determine whether or not this would be a danger to resident or others; and document date of re-evaluation and determination. Resident #82 had diagnoses that included congested heat failure (a condition where the heart is too weak to pump blood), hypertension (high blood pressure), and chronic obstructive pulmonary disease (chronic lung disease). The Minimum Data Set (a resident assessment) dated 02/06/2026 documented Resident #82 was cognitively intact. The comprehensive care plan dated 01/30/2026 documented Resident #82 was alert and oriented x3 (person, place, and time) and medications were to be administered as ordered.The Physician Orders dated 01/30/2026 - 02/27/2026 documented an order for Potassium Chloride (electrolyte supplement to prevent low blood potassium)10 milliequivalent extensive release tablet, give two (2) tablets to equal 20 milliequivalents once daily in the morning. The Medication Administration Record dated 02/2026 documented Resident #82's Potassium Chloride was signed out as administered on 02/24/2026 at 6:25 AM, 02/25/2026 at 7:06 AM, and 02/26/2026 at 6:35 AM.During an observation and interview on 02/24/2026 at 8:55 AM, Resident #82 was observed sitting in their room in a recliner chair with two (2) yellow pills observed on the bedside table in a small round clear plastic container with a lid. Resident #82 stated the two pills were potassium and they preferred to take it at night. They stated the nurses brought the medication into them in the morning and they would put it to the side to take later before bed. Intermittent observations made on 02/24/2026 at 4:22 PM, 02/25/2026 at 10:37 AM and 02/26/2026 at 9:00 AM, revealed Resident #82 continued to have two (2) yellow pills in a small clear plastic container on their bedside table. During an observation and interview on 02/26/2026 at 9:23 AM, Licensed Practical Nurse #2 stated they had administered medications to Resident #82 this morning (02/26/2026) and on 02/25/2026. They stated this morning Resident #82 had five (5) pills left to take when they had left their room and was unaware of what two (2) yellow pills were left on their bedside table. Licensed Practical Nurse #2 entered Resident #82's room and identified the pills on the bedside table as potassium chloride. They stated nurses were expected to stay in the room with residents until all medications were taken. Licensed Practical Nurse #2 stated they did not check back to see if Resident #82 took all their pills and should have. During an interview on 02/26/2026 at 9:41 AM, Licensed Practical Nurse #3 stated they administered Resident #82's morning medications on 02/24/2026. They stated Resident #82 preferred to take their potassium after breakfast and Resident #82 would place them in a container on their bedside table. Licensed Practical Nurse #3 stated they left the potassium pills in Resident #82's room and would follow up with them after breakfast to ensure the medication was taken. Licensed Practical Nurse #3 stated when they followed up with Resident #82 after breakfast, they had witnessed them taking their potassium. Licensed Practical Nurse #3 stated medications should not be left unattended, it was important to ensure all medications (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were taken because they were ordered for a reason. Licensed Practical Nurse #3 stated Resident #82 was alert and oriented x3, knew their medications well, and assumed they would take their pills. During an interview on 02/26/2026 at 9:52 AM, Registered Nurse Manager #1 stated nurses were expected to stay with the residents until all medications were taken. They stated pills were not to be left with the residents for any reason unless there was a physician order to do so, they stated Resident #82 does not have an order to self-administer potassium. Registered Nurse Manager #1 stated if Resident #82 wanted to take their medication at a different time the pills should have been removed from their room immediately and the medical provider should have been contacted. During an interview on 02/26/2026 at 1:42 PM, the Director of Nursing stated medication was never to be left unattended in the resident's possession. They stated nurses were expected to stay with the residents and assess that proper intake of medication administration was being completed. The Director of Nursing stated leaving medications at the bedside increased the risk of missed doses which could lead to medical complications. They stated if Resident #82 wanted their medication at a different time, they would have expected the nurses to contact the medical provider and have the medication time changed. The Director of Nursing stated leaving medications at the bedside was unacceptable and should never have happened. 