STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335750	A. Building B. Wing	12/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fishkill Center for Rehabilitation and Nursing	22 Robert R. Kasin Way Beacon, NY 12508

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews during an abbreviated survey (2650093), the facility did not ensure the residents representative were informed when there was a significant change in the resident's physical condition for 1 out of 3 residents (Resident #1) reviewed for notification. Specifically, Resident #1's had a fall and sustained injuries to the face, eyes and head on 09/27/2025. The family representative was not notified timely of the change in condition and physical status until they visited the resident on 10/30/2025. The findings are: The facility Accident and Incident policy last reviewed 02/12/2025 documented all accidents and incidents will be investigated and documented. The nurse manager or supervisor will notify the family or significant others regarding the accident or incident. Resident #1 was admitted with diagnoses including but not limited to Cerebral Infarction, Aphasia and Altered Mental Status. A Quarterly Minimum Data Set, dated [DATE] documented Resident #1 had severe cognitive impairment with an altered level of consciousness. Resident #1's impaired cognition care plan last reviewed 10/18/2024 documented the goal was that Resident #1 would maintain their present level of mental awareness. Interventions included to speak to the resident in a clear manner, orient the resident to your identity, ensure residents right, safety, dignity, safety and anticipate needs. Review of the accident/incident report dated 09/27/2025 at 12:15 AM documented Resident #1 was observed lying on the floor in their room with the following injuries noted: right eye swollen, right side of forehead hematoma and a scratch to the right forearm measuring 13cm. Resident #1's representative was called at 12:50 AM and a voice message was left. Review of Resident #1's face sheet revealed the incorrect representative was listed as the emergency contact. The other listed family representees were not called. There was no documented evidence that the facility followed up calls when messages left for the wrong contact was not responded to. There was no documented evidence that other listed family representatives were reached by the facility to inform them about the fall. During a telephone interview on 11/14/2025 at 3:06 PM, Licensed Practical Nurse #2 stated they and the Nurse Practitioner called Resident #1's representative, but there was no answer, so they left a message for them to call back the facility. Licensed Practical Nurse #2 stated Resident #1's representative did not call the facility back before they left their shift at 7:00 AM. Licensed Practical Nurse #2 stated they usually leave a message for the representatives to call back, and the Nurse Practitioner stated they would try to reach the representatives again. During an interview on 11/17/2025 at 10:43 AM, Licensed Practical Nurse #5 stated Resident #1's representative was notified, but there was a discrepancy as the first person on the face sheet was called instead of the right person. Licensed Practical Nurse #5 stated when Resident #1's representative came to the facility to visit Resident #1 they stated they were never informed about the fall incident, because the facility staff had been calling the wrong person. Licensed Practical Nurse #5 stated they recently had a care plan meeting with Resident #1's representative on 11/14/2025 and when the fall incident was brought up, the representative stated the wrong person had been contacted and that was an issue. Resident #1's representative was not happy about the wrong person being contacted.During an interview on 11/17/2025 at 11:42 AM, the Social Worker stated Resident #1's representatives did not voice any concerns regarding the resident's recent fall. The Social Worker stated that there was an issue with contacting the first person designated on Resident #1's face sheet s they would never return their calls or get back to them. On October 31, 2025, they spoke with another representative and made them the point of contact. During a telephone interview on 11/24/2025 at 10:50 AM, Resident #1' s representative stated the facility called another family representative regarding the fall incident who lives out of state in New Mexico over the weekend, but they did not receive a call although they were also listed as a contact on the face sheet. Resident #1's representative stated they should have been the one to be contacted regarding the fall because they had a conference in April 2025 with the facility and it was determined that they would be the first to be contacted. 10 NYCRR 415. 