STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335735	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delmar Center for Rehabilitation and Nursing	125 Rockefeller Road Delmar, NY 12054

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview conducted during a survey, the facility did not ensure licensed nurses and Certified Nurse Aides had the specific competencies and skills necessary to care for resident's need. Specifically, (a.) Resident #63's herpes zoster eye disease (shingles of the eyelid) was resolved and their order for Enhanced Barrier Precautions was discontinued instead of contact precautions; (b.) Licensed Practical Nurse #2 was unaware of medication shortened expiration dates and was not able to demonstrate insulin Kwik pen administration; (c.) Licensed Practical Nurse #1 was unable to identify which resident in a shared room was on Enhanced Barrier Precautions and was unable to verbalize the difference in other types of infection control precautions; and (d.) Infection Control training was not routinely conducted. Licensed Practical Nurse #5 stated they did not have any rosters for staff who attended additional training, or audits. Additionally, there were multiple interviews conducted where staff did not know the difference between Contact and Enhanced Barrier Precautions. This is evidenced by:The Facility Assessment, documented Staff Training/Education and Competencies 3.4 based upon the resident review of the facility assessment it was determined the major diagnoses of the resident population included dementia, diabetes, chronic obstructive pulmonary disease (COPD), and congestive heart failure (CHF). In addition to the existing facilities, mandatory education of abuse prevention, resident rights, infection control to name a few identified educations have been implemented with competencies. Training topics and competencies may/will change as resident needs are identified. Facility's staff development nurse and directors completed competencies with their staff at least annually.Policies and Procedures3.5 Policies and procedures were reviewed on an ongoing basis by the Director of Nursing/Assistant Director of Nursing, Medical Director, staff development and corporate compliance officer. These policies were reviewed against evidenced based practice for the most current professional standards of practice. When revision and or change was needed the Director of Nursing along with all those involved with the policy need scribes the revision and then was approved through the Quality Assurance process. Policy changes were reviewed with appropriate staff to educate regarding changes and assure competency and professional practice standards.The undated facility policy titled Infection Control Guidelines for All Nursing Procedures, documented staff were required to receive in-service training on infection control, including protocols for standard and transmission-based precautions. It further documented: Standard Precautions were to be used for all residents. Transmission-Based Precautions were to be implemented when indicated. Staff were to perform hand hygiene, including washing hands with soap and water under specified conditions. staff were to wear appropriate personal protective equipment to prevent exposure to infectious materials. Resident #63 Resident #63 was admitted to the facility with diagnoses of rhabdomyolysis (a serious condition characterized by the breakdown of muscle fibers, leading to the release of harmful substances into the bloodstream, which can lead to kidney damage), herpes zoster eye disease (shingles of the eyelid), and chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe). The Minimum Data Set, dated [DATE], documented the resident had moderate cognitive impairment, could be understood and (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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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	could understand others.During an observation on [DATE] at 12:23 PM, a Contact Precaution sign was posted outside Resident #63's room. Certified Nurse Aide #4 entered the room, delivered a meal tray, and exited without performing hand hygiene. Certified Nurse Aide #4 then picked up another tray and proceeded into another resident's room.During an interview on [DATE] at 12:23 PM, Certified Nurse Aide #4 stated they had not known the difference between Contact Precautions and Enhanced Barrier Precautions and acknowledged they had not followed the required steps listed on the signage.During an observation on [DATE] at 12:20 PM, Certified Nurse Aide #4 entered and exited Resident #63 room labeled Contact Precautions without personal protective equipment. Certified Nurse Aide #4 used hand sanitizer for hand hygiene although the signage indicated the use of soap and water after contact with residents.During an interview on3.06.2026 at 12:20 PM, Certified Nurse Aide #4 stated they had used hand sanitizer and reported staff usually just used hand sanitizer.A nursing progress note dated [DATE] at 12:48 PM, written by Director of Nursing #1, documented Resident #63's shingles rash resolved, Enhanced Barrier Precautions discontinued, and care plan updated.An order for Enhanced Barrier Precautions (EBP) (wound) every shift for wound was created on [DATE] at 5:27 PM by Licensed Practical Nurse #5 and discontinued on [DATE] at 12:48 PM by Director of Nursing #1.An order for Contact Precautions, shingles, every shift for monitoring, was created on [DATE] at 4:33 PM by Registered Nurse #1 and discontinued on [DATE] at 12:52 PM by Licensed Practical Nurse #5.An order for Enhanced Barrier Precaution (EBP) (wound), every shift for wound dated [DATE] at 4:33 PM was created by Licensed Practical Nurse #5. During an observation on [DATE] at 11:45 AM, Licensed Practical Nurse #2 was unaware of medication shortened expiration dates and was not able to demonstrate insulin Kwik pen administration. After obtaining a blood glucose fingerstick on Resident #5, Licensed Practical Nurse #2 administered Novolog insulin 25 units via kwik pen. They did not perform a Safety Test (Priming) per manufacturer insert. Attach the needle, dial 2 units, and press the injection button. Ensure insulin comes out to remove air bubbles. During an interview on [DATE] at 11:50 AM, Licensed Practical Nurse #2 stated they had never primmed insulin kwik pens in the past. They stated they had been a nurse for about one year and were never told to prime insulin pens. Licensed Practical Nurse #2 also stated that insulin expired on the date printed on the bottle or pen. They stated they did not know that there was a list of medications that had shortened expiration dates.During an observation on [DATE] at 4:43 PM, Licensed Practical Nurse #1 and Certified Nurse Aide # 8 were observed providing colostomy care to Resident #10 in a room posted for Enhanced Barrier Precautions. Both staff exited the room wearing gloves and did not perform hand hygiene afterwards.During an interview on [DATE] at 4:43 PM, Licensed Practical Nurse #1 stated they did not know which resident in the room was on Enhanced Barrier Precautions. When asked what Enhanced Barrier Precautions meant, they stated they were not sure. Licensed Practical Nurse #1 stated they thought they received education on the different types of precautions when they were hired. When asked if they knew the difference between Contact Precautions and Enhanced Barrier Precautions, they were unable to describe the difference.During an interview on [DATE] at 12:33 PM, Certified Nurse Aide #1 stated they did not know the difference between Contact Precautions and Enhanced Barrier Precautions and believed all precaution signage required full personal protective equipment.During an interview on [DATE] at 12:38 PM, Certified Nurse Aide #8 stated they were unaware of the difference between Contact Precautions and Enhanced Barrier Precautions and treated both the same.During an interview on [DATE] at 5:50 PM, Certified Nurse Aide #10 stated they had been employed for approximately one month and were not certain of the difference between Contact Precautions and Enhanced Barrier Precautions and were unsure if infection control education was included in orientation.During an interview on [DATE] at 12:25 PM, Licensed Practical Nurse #5 stated they divided their responsibilities between infection control. wound care, and nurse educator and worked remotely for a portion of their schedule. They stated all new staff were trained upon hire and as needed, and the orientation packets were kept in their employee file. They stated nursing staff received instruction during orientation regarding the (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	difference between Contact Precautions and Enhanced Barrier Precautions, and that precaution signage posted outside resident rooms identified the required personal protective equipment. Licensed Practical Nurse #5 stated their tracking system was poor and did not capture who and when training took place. They stated the tracking system for as needed in services consisted of an employee roster with a check mark. They were unable to provide any of these rosters.During an interview on [DATE] at 6:05 PM, Director of Nursing #1stated staff entering rooms with Enhanced Barrier Precautions should wear gloves, and precautions for Contact Precautions depend on the infection. Director of Nursing #1 stated hand sanitizer was acceptable unless otherwise specified on the signage. They further stated the facility had been without a nurse educator.During an interview on [DATE] at 10:00 AM, Director of Nursing #1 stated insulin administration including insulin kwik pens were reviewed and demonstrated during nurse orientation. They stated shortened expiration dates were also covered during nurse orientation and the list of these medications should be posted in the medication room.During an interview on [DATE] at 9:30 AM, Administrator #1 stated all staff received infection control training upon hire and completed annual competency training. Administrator #1 stated initial training was conducted in person, with annual training provided through web-based education and additional training provided as needed by the Nurse Educator. They further stated they were uncertain if the web-based learning was available in other languages apart from English. Precaution signage with pictorial instructions for use of personal protective equipment was posted outside resident rooms and as of this survey was both in English and Spanish. 