10 New York Code Rules Regulations 415.11(c)(3)(i)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, interview, and record review conducted during a the facility did not ensure that drugs and biologicals were securely store in accordance with State and Federal laws for one (1) (Resident #82) of one (1) reviewed. Specifically, Resident #82 had medications stored and unsecured on an over the bed table in their room.The findings are:Refer to F 658 scope and severity= DThe policy and procedure titled Medication Administration dated 10/17/2019 documented the designated licensed nurse shall never leave any medication in the resident's possession or at the bedside unless the physician orders in writing, state to do so.Resident #82 had diagnoses that included congested heat failure (a condition where the heart is too weak to pump blood), hypertension (high blood pressure), and chronic obstructive pulmonary disease (chronic lung disease). The Minimum Data Set (a resident assessment) dated 02/06/2026 documented Resident #82 was cognitively intact, was understood and understands others.The comprehensive care plan dated 01/30/2026 documented Resident #82 was alert and oriented x3 (person, place, and time) and medications were to be administered as ordered. The comprehensive care plan lacked documented evidence that Resident #82 preferred or was able to self-administer medications.Review of Physician Orders from 01/30/2026 - 02/27/2026 including all discontinued and completed orders revealed there was no physician's order to self-administer oral medications or to leave medications at the bedside. In addition, an order Potassium Chloride (electrolyte supplement to prevent low blood potassium) 20 milliequivalent extensive release was to be administered once daily in the morning.During an observation and interview on 02/24/2026 at 8:55 AM, Resident #82 was observed sitting in their room in a recliner chair with two (2) yellow pills observed on the bedside table in a small round clear plastic container with a lid. Resident #82 stated the two pills were potassium and they preferred to take it at night. They stated the nurses brought the medication into them in the morning and they would put it to the side to take later before bed.Intermittent observations made on 02/24/2026 at 4:22 PM, 02/25/2026 at 10:37 AM and 02/26/2026 at 9:00 AM, revealed Resident #82 continued to have two (2) yellow pills in a small clear plastic container on their bedside table.During an observation and interview on 02/26/2026 at 9:23 AM, Licensed Practical Nurse #2 stated they had administered medications to Resident #82 this morning (02/26/2026) and on 02/25/2026. Licensed Practical Nurse #2 entered Resident #82's room and identified the pills on the bedside table as potassium chloride.During an interview on 02/26/2026 at 9:41 AM, Licensed Practical Nurse #3 stated they administered Resident #82's morning medications on 02/24/2026. They stated Resident #82 preferred to take their potassium after breakfast and Resident #82 would place them in a container on their bedside table.During an interview on 02/26/2026 at 9:52 AM, Registered Nurse Manager #1 stated pills were not to be left with the residents for any reason unless there was a physician order to do so, and further stated Resident #82 does not have an order to self-administer medications.During an interview on 02/26/2026 at 1:42 PM, the Director of Nursing stated medication was never to be left unattended in the resident's possession. The Director of Nursing stated leaving medications at the bedside was unacceptable and should never have happened.10 New York Code Rules and Regulations 415.18 (e) (1)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review conducted during the survey, the facility did not provide food and drink that was palatable and served at a safe and appetizing temperature for two (2) (Park Unit and Lake Unit) of three (3) unit test trays. Specifically, food and beverages during meals were served at suboptimal temperatures and were not palatable. Residents #8, 11, 32, 37, 41, and 71 were involved. The findings are:The policy titled Food Safety Requirements dated 06/13/2018, documented it is important to focus attention on the risks that are associated with foodborne illness by identifying critical control points in the food preparation processes that, if not controlled, might result in food safety hazards including, thawing, cooking, cooling, holding, reheating of foods, and employee hygienic practices.The policy titled Mealtime Procedure revised on 06/23/2015, documented to serve the tray so that trays may be served promptly - all nursing personnel are expected to assist.The policy titled Food Preparation dated 09/20/2002, documented foods will be heated to a minimum of 165 degrees Fahrenheit and foods will be held at 140 degrees Fahrenheit or higher until service. Refrigerators must be in good repair and hold cold foods at 41 degrees Fahrenheit or less.During an interview on 02/23/2026 at 11:14 AM with Resident #71 they stated the food was awful, it was good when they first came to the facility, but it had gone downhill. They stated it was always cold, and the coffee was always cold.During an interview on 02/23/2026 at 11:38 AM, Resident #11 stated the food used to be better, frequently have tuna and chicken casserole and only receive one (1) scoop. They stated when they asked for salad, they received only lettuce and tomato, and the food lacked seasoning and taste.During an interview on 02/23/2026 at 3:18 PM, Resident #41 stated the food was terrible, had no taste, sometimes was cold and did not get enough on their plate. They stated the food was just not decent.During an interview on 02/24/2026 at 9:14 AM with Resident #37 they stated the coffee was lukewarm and that there was not sufficient staff to pass trays.During an interview on 02/24/2026 at 11:38 AM with Resident #8 they stated that the food was always cold, especially breakfast.A continuous observation of the kitchen lunch tray line on 02/25/2026 from 11:37 AM to 1:21 PM revealed multiple delays that included food items that needed to be reheated (gravy), running out of food items (squash) and the need to substitute and heat up a new vegetable, and running out of clean plates mid-service resulting in carts that left the kitchen late.1.During a lunch meal test tray observation on 02/25/2026 tray cart that contained the test tray arrived on the Park Unit at 12:52 PM. All trays were passed by 12:54 PM. At 12:55 PM the following food temperatures were obtained by the Director of Food Service using the facility's thermometer:-Pork: 89.5 Fahrenheit tasted cold and dry.