3(f)(2)(ii)(c)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview during an abbreviated survey (2650093) the facility did not ensure the comprehensive care plans were reviewed, updated, and revised for 2 out of 3 residents (Resident #1, Resident #3) reviewed for care planning. Specifically, (1) Resident #1's cognitive impairment care plan had not been reviewed or updated since 10/18/2024. (2) Resident #3's cognitive impairment care plan had not been reviewed or updated since 08/27/2024.The findings are:The facility Comprehensive Care Planning policy last reviewed 02/14/2025 documented the interdisciplinary team: reviews care plans at a minimum of quarterly to ensure that all goals and interventions are current, appropriate and accurate and updates care plans as needed with changes in treatment, needs and conditions.1)Resident #1 was admitted with diagnoses including but not limited to Cerebral Infarction, Aphasia and Altered Mental Status.A Quarterly Minimum Data Set, dated [DATE] documented Resident #1 had severe cognitive impairment with an altered level of consciousness. The resident had unclear speech and sometimes was understood and sometimes not understood. A review of the care plan for impaired cognition revealed it was last reviewed on 10/18/2024. Although, it documented Resident #1 had a decline in their cognition and established a goal that the resident would maintain their present level of mental awareness. Interventions listed included speak to the resident in a clear manner, orienting the resident to your identity, ensure residents safety, dignity and rights and anticipate needs. However, the care plan had not been reviewed or updated in accordance with the most current comprehensive or quarterly assessment. As a result, there were no documented evidence if the goals had been met or if interventions were effective. 2) Resident #3 was admitted with diagnoses including but not limited to Dementia, Anxiety disorder and Unspecified Fracture of Upper End of Right Humerus.A Quarterly Minimum Data Set, dated [DATE] documented Resident #3 had a Brief Interview of Mental Status score of 99 with moderately impaired cognitive decision-making skills. The resident required supervision for eating, moderate assistance for toileting and was independent for bed mobility and transfers.A review of the care plan for impaired cognition revealed it was last reviewed on 08/27/2024. It documented Resident #3 had a mental illness and impaired decision-making ability. Interventions listed included speak to the resident in a clear manner, orienting the resident to your identity, ensure residents safety, dignity and rights and anticipate needs. There was no documented evidence that the care plan had been reviewed and updated in accordance with the most recent quarterly or comprehensive assessment. As a result, there is no evidence that established goals were met or that interventions were effective. During an interview on 11/17/2025 at 10:43 AM Licensed Practical Nurse #5 stated the unit managers (Registered Professional Nurses) are responsible for updating the residents care plans, but the Social Worker usually updates the cognitive care plan for the residents.During an interview on 11/17/2025 at 11:42 AM the Social Worker stated they are responsible for updating the care plans for cognitive impairment and they are updated on a quarterly and annually basis as well as with any significant changes. The Social Worker stated Resident #1's cognitive impairment care plan was last updated on Friday, 11/14/2025. The Social Worker reviewed the care plan and stated they can see that the care plan looks like it had not been reviewed since 2023 or 2024. The Social Worker stated the goals are always updated and they are not sure why the updates and revisions are not reflecting on the document. The Social Worker stated the care plan meeting documentation are supposed to carry over to the care plan after the meeting via electronic medical record system. They were not sure why previous care plan meeting documentation did not transfer. Their meeting on Friday, 11/14/2025, did transfer over to the care plan. The Social Worker stated a care plan meeting is always done when a goal is updated. During an interview on 11/17/2025 at 1:47 PM the Director of Nursing reviewed Resident #1's care plan and stated they see that the care plans look like they were not reviewed, but the Social Worker needs to connect their meeting notes in Visual (the electronic medical record) system because the care plans coincide with the quarterly assessments and the care plan meetings.10 NYCRR 415.11 (c)(2)(i-iii)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure that the resident environment remained as free of accident hazards as is possible; and that each resident received adequate supervision to prevent accidents for one (1) of three (3) residents (Resident #1) reviewed for accidents. Specifically, a review of the facility's fall risk assessment revealed that on 08/12/2025, Resident #1 was identified as a high