10 New York Codes, Rules, and Regulations 415.26(c)(2)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviewsˆconductedˆduring aˆsurvey, the facility did not ensure residents were treated with respect and dignity in a manner and in an environment that promoted maintenance or enhancement of quality of life for two (2) (Resident #'s 92 and 130) of three (3) residents reviewed.ˆSpecifically,ˆ(a.)ˆResident #92 wasˆobservedˆslumped over in their wheelchair inˆa common areaˆfor over 45 minutesˆwithout any staff interaction; and (b.)ˆˆResident #120 was told by staff to soil themselves. Additionally,ˆduring a lunch observationˆin the main dining room, staff wereˆobservedˆtalking amongst themselves and using their phonesˆoff to the side of the room, while residents were eating.ˆˆˆ This isˆevidencedˆby:ˆˆ Theˆundatedˆfacilityˆpolicyˆtitled Resident Dignity, documentedˆthe facility shall care for its residents in a manner and in an environment that promoted maintenance or enhancement of each resident's quality of life.ˆIt was documented thatˆeach staff member would treat each resident as individual human beings. The residents shall have the right to participate in care planning, each resident's care plan shall beˆindividualizedˆto meet the resident's needs and preferences. Treating residents as individual human beings leads to increased dignity and trust; and 5.)ˆall employees must remain aware that they have a responsibility to maintain each resident's dignity.ˆˆ Resident #92ˆˆ Resident #92 was admitted to the facility with a diagnoses of Cerebral Palsyˆ (a group of permanent, non-progressive neurological disorders that affect movement, muscle tone, and posture due to abnormal brain development or damage), Developmental Disorder of Scholastic Skills (refers to persistent, significant learning difficulties in reading, writing, or mathematics that are not caused by low intelligence, sensory impairment, or inadequate schooling);ˆand adultˆfailure toˆthrive (a rapid decline in physical, mental, and functionalˆhealth, often without a single, clear cause). The Minimum Data Set, dated [DATE], documented theˆresidentˆhad severe cognitive impairment.ˆ During an observation on 3/04/2026 at 8:30 AM, Resident #92 wasˆobservedˆinˆaˆcommon areaˆfor over 45 minutes dozing off, slumped over inˆtheirˆwheelchair. There were no staff interactions with theˆresident.ˆˆˆ During an observation on 3/11/2026 at 1:45 PM, Resident #92 wasˆobservedˆlying in their room, in bed, lights off, awake and chewing on a toy.ˆˆˆ Resident #130ˆˆ ˆ Resident #130 was admitted to the facility with diagnoses of fracture of right acetabulum (a break to the right-side socked portion of the pelvic bone that forms the hip joint), type 2 diabetes (an endocrine dysfunction causing unregulated blood glucose levels), and cerebral infarction (a medical condition where blood flow to the brain is interrupted, leading to brain tissue damage). The Minimum Data Set (an assessment tool) dated 3/03/2026, documented the resident was cognitively intact,ˆusuallyˆunderstood others, and was usually understood by others.ˆˆ Resident #130'sˆBaselineˆCareˆPlan, dated 2/25/2026,ˆdocumented the residentˆrequiredˆsubstantial/maximal assist forˆtoileting hygiene.ˆIt furtherˆdocumentedˆtoilet transfer was not attempted due to medical condition or safety concerns.ˆˆ Resident #130's Comprehensive Care Plan forˆ Activities of Daily Livingˆinitiatedˆ3/08/2026, documentedˆthe resident was dependentˆon staff daily in meeting activities of daily living needs related to weakness and debility.ˆˆInterventions includedˆtoileting hygiene: substantial/maximumˆassistanceˆof one (1)ˆand toilet transfer: supervision or touching assist of one (1).ˆˆ During an interview on 3/04/2026 at 8:22 AM, Resident #130ˆstatedˆyesterday a Certified Nurse Aide told them to urinate in their pants. Theyˆstatedˆthey were told the same thing over the weekend.ˆResident #130ˆstatedˆit made them feel like a little kid, because they knew when they neededˆto urinateˆand should not have to urinate in their pants.ˆˆ During an interview on 3/09/2026 at 12:06 PM,ˆFamily Member #1 statedˆResident #130 was told again over the weekend toˆsoil themselves by the same Certified Nurse Aide. Family Member #1ˆstatedˆtheyˆtalked with the Certified Nurse Aideˆ#10ˆdirectly and told them that it was inappropriateˆand not to do that. Theyˆstatedˆ Certified Nurse Aideˆ#10ˆhas been more (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	respectfulˆsince they spoke to them.ˆˆ During an interview on 3/12/2026 at 11:58 AM,ˆCertified Nurse Aide #10ˆstatedˆtheyˆhave not heard staff tell residents to soil themselvesˆand if theyˆdid,ˆthey wouldˆtell a nurse.ˆTheyˆstatedˆif a residentˆwasˆtold to soil themselves,ˆitˆwouldˆprobably makeˆtheˆresidentˆfeelˆpretty badˆand degraded.ˆWhen questionedˆabout such statements being made to Resident #130, theyˆstatedˆtheyˆtoldˆtheˆresidentˆthey would come back and change them once they were finished with what they were doing, rather thanˆassistingˆtheˆresident with care at that time.ˆ During an interview on 3/12/2026 at 12:14 PM, Licensed Practical Nurse #7ˆstatedˆthey have neverˆwitnessedˆa staff member tell a resident to soil themselves.ˆIf they didˆwitnessˆthat they would talk with the Certified Nurse Aide, check the resident'sˆcare card,ˆofferˆassistance, then report it to the Director of Nursing.ˆThey would consider this a dignity concern. When questioned about Certified Nurse Aide #10'sˆinteraction with Resident #130, theyˆstatedˆthey thoughtˆFamily Member #1 had called them to check on the resident because someone had told the resident to go in their pants.ˆTheyˆstatedˆthey told Certified Nurse Aide #10 that it was unacceptable to tell a resident this and made them apologize to theˆresident.ˆ During an interview on 3/13/2026 at 12:24 PM, Director of Nursing Nursing#1ˆstatedˆtheyˆhave notˆobservedˆor heard staff tell a resident to soil themselves, butˆtheyˆhave received complaints aboutˆitˆand have educated staff.ˆˆTheyˆstatedˆit madeˆtheˆresidentsˆfeel terrible and like theyˆwereˆnotˆimportantˆwhen told to soil themselves. Director of Nursing #1 stated Family Member #1 called themˆand told them what had happened, but they could notˆlocateˆtheˆparticular staffˆmember. Theyˆstatedˆthey were notˆaware that Certified Nurse Aide #10ˆwas involved.ˆˆ Facility:ˆˆ During a meal observation on 3/04/2026 at 12:29 PM, three (3) staff members wereˆobservedˆto the side of the main dining room away from the residents, talking amongst themselves while the residents were eating. One (1) staff member wasˆobservedˆsitting with the residents.ˆˆ During a meal observation on 3/05/2026 at 12:27 PM, three (3) staff members wereˆobservedˆsitting on the side of the main dining room talking with each other away from theˆresidentsˆand using their phones periodically. No staff wereˆobservedˆsitting with residents while they were eating.ˆˆ During a meal observation on 3/06/2026 at 12:21 PM, three (3) staff members wereˆobservedˆsitting away from the residents to the side of the main dining room, talking amongst themselves, and using their phones periodically.ˆˆ During an interview on 3/13/2026 at 8:55 AM, Activities Director #1ˆstatedˆthey thought the staff should be sitting and engaging with the residents during lunch. Theyˆstatedˆthey had spoken withˆtheirˆstaff about being on their phones. They furtherˆstatedˆthey would consider it a dignity issue if the activity staff were sitting apart from the residents and engaging with themselves rather than with the residents duringˆmealtime.ˆˆ During an interview on 3/13/2026 at 12:24 PM, Director of Nursing #1ˆstatedˆit was notˆappropriate forˆstaff to sit off to the side of the main dining room while the residents ate. They could notˆobserveˆresident needs if they were sitting off to the side and using their phones. They furtherˆstatedˆit was not respectful.ˆˆ 10 New York Codes, Rules, and Regulations 415.5(d)(1)(i)ˆ

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record review and interviews during a survey, the facility did not ensure that as needed psychoactive medications had an end date for one (1) (Resident #10) of five (5) residents reviewed for unnecessary medications.ˆ Specifically, for Resident #10, there was no end date to an order for lorazepam (a psychoactive medication). This is evidenced by:ˆ ˆThe policy and procedure titled Psychotropic Medications, reviewed 12/2025, stated as needed orders for psychotropic medications including anti-psychotic, anti-anxiety, anti-depressant, and hypnotic medications, are limited to 14 days. Resident #10 was admitted with the diagnoses of schizophrenia (serious mental illness that affects how a person thinks, feels, and behaves), chronic kidney disease (when the kidneys stop filtering waste from the blood), and iron deficiency anemia (when there is not enough iron in the body).ˆ The Minimum Data Set (an assessment tool) dated 2/9/2026, documented the resident was understood, could understand others, and was cognitively intact.ˆ ˆThe physician's order dated 02/20/2026, documented lorazepam (an anti-anxiety medication) 2 milligrams per milliliter give 0.5 milliliters by mouth every six hours as needed for anxiety with no end date ordered. During an interview on 03/06/2026 at 11:09 AM, Director of Nursing #1 stated the nurses should be aware that as needed psychotropic and narcotic medications required a 14-day end date.ˆ They stated that when a provider entered an order it went into pending order status that the nurses should check and correct with the provider if necessary. During an interview on 03/06/2026 at 12:53 PM, Medical Doctor #1 stated they depended on the nurses to cue them for any order changes that should be made.ˆ They stated they trusted their nurses to know about any required end dates for medications.