-Stuffing: 122.9 Fahrenheit, tasted lukewarm.During an interview on 02/25/2025 at 1:00 PM, the Director of Food Service stated the pork temperature was 172 degrees Fahrenheit on the steam table at the start of tray line. They stated the pork should have been at least 120 degrees Fahrenheit when the cart reached the unit. They stated they had different staff learning new positions and that didn't help with the delay. During an interview on 02/25/2026 at 1:05 PM with Resident #32 they stated that their pork chop was cold and dry and did not have any gravy on it.2. During a lunch meal test tray observation on 02/25/2026 the tray cart that contained the test tray arrived at 1:00 PM. All lunch trays from the Lake Unit were passed to the residents by 1:08 PM. The test tray temperatures were taken by the Director of Food Service at 1:09 PM using the facility's digital thermometer. The temperatures and taste were as follows:-Pork with gravy: 112.9 degrees Fahrenheit - tasted lukewarm was not hot, light flavor noted-Stuffing with gravy 110 degrees Fahrenheit - lukewarm to taste, lacked flavorDuring an interview on 02/25/26 at the time of the Lakeside Unit test tray, Director of Food Service stated they would have liked the temperature of the pork and the bread stuffing to have been a little higher. They stated the temperature of both the pork and bread stuffing should have been served at 120 degrees Fahrenheit or higher. The Director of Food Service stated it was difficult to maintain the temperature of pureed food because once it was plated the food would spread causing the temperature to drop fast. During an interview on 02/26/2026 (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 11:00 AM with [NAME] #1 they stated during tray line, staff did not take mid trayˆline temperatures only before the food goes in the steam table and the steam table was set at 190 degrees Fahrenheit to hold the temp until served. They stated hot food needs to be at 165 degrees Fahrenheit to avoid foodborne illness and acknowledged that a temperature of 86 degrees Fahrenheit could cause a problem. They stated, when residents complained food was cold, staff replaced the meal. They stated it was important to maintain resident's food temperatures, so they won't get sick, and no one enjoyed cold food. They stated trays often sat for extended periods of time before trays were delivered to residents by the unit staff. Regarding tray line timing, lunch began at 11:15 AM and was usually completed by 12:35 PM.During an interview on 02/26/2026 at 01:08 PM with the Dietitian Assistant #1 they stated the temperature of hot foods should be heated to 165 degrees Fahrenheit and held at 135 degrees Fahrenheit, so no one gets ill. They stated the steps staff should complete to maintain the appropriate temperature of the food, would be to take the temperature of the food before tray line starts, and ensure the food was held at appropriate temperatures throughout tray line. They stated the food temperatures should be done when it came out of the oven but was not certain if food temperatures were checked throughout tray line. They stated the steams tables should maintain the temperature up until serving time, but after a certain amount of time they would expect staff to re-temp to ensure the food held its appropriate temperatures.During an interview on 02/26/2026 at 1:38 PM with the Director of Food Service they stated normally test trays were audited monthly but recently had been doing them weekly due to complaints of cold food. They stated the lunch carts were extremely late on 02/25/2026 and thought the biggest issue was staffing on the units. They stated the carts sat there and the staff did not start passing the trays right away because they were busy providing care. They stated they would expect food temperatures to be at least at 120 degrees Fahrenheit when served. They stated this was important because bacteria could be created if the temp was not maintained and also the residents want to eat hot food. They stated their process to ensure food temperatures were held at an acceptable range during tray line and up to service, was to take food temperatures before placing it in the steam tables, but they did not have a process in place to test the temperatures during tray line. They stated they should, especially when tray line took over an hour.During an interview on 02/27/2026 at 10:45 AM with the Administrator they stated meals should be delivered within one hour of leaving the kitchen to all residents. They confirmed receiving complaints about food temperatures and that temperature audits were conducted and discussed in morning meetings and at resident council. They stated their expectation was for food temperatures to be taken at the start of tray line, in between and when the last tray was put on the cart in the kitchen. They reported instances when staff did not pass food trays promptly; they observed delays of about 10 minutes and notified the nurse manager and assisted when needed. They expected trays to be passed immediately to avoid foodborne illness and to ensure residents receive hot meals. They expected the cook to take temperatures during tray line to ensure food is holding temperature and stated this issue had been brought to their attention previously.10 NYCRR 415.14(d)(2)