risk for falls and further review of the resident's medical record revealed that the facility failed to implement interventions to prevent the resident from potential falls or to mitigate harm from actual falls. On 09/27/2025, Resident #1, had a fall and was found in their room on the floor and sustained a swollen right eye, a hematoma to the right side of their forehead and a scratch to their right forearm. Resident #1 was transferred to the emergency room for further evaluation. This failure to implement interventions to prevent and or mitigate harm from falls resulted in actual harm to Resident #1 that was not Immediate Jeopardy. The findings are:The facility policy titled Fall Risk Intervention Protocol last reviewed 02/12/2025 documented it is the policy of the facility to ensure every resident is treated in a manner that reduces the risk of falls and fall related injuries. To achieve this, the following interventions are in place. Interventions can and should be implemented as soon as necessary. After a fall risk assessment is completed, a score of greater than seven (7) would require review and implementation of the fall risk intervention protocol. The listed interventions that could be implemented included to note fall risk on care summary and nursing should place the resident on high alert fall safety observation (every 30 minutes or one (1) hour). Resident #1 was admitted with diagnoses including but not limited to cerebral infarction (an area of brain tissue death caused by lack of blood flow and oxygen), aphasia (a language disorder caused by brain damage) and altered mental status (a sudden or significant change in a person's usual brain function). A Quarterly Minimum Data Set (a resident assessment tool) dated 08/13/2025 documented Resident #1 had severe cognitive impairment with altered level of consciousness. The resident had unclear speech and was sometimes understood. The resident had functional limitations to their upper and lower extremities on one (1) side and used a wheelchair for locomotion. The resident was dependent for eating, toileting, bed mobility and transfers, and did not have a history of falls. Resident #1's Risk for Falls care plan last reviewed 08/12/2025 documented Resident #1 was at risk for falls related to their medical diagnoses and poor trunk control. Interventions listed included: ensure call bell is always within reach and is answered in a timely manner, bed in lowest position and provide a clutter free environment with adequate lighting. Review of an Activities of Daily Living care plan last revised on 08/12/2025 documented Resident #1 was dependent for bed mobility. Interventions listed included: position in bed using proper alignment and reposition for comfort, two (2) quarter side rails up when in bed as bed enablers for mobility. Review of Resident #1's care profile dated 07/09/2025 revealed Resident #1 had no fall selected under safety precautions. Review of a Fall Risk assessment dated [DATE] documented Resident #1 had a fall risk score of 12, indicating they were at risk for falls. The facility Fall Risk Assessment instruction documented if the total score is ten (10) or greater, the consumer should be considered at high risk for potential falls. A prevention protocol should be initiated immediately and documented on the care plan. Review of an Interdisciplinary Siderail Screen and Evaluation dated 08/13/2025 documented Resident #1 was receiving side rails to utilize as enablers for bed mobility. The resident was to have bilateral quarter side rails when in bed. The Interdisciplinary Siderail Screen documented Resident #1 would use the side rails to adjust themself in bed or transfer out of bed and their representative requested the use of the siderails to enable bed mobility. The facility Accident/Incident report documented on 09/27/2025 at 12:15 AM, Resident #1 was observed lying on the floor in their room with the following injuries noted: right eye swollen, right side of forehead hematoma (bruise) and a scratch to the right forearm. The investigative summary documented the root cause was increased confusion, resident reported falling out of bed after attempting to self-transfer. Interventions listed were Occupational Therapy screen and bilateral bolster placement to assist resident with determining depth perception of bed. Immediate safeguards are in place to keep the resident safe and prevent reoccurrence.Review of Resident #1's care profile dated 10/01/2025 did not reflect Resident #1 was on fall precautions for safety. During a telephone interview on 11/14/2025 at 2:22 PM, Certified Nurse Aide #3 stated they were assigned to Resident #1 on the night of their fall on 09/27/2025. They found Resident #1 the day before the fall trying to get out of the bed with half of Resident #1's body hanging off the bed and they informed Licensed Practical Nurse #3 about it. Certified Nurse Aide #3 stated