ˆ They did not state they did not know about the regulation but that they had received so much education on regulations over the year.ˆ 10 New York Codes, Rules, and Regulations 415.4(a)(1)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews conducted duringˆa survey,ˆtheˆfacilityˆdid not ensure that comprehensive care plans were developed and implemented for residents according to professional standards forˆthree (3) residents (Resident #'s 2, 6, and 111)ˆofˆ23ˆresidents reviewed. Specifically,ˆ(a.)ˆResident #2'sˆcare plan for impaired cognition did not have person-centered interventionsˆand the interventions listedˆwere not included on the resident's Kardex;ˆ(b.) Resident #6 didˆnot include person-centered approaches/interventionsˆto managing the resident's disruptive behavior;ˆandˆ(c.) Resident #111ˆdid not have a care plan that indicated the resident was at risk for aspiration, although the resident had a history of aspiration pneumonia.ˆˆˆ ˆ This is evidenced by:ˆˆ The facility policy titled Care Planning reviewed 9/2023, documentedˆan individualized comprehensive care plan that included measurableˆobjectivesˆand timetables to meet the resident's medical, nursing, mental and psychological needs was developed for each resident.ˆEach resident's comprehensive care plan was designed to:ˆ(a.) incorporate identified problem areas; (b.)ˆincorporate risk factors associated with identified problems; (c.) build on resident's strengths; (d.)ˆreflect resident's wishes regarding care and treatment goals; (e.)ˆreflect treatment goals, timetables and objectives in measurable outcomes;ˆ(f.) identify professional services; (g.)ˆaid in reducing declines in resident's functional status/levels;ˆ(h.) enhance the optimal functioning of the resident by focusing on a rehabilitative program; and (i.)ˆreflect currently recognized standards of practice for problem areas and conditions.ˆIt further documentedˆidentifying problem areas and theirˆcauses andˆdeveloping interventions that areˆtargeted and meaningful to the residentˆrequiredˆan interdisciplinary approach.ˆˆ Resident #2ˆ Resident #2 was admitted to the facility with diagnoses ofˆdementia (a group of conditions that cause a progressive decline in cognitive abilities), depression (a mental health condition characterized by persistent sadness, loss of interest, and other symptoms thatˆsignificantly impair daily life), andˆhip fracture (a serious, often life threatening break in the upper femur). The Minimum Data Set (an assessment tool) dated 1/12/2026, documented the residentˆhad severe cognitive impairment, could be understood, and could understand others.ˆˆ Resident #2'sˆcomprehensive care plan for Impaired Cognition, initiated 9/11/2025, documentedˆthe resident had impaired cognition related to dementia in other disease classified elsewhere mild with other behavioral disturbance.ˆThe goal documentedˆthatˆthe resident wouldˆmaintainˆcurrent level of functioning through next review date.ˆˆThe interventions included: communicate with the resident and/or resident representativeˆregardingˆresident's capabilities, engage the resident toˆparticipateˆin simple, structured activities, present just one thought, idea, question, or direction at a time, and provide a safe, clutter-free environment.ˆˆThe interventionsˆincluded in the care plan were not-person centered as the care planˆdidˆnotˆindicateˆwhat theˆstructuredˆactivitiesˆconsisted of.ˆˆˆ The Kardex (toolˆused by staff that lists resident care needs/interventions from the care plan)ˆˆdocumented: provide a safe,ˆclutter-freeˆenvironment. The other interventionsˆlisted in the care plan were not includedˆonˆthe Kardex.ˆˆ Resident #6ˆˆ Resident #6 was admitted to the facility with diagnoses ofˆSchizophrenia (a chronic, severe brain disorder, characterized by distortions in thinking, perception, emotions, and behavior),ˆdepression,ˆand anxiety (mental health condition characterized by excessive fear or anxiety that interferes with daily activities). The Minimum Data Set, dated [DATE],ˆdocumentedˆthe resident could be understood, sometimes understand others, andˆhad moderate cognitive impairment.ˆˆ Resident #6's comprehensive care plan for Behavior symptoms initiated 10/21/2025 documented the resident exhibited behavior symptoms such as hallucinations, delusions, paranoia, anxiety, depressed mood, difficulty sleeping, agitations, displacement of anger, accusatorial comments, homicidal ideations, homicidal threats, and using racial slurs. The goal indicated that the (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident would not harm self or others through the review day. Interventions included: administer psychoactive medications as ordered, check for thirst/hunger and provide snack/food/drink as indicated per diet orders, distract resident with preferred activities, initiate psychiatric evaluation as needed, initiate psychology evaluation as needed, redirect behaviors as needed, redirect resident with preferable television shows, reorient to surroundings as needed, staff to approach the resident in a slow and calm manner, staff to offer emotional support. During an observation on 3/04/2026 at 7:52 AM, Resident #6 was overheard yelling and screaming. It was unclear what they were saying.^^ During an observation on 3/04/2026 at 8:29 AM, Resident #6 was still yelling and screaming.^^ During an observation on 3/04/2026 at 10:34 AM, Resident #6 was heard yelling out and using derogatory language. Staff entered the room and the resident calmed down for a few minutes.^Resident^began yelling a few minutes after staff exited the room.^^ Resident #6's comprehensive care plan did not include^the resident's behavior of yelling/screaming^and^its disruption to the environment.^The interventions did not include Resident #6's preference^for male caregivers^or use of^[lip balm]^as a tool to redirect the resident's behavior.^The interventions^did not include what the resident's preferred activities or^televisions shows were.^^^ During an interview^on^3/11/2025^at 11:14^PM, Registered Nurse #3 stated Resident #6 was followed by both psychiatry and psychology. They^stated^when Resident #6 had episodes of yelling, screaming, or cursing they tried to reorient the resident. They^stated^sometimes Resident #6 could be^swayed with coffee or snacks. They also^stated^the resident responded better to men than women, so if they had a male^staff member^working,^they would have them approach Resident #6 and^attempt^to redirect.^^ During an interview on 03/13/2026 9:34 AM, Licensed Practical Nurse #8^stated^sometimes they could redirect Resident #6 with^a beverage if they were having behaviors of yelling/screaming.^They^also^stated^Resident #6^could sometimes be redirected^with [lip balm} for their dry lips.^^ During an interview on 3/13/2026 at 12:24 PM, Director of Nursing #1 stated^care plans^were a work in progress^and that they were lacking within the facility.^They^stated^the purpose of^the care plan was^to^guide staff members on how care should be provided for the resident. They further^stated^resident care plans should be individualized.^^ Resident #111^ Resident #111 was admitted to the facility with diagnoses of^pneumonitis^due to inhalation of food and vomit (also known as aspiration pneumonia, an acute lung inflammation caused by inhaling foreign material, typically food, vomit, or saliva into the airway),^^dysphagia^(difficult swallowing), and^encephalopathy (a broad term for brain dysfunction, damage, or disease, characterized by an altered mental state. The Minimum Data Set, dated [DATE], documented^the resident^was cognitively intact,^understood others,^and^was usually understood by others.^^ ^ Resident #111's Comprehensive Care Plan for Self-Care and Mobility dated 8/30/2024 documented the resident^required^assistance^with self-care and mobility related to^stroke with^weakness to (1) side, traumatic brain injury,^ventriculoperitoneal^shunt placed. The goal was:^resident's^self-care and mobility status would improve through the review date. Interventions included: alternate solids and liquids with by mouth intake; encourage^resident^to get out of bed for all meals; resident to remain upright for 30 minutes after meals;^ensure^oxygen^was greater than 92% during^by^mouth intake; monitor for changes in status, notify interdisciplinary team as needed^^ Resident #111's Comprehensive Care Plan for Activities of Daily Living^initiated^3/08/2026, documented the resident was dependent on staff daily in meeting activities of daily living.^Goal was resident would^maintain^current self-care and mobility status through the review date.^Some interventions included:^offer out of bed daily,^eating, dependent assist of one (1), encourage resident to get out bed for meals due to dysphagia,^monitor^turn^and reposition.^^ There was no documented evidence that Resident #111^had^an aspiration^related care plan although they had a history of^pneumonitis^due to inhalation of food and vomit^or aspiration pneumonia.^^ During an observation on^3/06/2026 at^12:08 PM, Certified Nurse Aide #13 was^observed^assisting^Resident #111 with their lunch meal.^The resident remained in bed for the duration of the meal.^^ During an interview on 3/06/2026 at 12:08 (continued on next page)

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	335735	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delmar Center for Rehabilitation and Nursing	125 Rockefeller Road Delmar, NY 12054