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation, interviews and record review during the survey, the facility did not ensure the results of the most recent health surveys were posted in a place readily accessible to residents, family members, and legal representatives of residents. Specifically, the facility's past survey results were located in a binder stored behind the reception desk with other binders and were not readily accessible. Additionally, the facility's past survey results binder did not contain all complaint investigation results with plan of corrections for the past three (3) years. Residents #1, 43, 60, 79, and 85 were involved. The finding is:The facility's policy titled Required Postings and Bulletin Board, dated 9/23/2009 documented the required postings on unit bulletin boards were to contain the results of the most recent New York State Health Department Survey of the facility.The State Operations Manual dated 07/23/2025 documented the definition for a Place readily accessible is a place (such as a lobby or other area frequented by most residents, visitors or other individuals) where individuals wishing to examine survey results do not have to ask to see them. The State Operations Manual dated 07/23/2025 documented the definition for Results of the most recent survey means the Statement of Deficiencies (Form CMS-2567) and the Statement of Isolated Deficiencies generated by the most recent standard survey and any subsequent extended surveys, and any deficiencies resulting from any subsequent complaint investigation(s). A resident council meeting as part of the survey facility task process was conducted on 02/24/2026 at 10:04 AM. Residents #1, #43, #60, #79 and #85 were present. Resident #1 stated they were unsure if the facility posted past survey results or knew where to locate those results. Resident #43, #60, #79 and #85 also agreed with Resident #1 that they were all unsure where the results were located and all were interested in where the results could be reviewed.During an interview and observation on 02/25/2026 at 9:08 AM, Social Worker #1 stated they oversee the resident council, plan the resident council meeting agendas and run the meetings. Social Worker #1 stated they believed past survey results were in a binder located at the reception desk. Observation of the reception desk revealed there was no binder visible around the area nor around the bulletin board across from the reception desk. Social Worker #1 went behind the reception desk and was unable to locate the binder with survey results. Social Worker #1 asked Unit Assistant #1, who was sitting behind the reception desk, if they knew where the past survey results were stored. Unit Assistant #1 stated the binder should be on the countertop stacked next to the other binders behind them. Unit Assistant #1 was able to locate the binder on top of a countertop behind the L shaped reception desk. The binder spine was not labeled, and it was stacked with other binders. Social Worker #1 stated the survey results book was not in a place that was readily accessible to residents and visitors without having to ask for them. They stated the residents could come behind the reception desk if they chose to, but the binder should be stored in an area where residents could see it. Observation and review of the binder revealed FORM CMS 2567 (an official document of Statement of Deficiencies and Plan of Correction) dated 02/01/2024 was in the binder but there was no evidence of any deficiencies resulting from any subsequent complaint investigations within the binder. After reviewing the contents of the binder, Social Worker #1 stated the binder only contained the survey results with the plan of correction dated 02/01/2024 and they were not sure of the regulations of posting past survey results. Social Worker #1 stated it was important for residents and visitors to be able to view past survey results so they knew what concerns the facility had and the corrective action of those concerns.During an interview on 02/25/202 at 9:22 AM, the Administrator reviewed the facility's binder of past survey results. They stated the only results of past survey results with the facilities plan of correction that was in the binder was from the 02/01/2024 recertification survey. The Administrator stated the binder did not contain any results of complaint surveys and the facility did have a complaint survey requiring a plan of correction after the last recertification survey. The Administrator stated that the binder was not in an easily accessible (continued on next page)

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	location for residents and visitors if it was stored behind the reception desk with other binders. They stated the spine of the binder should also be labeled. The Administrator stated it was important for residents and visitors to have access to past survey results because it was part of their resident rights. 10 NYCRR 415.3(d)(1)(v)