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PM, Certified Nurse Aide #13ˆstatedˆthey did not know if Resident #111 usually got out of bed for lunchˆandˆthey were told to go feed the resident. TheyˆstatedˆthŠy were not aware of any reason thatˆResident #111 needed to be up and out of bed.ˆCertified Nurse Aide #13ˆwas not aware of Resident #111's history of aspiration or of anyˆdirectives for feeding Resident #111 such as alternating liquids and solids.ˆ During an interview on 3/13/2026 at 9:20 AM,ˆOccupational Therapistˆ#1ˆstated Resident #111 was on aspiration precautions.ˆˆ During an interview on 3/11/2026 at 2:18 PM, Registered Nurse #4ˆstatedˆthat aspiration risk should be included inˆResident #111's care plan due theirˆhistory.ˆTheyˆstatedˆCertified Nurse Aides shouldˆknow a resident'sˆcondition/history, including aspiration risk prior toˆassistingˆwith feeding.ˆTheyˆstatedˆCertified Nurse Aide #13 should have beenˆinstructed on the Resident #111's care needs prior toˆassistingˆthem with feeding.ˆˆ During an interview on 3/13/2026 at 12:36 PM, Director of Nursing #1ˆstatedˆif a resident had a history ofˆpneumonitis related to inhaling food,ˆsuch as Resident #111,ˆan aspiration-related care plan should be in place.ˆThey furtherˆstatedˆthat residents with theˆcondition should beˆmonitoredˆduring meals to reduce the risk of aspiration,ˆoptimally out of bed.ˆˆ During an interview on 3/13/2026 at 11:52 AM,ˆRegional Clinical Coordinatorˆ#1ˆstatedˆResident #111 should have had an aspiration care plan due to their history of aspiration andˆsince they were on aspiration precautions since admission.ˆˆ 10 New York Code of Rules and Regulations 415.11(c)(1)ˆˆ ˆ ˆ

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews during a survey, the facility did not ensure that each resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for three (3) (Resident #'s 4, 111, and 130) of four (4) residents reviewed. Specifically, (a.) Resident #4 was not provided with feeding assistance as indicated per the resident's plan of care, (b.) Resident #111 was not assisted out of bed for meals and positioned upright for meals as indicated in their care plan and staff did not know interventions listed in the resident's care plan for feeding Resident #111 who had a history of aspiration (accidental breathing of food, liquid, or foreign material into the airway on lungs, rather than the stomach, often caused by swallowing difficulties); and (c.) Resident #130 was dependent on staff for care and was not provided with toileting assistance when requested. This is evidenced by: The undated facility policy titled Activities of Daily Living (ADL) Total Care Policy documented the facility aimed to ensure that each individual's basic needs were met while promoting dignity, independence, and comfort. The policy applied to all caregivers, nurses, and staff involved in the direct care of residents who required assistance with activities of daily living, which included but was not limited to: bathing, dressing, toileting, eating, mobility and transferring, and personal hygiene. Caregivers and nursing staff provided direct assistance with activities of daily living, monitoring resident needs, and documented care provided. Supervisors/manager oversaw implementation of care plans, ensured compliance with activities of daily living policy, and provided training to staff. Under activities of daily living procedures for eating it was documented to assist with feeding if a resident was unable to eat independently, ensure that residents are seating in a comfortable, safe position for eating. For mobility and transferring it was documented provide assistance with walking, using mobility aids, or transferring from bed to char or wheelchair and encourage residents to participate in mobility activities as much as possible to maintain their physical abilities. The undated facility policy titled Activities of Daily Living, documented it was the policy of the facility to provide activity of daily living care to all residents based on assessment of needs. Activity of daily living consisted of but was not limited to: bathing, dressing, eating, transfers, toileting, bed mobility, and ambulation on and off the unit. Resident #4 Resident #4 was admitted to the facility with diagnoses of cerebral infarction (a medical condition where blood flow to the brain is interrupted, leading to brain tissue damage), hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (a neurological condition causing paralysis or weakness on the left side of the body, stemming from right brain damage, and dysphagia (difficulty swallowing). The Minimum Data Set (an assessment tool) dated 1/07/2026, documented the resident was cognitively intact, sometimes understood others, and was sometimes understood by others. Resident #4's comprehensive care plan for Activities of Daily Living initiated 11/04/2025 documented the resident was dependent on staff daily in meeting activity of daily needs. The goal was: the residents' needs would be met by staff as evidenced by being well groomed, appropriately dressed daily. An intervention included: eating: substantial assistance initiated on 10/07/2025. On 3/11/2026, the intervention for eating was updated to supervision/touching assistance. During an observation on 3/05/2026 at 9:00 AM, Resident #4 was observed in bed attempting to feed himself. The tray table with breakfast tray was not directly in front of the resident. The resident attempted to use a fork to bring food to their mouth, but they were too shaky. A Rehabilitation Recommendation and Communication form dated 3/11/2026, completed for Resident #4, documented self-performance for eating was supervision or touching assist. During an observation on 3/13/2026 at 9:18 AM, Resident #4 was heard calling out for something to drink. Resident #4 was observed in bed sitting upright with tray table and breakfast tray placed in front of them. The resident had eaten the toast, but the eggs were untouched. There was a fork observed in the resident's cream of wheat. Resident #4 stated they had a hard time seeing. Certified Nurse Aide #10 brought the (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident a nectar thickened juice and placed it on their tray. The resident was unable to locate it. There were several observations of staff entering the resident's room to check if they were done with their meal. There were no observations made of staff providing cues or assistance to the resident with their meal during a 15- minute timeframe. During an interview on 3/11/2026 at 10:48 AM, Licensed Practical Nurse #9 stated someone had to feed Resident #4. During an interview on 3/11/2026 at 10:59 AM, Certified Nurse Aide #9 stated Resident #4 did not require assistance with meals. They needed cues to feed themselves and supervision. During an interview on 3/11/2026 at 11:40 AM, Certified Nurse Aide #1 stated they looked at the kiosk to find out if a resident required assist with feeding themselves. Substantial max assist meant they had to feed the resident/do everything for the resident. During an interview 3/11/2026 1:16 PM, Registered Nurse #3 stated Resident 4 did not require assistance with eating. After review of Resident #4's care plan, they stated the resident needed substantial assistance for feeding. They further stated Certified Nurse Aides reviewed the resident's Kardex at the kiosk or the laptop at the desk to find a resident's care needs. During an interview on 3/12/2026 at 12:28 PM, Dietitian #1 stated Resident #4 had significant weight loss. They stated Resident #4's feeding tube was recently stopped. They stated speech therapy which recommended Resident #4 be switched to consuming food by mouth rather than the feeding tube and it was a very slow and gradual process. They stated weight loss for Resident #4 was favorable and that their intake was adequate. During an interview on 3/13/2026 at 10:04 AM, Rehabilitation Director #1 stated Resident #4's feeding status was upgraded a few days prior. They stated Resident #4 had trouble with their vision. Rehabilitation Director #1 stated supervision meant the resident needed to be provided with cues during the meal. The staff should set up the tray so that everything was in the right area so the resident could see and reach everything. They stated they were not sure why they would need touching assistance for eating. They stated maybe the staff would provide hand over hand assistance or put the drink in the resident's hand. Rehabilitation Director #1 stated if Resident #4 was eating in their room, someone should be in the room to set up their tray and supervision could be offered intermittently. During an interview on 3/13/2026 at 12:24 PM, Director of Nursing #1 stated supervision/touching assist was the new equivalent to limited assist. They stated staff may need to guide the resident's hand to their mouth or guide their hand to an item on their tray. They stated staff were not actually picking up the fork and doing it for them. Director of Nursing #1 stated if a resident required supervision/touching assist with feeding and ate in their room, they expected staff to check on the resident intermittently and provide assist as needed. They stated they would encourage a resident to eat out of their room. They stated substantial assist meant staff would feed the resident most of their meal. Director of Nursing #1 stated they would be concerned if Resident #4 lost weight now that they were no longer using their feeding tube. Resident #111 Resident #111 was admitted to the facility with diagnoses of pneumonitis due to inhalation of food and vomit (also known as aspiration pneumonia, an acute lung inflammation caused by inhaling foreign material, typically food, vomit, or saliva into the airway), dysphagia (difficult swallowing), and encephalopathy (a broad term for brain dysfunction, damage, or disease, characterized by an altered mental state. The Minimum Data Set, dated [DATE], documented the resident was cognitively intact, understood others, and was usually understood by others, Resident #111's Comprehensive Care Plan for Self-Care and Mobility initiated 3/08/2026 documented the resident required assistance with self-care and mobility related to stroke with weakness to (1) side, traumatic brain injury, ventriculoperitoneal shunt placed. The goal was: resident's self-care and mobility status would improve through the review 06/05/2026 Interventions included: alternate solids and liquids with by mouth intake; encourage resident to get out of bed for all meals; resident to remain upright for 30 minutes after meals; ensure oxygen was greater than 92% during by mouth intake; monitor for changes in status, notify interdisciplinary team as needed. Resident #111's Comprehensive Care Plan for Activities of Daily Living initiated 3/08/2026, documented the resident was dependent on staff daily in meeting activities of daily living. Goal was resident would maintain (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	current self-care and mobility status through the review06/05/2026 dat. Some interventions included: offer out of bed daily, eating: dependent assist of one (1), encourage resident to get out bed for meals due to dysphagia, monitor turn and reposition. During an interview on 3/06/2026 at 10:16 AM, Resident #111 stated they wanted to get out of bed. They stated they did not get out of bed often but did at times. During an observation on 3/06/2026 at 12:08 PM, Certified Nurse Aide #13 was observed assisting Resident #111 with their lunch meal. The resident remained in bed for the duration of the meal, the position of their bed was approximately 80 degrees, and the resident was slightly slouched. During an observation on 3/07/2026 at 5:06 PM, Resident #111 was observed in bed during dinner. There was no assistance nearby. The head of the bed was not at 90 degrees. During an interview on 3/06/2026 at 12:08 PM, Certified Nurse Aide #13 stated they did not know if Resident #111 usually got out of bed for lunch and that they were told to go feed the resident. They stated they were not aware of any reason that Resident #111 needed to be up and out of bed. Certified Nurse Aide #13 was not aware of any directives for feeding Resident #111 such as alternating liquids and solids or of their history of aspiration. During an interview on 3/06/2026 at 12:12 PM, Licensed Practical Nurse #11 stated Resident #111 did not get out of bed for meals anymore. They stated it had been a while since Resident #111 had gotten out of bed to eat. During an observation on 3/12/2026 at 12:14 PM, Resident #111 was observed in bed during a lunch meal and Certified Nurse Aide #15 was assisting them with eating their meal. During an interview on 3/12/2026 at 12:14 PM, Certified Nurse Aide #15 stated they did not know Resident #111's care plan or what it said, but knew the resident needed to be up. They stated they did not know details of the resident's care plan, such as alternating liquids and solids. During an interview on 3/13/2026 at 9:20 AM, Occupational Therapist #1 stated Resident #111 was on aspiration precautions. During an interview on 3/11/2026 at 2:18 PM, Registered Nurse #4 stated Certified Nurse Aides should know a resident's condition/history, including aspiration risk prior to assisting with feeding. They stated Certified Nurse Aide #13 should have been instructed on the Resident #111's care needs prior to assisting them with feeding. During an interview on 3/13/2026 at 12:36 PM, Director of Nursing #1 stated that residents with a history of pneumonitis related to inhaling food, such as Resident #111, should be monitored during meals to reduce the risk of aspiration, optimally out of bed. Resident #130 Resident #130 was admitted to the facility with diagnoses of fracture of right acetabulum (a break to the right-side socked portion of the pelvic bone that forms the hip joint), type 2 diabetes (an endocrine dysfunction causing unregulated blood glucose levels), and cerebral infarction (a medical condition where blood flow to the brain is interrupted, leading to brain tissue damage). The Minimum Data Set (an assessment tool) dated 3/03/2026, documented the resident was cognitively intact, usually understood others, and was usually understood by others. A complaint filed with the New York State Department of Health on 3/02/2026 at 9:13 AM, documented Resident #130 requested to use the bed pan and a Certified Nurse Aide told Resident #130 that they could not put the resident on the bed pan because they did not have time and stated they should poop in their pants. Resident #130's Baseline Care Plan, dated 2/25/2026, documented the resident required substantial/maximal assist for toileting hygiene. It further documented toilet transfer was no attempted due to medical condition or safety concerns. Resident #130's Comprehensive Care Plan for Activities of Daily Living initiated 3/08/2026 documented the resident was dependent on staff daily in meeting activities of daily living needs related to weakness and debility. Interventions included toileting hygiene: substantial/maximum assist of one (1) and toilet transfer: activity does not occur or partial moderate assist of one (1). Toilet transfer was updated to supervision or touching assist of one (1) on 3/12/2026. During an interview on 3/04/2026 at 8:22 PM, Resident #130 stated yesterday a Certified Nurse Aide told them to urinate in their pants. They stated they were told the same thing over the weekend. Resident #130 stated it made them feel like a little kid, because they knew when they needed to urinate and should not have to urinate in their pants. During an interview on 3/09/2026 at 12:06 PM, Family Member #1 stated Resident #130 was told again over the weekend to soil themselves by the same Certified Nurse Aide. Family Member #1 stated they talked with the Certified (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delmar Center for Rehabilitation and Nursing	125 Rockefeller Road Delmar, NY 12054

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse Aide #10 directly and told them that it was inappropriate and not to do that. They stated Certified Nurse Aide #10 has been more respectful since they spoke to them. During an interview on 3/12/2026 at 11:58 AM, Certified Nurse Aide #10 stated they have not heard staff tell residents to soil themselves and if they did, they would tell a nurse. They stated if a resident was told to soil themselves, it would probably make the resident feel pretty bad and degraded. When questioned about such statements being made to Resident #130, they stated they told the resident they would come back and change them once they were finished with what they were doing, rather than assisting the resident with care at that time. Certified Nurse Aide #10 stated they thought Resident #130 was a check and change, but they should have used a bed pan. When asked how they knew what a resident's care needs were, they stated they looked at the kiosk. They stated for Resident #130, for toileting it just said substantial assist. Certified Nurse Aide #10 stated they talked with Licensed Practical Nurse #7 after it happened. During an interview on 3/12/2026 at 12:14 PM, Licensed Practical Nurse #7 stated they had never witnessed a staff member tell a resident to soil themselves. If they witnessed that they would talk with the Certified Nurse Aide, check the resident's care card, offer assistance, then report it to the Director of Nursing When questioned about Certified Nurse Aide #10's interaction with Resident #130, they stated they thought Family Member #1 had called them to check on the resident because someone had told the resident to go in their pants. They stated they told Certified Nurse Aide #10 that that was unacceptable and made them apologize to the resident. Licensed Practical Nurse #7 stated Certified Nurse Aide #1 stated they had just helped Resident #130 use the urinal and lunch trays were out and that they would be right back, so if the resident went in their pants, they did not mind changing them when they returned. During an interview on 3/13/2026 at 12:24 PM, Director of Nursing #1 stated they had not observed or heard staff tell a resident to soil themselves, but they have received complaints about it and have educated staff. They stated it made the residents feel terrible and like they were not important when told to soil themselves. Director of Nursing #1 stated Family Member #1 called them and told them what had happened, but they could not locate the particular staff member. They stated as they were interviewing, they were educating. They stated they were not aware that Certified Nurse Aide #10 was involved. 10 New York Codes, Rules, and Regulations 415.12(a)(3)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews conducted during a survey, the facility did not ensure 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 for two (2) (Resident #'s 68 and 92) of two (2) residents reviewed. Specifically, Resident #68 was not consistently offered or provided with activities that were meaningful to them and met their interests and preferences; and Resident #92 did not attend any activities, nor were one-to-one activities documented as provided. This is evidenced by: The policy titled Activities revised 1/2026, documented it was the policy of the facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences. Facility sponsored group, individual, and independent activities would be designed to meet the interests of each resident, as well as support their physical, mental, and psychosocial well-being. Activities would encourage both independence and interaction within the community. It further documented that activities would be designed with the intent to: (a.) enhance the resident's sense of well-being, belonging, and usefulness; (b.) create opportunities for each resident to have a meaningful life; (c.) promote or enhance physical activity; (d.) promote or enhance cognition; (e.) promote or enhance emotional health, (f.) promote self-esteem, dignity, pleasure, comfort, education, creativity, success, and independence; (g.) reflect resident's interest and age; (h.) reflect cultural and religious interests of the residents; and (i.) reflect choices of the residents. Resident #68 Resident #68 was admitted to the facility with diagnoses of major depressive disorder (a mental health condition characterized by persistent sadness, loss of interest, and other symptoms that significantly impair daily life), type 2 diabetes (an endocrine dysfunction causing unregulated blood glucose levels), and mild cognitive impairment (a condition marked by memory or thinking problems that are more severe than normal aging but do not significantly disrupt daily life). The Minimum Data Set (an assessment tool) dated 12/05/2026, documented the resident was sometimes understood by others, sometimes understand others, and was severely cognitively impaired. Resident #68's Comprehensive Care Plan for Activities initiated 9/15/2025, documented the resident was able to make recreation and leisure preferences known. They enjoyed being around other people but stated they were shy and would not initiate conversations. The goal documented Resident #68 would attend programs of known interest such as bingo, coloring, arts and crafts, discussions during this review. Interventions included: assist resident in finding programs of interest, introduce resident to peers with similar interests, invite/escort/provide resident transportation to activities of choice/interest, and provide monthly calendar/daily schedule of events. A progress note dated 1/15/2026 at 9:30 AM, documented a one-to-one visit was provided to Resident #68. It further documented they shared some laughs and Resident #68 shared some of their past memories. There was no documented evidence that Resident #68 was provided with activities or attended activities after the progress note dated 1/15/2026 was written. During an observation on 3/04/20206 at 10:22 AM, Resident #68 was observed sitting with other residents at a table in the common area in between the [NAME] and Daffodil units. No activities were present. The television was on. ˆ During an observation on 3/12/2026 at 10:28 AM, five (5) residents were observed in the common area in between the [NAME] and Daffodil units. There were no activities present. There was music playing on the television. Resident #68 declined going to the activity offered in the main dining room and remained in the common area. During an observation on 3/13/2026 at 10:00 AM, Resident #68 was sitting at the table in the common area with other residents. There were no activities present. During an Interview on 03/11/2026 at 10:48 AM, Licensed Practical Nurse #9 stated activities were done in the main dining room, like coloring. They stated the residents would sometimes watch movies on the unit. During an interview on 3/11/2026 at 10:59 AM, Certified Nurse Aide #9 stated there were no activities offered on the unit, only in the main dining (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room. During an interview on 3/11/2026 at 11:14 AM, Registered Nurse #3 stated activities wereusually held in theˆmain dining room. They stated that was where they had the fun activities. On the unit they had dolls, put on calming music, and some residents would look at magazines. Registered Nurse #3 stated activities were also provided in the resident rooms and the activity aides would go from room to room and try to engage with the residents. During an interview on 3/13/2026 at 8:55 AM, Activities Director #1 stated Resident #68 had minimal participation in activities. They stated Resident #68 did attend coffee hour, music, and their family would visit and take them outside when the weather was nice. Activities Director #1 stated they had 2 full-time activity aides and a per-diem aide. They did not have any volunteers. Activities Director #1 stated they would love to have one (1) activity aide per unit. Then they could have one (1) aide in the main dining room and the others on the units doing one-to-one visits. Activities Director #1 stated all residents were offered to attend activities in the main dining room, if appropriate. They offered some smaller group activities on the unit, such as reminiscing group for those that did not go to the main dining room. When asked to see Resident #68's activity record, they stated they were not sure what was going on with their documentation in the electronic medical record. When they tried to pull up Resident #68's documentation of activities attended/offered it documented no documentation selected for this criteria could be found. Resident #92 Resident #92 was admitted to the facility with a diagnoses of Cerebral Palsy (a group of permanent, non-progressive neurological disorders that affect movement, muscle tone, and posture due to abnormal brain development or damage); Developmental Disorder of Scholastic Skills (refers to persistent, significant learning difficulties in reading, writing, or mathematics that are not caused by low intelligence, sensory impairment, or inadequate schooling); and adult failure to thrive (a rapid decline in physical, mental, and functional health, often without a single, clear cause). The Minimum Data Set, dated [DATE], documented the resident had severe cognitive impairment. Resident #92 had no documented evidence of comprehensive care plan for Activities. During an observation on 3/04/2026 at 8:30 AM, Resident #92 was observed in a common area for over 45 minutes dozing off, slumped over in their wheelchair. There were no staff interactions with the resident. Resident #92 did not attend the activity that took place in the dining room. During an observation on 3/11/2026 at 1:45 PM, Resident #92 was observed lying in their room, in bed, lights off, awake and chewing on a toy. Staff were preparing for a group activity in the dining room. During an interview on 3/11/2026 at 1:45 PM, Certified Nurse Aide #12 stated Resident #92 did not go to group activities. There was no documented evidence that Resident #92 was offered or provided with activities. During an interview on 3/11/2026 at 1:55 PM, Activities Director #1 stated on Tuesdays, Wednesdays and Thursdays there were two activity aides plus the director. On Fridays and Mondays there was one (1) activity aide and the director. On Saturday and Sunday, there was only one (1) activity aide. They stated they would like to have an additional activity aide hired so that there was an activity aide assigned to each unit. There were no activities scheduled on weekends after 4:00PM. Activities Director #1 stated for those residents who were unable to attend group activities, they had one-to-one sensory programs. They stated there were two (2) Residents (#37 and #74) that did not attend group activity but made use of personal iPad. They stated Resident #92 had sensory visits two to three times a week. Activities Director #1 was asked to show documentation of Resident #92's log of sensory visits. They accessed Point Click Care (charting system for the facility) and the tracking activities for Resident #92 dated 2/24/26 - 3/11/26 were blank. Activities Director #1 stated there was no routine of sensory visits for Resident #92, they provided visits ad-lib. Resident #92 did not attend the group music activity the previous day and Activities Director #1 had no explanation as to why they did not. During an interview on 3/11/2026 at 2:15 PM, Activity Aide #1 and #2 stated they had not done any one-to-one sensory with Resident #92 and were not aware of who does. During an interview on 3/13/2026 at 12:24 PM, Director of Nursing #1 stated they thought the activities program faced some challenges. They stated they would like to see more activities on the unit for those that could not or did not go to the main dining room. They further stated they would like (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delmar Center for Rehabilitation and Nursing	125 Rockefeller Road Delmar, NY 12054

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to have one (1) more activity aide, that way they would have one (1) activity aide for each unit. 10 New York Codes, Rules, and Regulations 415.5(f)(1)h

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observations, record review, and interviews conducted during a survey, the facility did not ensure that each resident received the necessary respiratory care and services that followed professional standards of practice, for one (1) (Resident #43) of one (1) resident reviewed for oxygen administration. Specifically, Resident #43 supplemental portable oxygen tank was noted to be in the red empty zone on 3/4/2026, 3/7/2026 and 3/8/2026.This is evidenced by:Resident #43 was admitted with a diagnoses of unspecified diastolic congestive heart failure (occurs when the heart's left ventricle (heart chamber) becomes stiff and fails to relax properly between beats, preventing it from filling fully with blood), chronic respiratory failure with hypoxia (a long-term condition where the lungs cannot adequately transfer oxygen into the blood), pleural effusion elsewhere classified (abnormal accumulation of fluid within the pleural space, the thin cavity between the layers surrounding the lungs). The Minimum Data Set (an assessment tool) dated 1/26/2026, documented the resident usually could be understood and was understand by others with intact cognition.The facility's Policy and Procedure titled Oxygen Administration revised 5/2025, documented check the mask, tank, humidifying jar, etc., to be sure they are in good working order and are securely fastened. Be sure there is water in the humidifying jar and that the water level is high enough that the water bubbles as oxygen flows through. Observe the resident upon setup and periodically thereafter to be sure oxygen is being tolerated.During an observation on 03/04/2026 at 08:30 AM, Resident #43's portable oxygen tank was empty, and resident noted to have a non-productive cough.During an observation on 03/04/2026 at 12:37 PM, Resident #43 was in dining room, and their oxygen tank was in the red zone for empty.During an observation on 03/08/2026 at 1:15 PM, Resident #43's tank was empty. Resident was in common area sitting in their wheelchair. Surveyor asked Licensed Practical Nurse #10 to check the oxygen and oxygen tank was replaced.Resident #43 Medication Administration Record documented Supplemental oxygen at 4 liters per minute via nasal cannula continuously every shift -Start Date 01/26/2026. On 3/8/2026 a new order was entered onto the Medication Administration Record, documented Check oxygen tank level and replace tank if less than 25% full every 2 hours for oxygen dependence -Start Date 03/08/2026 1600. The Comprehensive Care Plan for Oxygen dated 1/26/2026 documented Resident #43 receives supplemental oxygen therapy related to chronic respiratory failure. Monitor for signs and symptoms of respiratory distress and report to Medical Doctor as needed: Respirations, Pulse oximetry, Increased heart rate, Restlessness, Diaphoresis (sweating), Headaches, Lethargy (weakness), Confusion, Hemoptysis (coughing up blood), Cough, Pleuritic (lung) pain, Accessory muscle usage, Skin color.During an interview on 03/04/2026 at 12:37 PM, Licensed Practical Nurse #1 stated they recently checked Resident #43's oxygen tank and they were about to replace it.During an interview on 3/12/2026 at 10:30 AM, Director of Nursing #1 stated nursing staff were responsible for checking oxygen tanks per order and replacing oxygen tanks as needed.During an interview on 3/8/2026 at 1:44 PM, Director of Nursing #1 stated the oxygen tanks should be checked every 4 hours. They stated that this was an ongoing issue and would add an order to every resident on oxygen to check the tanks.10 New York Code of Rules and Regulations 415.12(k)(6)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on record review and interviews, the facility did not ensure that as needed psychoactive medications had an end date for one (1) (Resident #10) of five (5) residents reviewed for unnecessary medications. Specifically, for Resident #10, there was no end date to an order for an as needed narcotic medications. This is evidenced by:ˆ ˆThe policy and procedure titled Psychotropic Medications, reviewed 12/2025, stated as needed orders for psychotropic medications including anti-psychotic, anti-anxiety, anti-depressant, and hypnotic medications, are limited to 14 days. Resident #10 was admitted with the diagnoses of schizophrenia (serious mental illness that affects how a person thinks, feels, and behaves), chronic kidney disease (when the kidneys stop filtering waste from the blood), and iron deficiency anemia (when there isn't enough iron in the body).ˆ The Minimum Data Set (an assessment tool) dated 2/9/2026, documented the resident was understood, could understand others, and was cognitively intact.ˆ The physician's order dated 02/18/2026, documented tramadol HCl (a narcotic medication) oral tablet 25 milligrams give one tablet by mouth every 12 hours as needed for pain with no end date ordered. The physician's order dated 02/20/2026, documented morphine sulfate (a narcotic medication) solution 20 milligrams per milliliter give 0.25 milliliters sublingually every two hours as needed for pain with no end date ordered. During an interview on 03/06/2026 at 11:09 AM, Director of Nursing #1 stated the nurses should be aware that as needed psychotropic and narcotic medications required a 14-day end date.ˆ They stated that when a provider entered an order it went into pending order status that the nurses should check and correct with the provider if necessary. During an interview on 03/06/2026 at 12:53 PM, Medical Doctor #1 stated they depended on the nurses to cue them for any order changes that should be made.ˆ They stated they trusted their nurses to know about any required end dates for medications.ˆ They did not state they did not know about the regulation but that they had received so much education on regulations over the year.ˆ 10 New York Codes, Rules, and Regulations 415.12(l)(1)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews conducted during the survey, the facility did not ensure drugs and biologicals were labeled and stored in accordance with professional standards of practice for two (2) (Sunflower Unit Cart A and [NAME] unit cart B) of three (3) medication carts reviewed, and one (1) (Sunflower/Daffodil AD unit) of two (2) medication rooms reviewed. Specifically, three (3) bottles of eye drops; two (2) inhalers; one (1) Lantus insulin pen (1) one Lidocaine vial one; one (1) liraglutide insulin pen; one (1) NovoLog insulin kwik pen all had no open and, or expiration dates. One (1) outer lock of a narcotic lock box was left open; and one (1) narcotic lock box outer lock was broken leaving the door ajar. This is evidenced by: The facility's Policy and Procedure titled Medication Storage revised 9/2025 documented all injectable multi-dose vial preparations must be dated and initialed upon opening. When an open vial is found not dated it must be discarded. The facility's Policy and Procedure titled Medication Storage revised 09/2025, documented, Medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier. Schedule II, III, IV and V controlled medications are stored separately from other medications in a double locked cabinet designated for that purpose. Regulation S483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. During an observation on [DATE] at 9:45 AM, the Sunflower Unit Medication Cart A contained one (1) bottle of Artificial Tears open; one (1) bottle of Brimonidine 1% eye drops; and one (1) Albuterol HFA (hydrofluoroalkane) inhaler all without open and, or expiration dates. During an observation on [DATE] at 10:00AM, the Sunflower/Daffodil AD unit Medication room had Side D outer lock of a narcotic lock box left open; and Side A narcotic lock box outer lock was broken leaving the door ajar. During an observation on [DATE] at 10:30AM, the [NAME] Unit Cart B contained one (1) Lantus insulin pen; one (1) Lidocaine open vial; one (1) Liraglutide insulin pen; and one (1) fluticasone inhaler all with no open and no expiration dates. During an interview on [DATE] at 10:05AM, Licensed Practical Nurse #7 stated they contacted maintenance previously about the broken lock on narcotic box for Side A. Maintenance was called again and arrived during observation to repair lock. During an interview on [DATE] at 10:10AM, Licensed Practical Nurse #10 stated they were in a rush to get on the floor and left the outer lock of the narcotic box open. They also stated it was their understanding that the medication room counted as one of the double locks required for narcotics. During an interview on [DATE] at 11:45 AM, Licensed Practical Nurse #2 was unaware of medication shortened expiration dates. Licensed Practical Nurse #2 also stated that insulin expired on the date printed on the bottle or pen. They stated they did not know that there was a list of medications that had shortened expiration dates. During an interview on [DATE] at 10:00 AM, Director of Nursing #1 stated insulin administration including insulin kwik pens were reviewed and demonstrated during nurse orientation. They stated shortened expiration dates were also covered during nurse orientation, and the list of these medications should be posted in the medication room. 10 New York Codes, Rules, and Regulations 415.18(d)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews conducted during survey, the facility did not ensure it established and maintained an Infection Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for five (5) residents (Residents #63, #82, #106, #10, and #113) reviewed. Specifically, (a.) staff failed to follow posted Contact Precaution and Enhanced Barrier Precaution signage; (b.) staff failed to perform appropriate hand hygiene; and (c.) staff failed to demonstrate knowledge of the differences between Contact Precautions and Enhanced Barrier Precautions. This had the potential to affect residents requiring infection control precautions.This is evidenced by:The undated facility policy titled Infection Control Guidelines for All Nursing Procedures documented staff were required to receive in-service training on infection control, including protocols for standard and transmission-based precautions. It further documented: Standard Precautions were to be used for all residents. Transmission-Based Precautions were to be implemented when indicated. Staff were to perform hand hygiene, including washing hands with soap and water under specified conditions. staff were to wear appropriate personal protective equipment to prevent exposure to infectious materials.Resident #113 was admitted to the facility with diagnoses that included extended spectrum beta-lactamase (ESBL) producing organism (a drug-resistant bacterial infection), type 2 diabetes mellitus (a condition affecting blood sugar control), and high blood pressure. The Minimum Data Set (an assessment tool) dated 01/15/2026 documented the resident was cognitively intact and required substantial assistance with activities of daily living. The resident was identified as requiring Enhanced Barrier Precautions due to risk for transmission of multidrug-resistant organisms.During an observation on 03/05/2026 at 12:07 PM, a Contact Precaution sign was posted outside the resident's room. Licensed Practical Nurse #3 was observed in the room without personal protective equipment while setting up the resident's tray and assisting with the television.During an interview at that time, Licensed Practical Nurse #3 stated the resident was on Enhanced Barrier Precautions, not Contact Precautions, and reported they had not noticed the posted sign was a Contact Precaution rather than Enhanced Barrier Precautions.During an interview on 03/05/2026 at 12:21 PM, Registered Nurse Unit Manager #3 stated Resident #113 was intended to have been on Enhanced Barrier Precautions and was unsure why a Contact Precaution sign had remained posted on the door.Resident #82 was admitted to the facility with diagnoses that included Clostridium difficile infection (a contagious diarrheal infection), high blood pressure, and generalized weakness. The residents' care plan documented the resident required Contact Precautions for Clostridium Difficile infection, which required staff to follow appropriate infection control practices to prevent transmission. The Minimum Data Set, dated [DATE] documented the resident was cognitively intact; was on Enhanced Barrier Precautions; and needed substantial assistance with lower activities of daily living.During an observation on 03/05/2026 at 12:15 PM, an Enhanced Barrier Precaution sign was posted outside the resident's room. Review of the resident's care plan indicated the resident was to have been on Contact Precautions for Clostridium difficile infection.During an interview on 03/05/2026 at 12:21 PM, Registered Nurse Unit Manager #3 stated the resident was no longer infectious and had not required Contact Precautions and the Physician orders and care plan should have been updated to reflect the current precaution status.Resident #63 was admitted to the facility with diagnoses that included herpes zoster of the eye (a contagious viral infection), chronic obstructive pulmonary disease (a lung disease affecting breathing), and atrial fibrillation (an irregular heart rhythm). The Minimum Data Set, dated [DATE] documented the resident had moderate cognitive impairment and required substantial assistance with lower activities of daily living. The resident was on Contact Precautions for herpes zoster and had an active wound requiring Enhanced Barrier Precautions.During an observation on 03/05/2026 at 12:23 PM, a Contact Precaution sign was posted outside Resident #63 room. Certified (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse Aide #4 entered the room, delivered a meal tray, and exited without performing hand hygiene. Certified Nurse Aide #4 had picked up another tray and proceeded into another resident's room prior to intervention. They stated they had not known the difference between Contact Precautions and Enhanced Barrier Precautions and acknowledged they had not followed the required steps listed on the signage.During an observation on 03/06/2026 at 12:20 PM, Certified Nurse Aide #4 entered and exited Resident #63 room labeled Contact Precautions without personal protective equipment. Certified Nurse Aide #4 used hand sanitizer for hand hygiene despite the boldly written signage specifically indicating a necessity of soap and water after contact with residents.During an interview on 03/06/2026 at 12:20 PM, Certified Nurse Aide #4 stated they had used hand sanitizer and reported staff usually just use hand sanitizer, Certified Nurse Aide #4 despite the posted signage had been unaware with what the sign had indicated.Resident #10 was admitted to the facility with a diagnoses of methicillin-resistant Staphylococcus aureus (MRSA) infection (a drug-resistant bacterial infection), chronic kidney disease (reduced kidney function), and schizophrenia (a mental illness affecting thoughts and behavior). The Minimum Data Set, dated [DATE] documented the resident was cognitively intact; was on Enhanced Barrier Precautions; and had a colostomy (an external device that collects waste).During an observation and interview, on 03/07/2026 at 4:43 PM, Licensed Practical Nurse #4 and Certified Nurse Aide #9 were observed providing colostomy care in a room with an Enhanced Barrier Precaution signage. Both staff exited the room wearing gloves and did not perform hand hygiene. Licensed Practical Nurse #4 stated they had not known which resident in the room was on Enhanced Barrier Precautions and had not been educated on the difference between Contact Precautions and Enhanced Barrier Precautions. They stated they should have removed their gloves and washed their hands in the resident's room prior to exiting for infection control purposes.Resident #106 was admitted t othe facility with the diagnoses of congestive heart failure (a condition where the heart does not pump effectively), type 2 diabetes mellitus (a condition affecting blood sugar control), and conjunctivitis (infectious disease of the eye). The Minimum Data Set, dated [DATE] documented the resident was cognitively intact and was independent with upper body activities of daily living and dependent with lower body activities of daily living. The resident had an order for contact precautions.During an observation and interview on 03/11/2026 at 12:36 PM, Resident #106 was on contact precautions related to a contagious eye infection. A precaution sign was posted outside the resident's room in English only outlining required infection control measures. During the observation, Certified Nurse Aide # 14 entered the resident's room, performed hand hygiene using hand sanitizer, picked up a meal tray, delivered the tray to the resident, and exited the room. Upon exiting, Certified Nurse Aide#14 removed gloves and again performed hand hygiene using hand sanitizer. The Certified Nurse Aide did not wear the additional personal protective equipment indicated on the posted contact precaution signage. Certified Nurse Aide #14 stated they were aware the resident was on contact precautions; however, they reported that precautions were only required during direct care. They stated it was permitted for staff to enter and exit the room without wearing personal protective equipment unless they were providing care.During an observation and interview at 03/11/2026 1:30 PM, a family member approached Resident #106 s door, stopped, read the sign and began to put on the required personal protective equipment. They had not been educated by the facility about what to do if there was a particular sign on the residents' door, however they had worked in a nursing facility and knew the importance of maintaining the integrity of the precautions.During an interview on 03/05/2026 at 12:33 PM, Certified Nurse Aide #1 stated they had not known the difference between Contact Precautions and Enhanced Barrier Precautions and believed all precaution signage required full personal protective equipment.During an interview on 03/05/2026 at 12:38 PM, Certified Nurse Aide #8 stated they were unaware of the difference between Contact Precautions and Enhanced Barrier Precautions and treated both the same.During an interview on 03/05/2026 at 12:58 PM, Housekeeping Supervisor #1 stated housekeeping staff received training during orientation and on the job from more experienced staff. Housekeeping Supervisor #1 further (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated most housekeeping staff primarily spoke Spanish and communication occurred through bilingual staff when available. The staff was unable to utilize their electronic system for education as the version they maintained was only available in the English language. If an area needed a specific cleaning technique or chemical agent, they needed to find a bilingual staff member to translate and educate them.During an interview on 03/05/2026 at 1:30 PM, Infection Control Nurse #1 stated they had served as the Infection Preventionist since 01/2025. They divided responsibilities between infection control and wound care and worked remotely for a portion of their schedule. Staff were educated during orientation regarding infection control practices. Precaution signage was utilized to identification of required personal protective equipment. They had maintained infection tracking through a line list kept with each Unit Manager. Residents with a Clostridium difficile infection were placed on Contact Precautions and could be discontinued from precautions following completion of antibiotics. Housekeeping staff were expected to use a specific product for cleaning rooms of residents with Clostridium difficile; however, they were unable to identify the product or contents needed to have been utilized. Housekeeping staff were notified of cleaning needs through group communication; however, the process for discontinuation of precautions was not clearly defined.During an interview on 03/07/2026 at 5:50 PM, Certified Nurse Aide #10 stated they had been employed for approximately one month and were not certain of the difference between Contact Precautions and Enhanced Barrier Precautions and were unsure if infection control education was included in orientation.During an interview on 03/07/2026 at 6:05 PM, Director of Nursing#1 stated staff entering rooms with Enhanced Barrier Precautions should wear gloves, and precautions for Contact Precautions depend on the infection. Director of Nursing #1 stated hand sanitizer was acceptable unless otherwise specified on the signage. They further stated the facility had been without a nurse educator. Director of Nursing#1 identified Registered Nurse #3 as the Infection Control Nurse. The previously identified Infection Control Nurse, Licensed Practical Nurse #5, was the wound care nurse rather than the Infection Control Nurse. Director of Nursing #1stated they believed they themselves to have been the Infection Control Nurse and admitted they were uncertain of who was the actual infection control nurse was.During an interview on 03/09/2026 at 10:29 AM, Director of Nursing #1 stated they believed they were serving as the Infection Preventionist since starting in the role on 12/19/2025 and reported they assumed responsibility for infection control when Licensed Practical Nurse #3 was not present. Director of Nursing #1 later stated Licensed Practical Nurse #3 served as the Infection Preventionist and had transitioned from the Assistant Director of Nursing role effective 01/23/2026. Director of Nursing #1 was unable to explain why infection control activities were not consistently managed by Licensed Practical Nurse #3. Director of Nursing #1 stated no audits had been conducted for Enhanced Barrier Precautions and reported staff would likely be noncompliant.During an interview on 03/10/2026 at 9:30 AM, Administrator #1 stated all staff received infection control training upon hire and completed annual competency training. Administrator #1 stated initial training was conducted in person, with annual training provided through web-based education and additional training provided as needed by the Nurse Educator. Administrator #1 stated they were uncertain if the web-based learning was available in other languages apart from English. Precaution signage with pictorial instructions for use of personal protective equipment was posted outside resident rooms and as of this survey was both in English and Spanish. They further stated Licensed Practical Nurse #5 served as the Nurse Educator since 01/2025, and although Licensed Practical Nurse #5 submitted a resignation in 12/2025, the resignation was rescinded following an agreement for a flexible work schedule.During an interview on 03/10/2026 at 10:40 AM, Medical Doctor #1 stated they had been working at the facility since 01/12/2026 and were present two days per week. The physician stated approximately 80 percent of residents had signage posted for Enhanced Barrier Precautions or Contact Precautions, which was higher than typically observed in other facilities. The physician stated they had not been aware of an increase in resident infections or hospitalizations during their time at the facility. They had completed mandatory infection control (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	training to maintain licensure in New York State and reported they read the individual specifications and followed precaution signage prior to entering resident rooms.10 New York Codes, Rules, and Regulations 415.19(a)(b)(1-3)