STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335760	A. Building B. Wing	11/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eddy Heritage House Nursing and Rehabilitation Ctr	2920 Tibbits Avenue Troy, NY 12180

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews conducted during the abbreviated survey (Case #2665815), the facility did not ensure equal access to quality care regardless of diagnosis for (1) (Resident #1) of one (1) resident reviewed. Specifically, staff did not question, assess, or respond to a significant medication error because Resident #1 was receiving hospice services. Licensed Practical Nurse #2 stated they did not question medication that they dispensed to Resident #1 because the resident was on hospice. This compromised Resident #1's right to dignity, self-determination, and access to medically appropriate care. This is evidenced by: Cross reference to F-600: Free from Abuse and Neglect. Cross reference to F-760: Residents Are Free of Significant Med Errors. The Policy and Procedure titled Resident Rights, dated 5/28/2024 documented that the facility would ensure residents had the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. Further documented was that the facility must protect and promote the rights of the resident. The facility must provide equal access to quality care regardless of diagnosis, severity, condition, or payment source. The resident had the right to choose activities, schedules, healthcare and providers of healthcare consistent with his or her interests, assessments, and plan of care. Record review revealed Resident #1 was admitted to the facility on [DATE] for five (5) days of respite care (a short-term, substitute care for a person who requires assistance by a caregiver. Respite care provides temporary relief for primary caregivers, giving the caregiver a break for rest, errands, or personal time, preventing caregiver burnout, and ensuring the care recipient is still looked after in a setting able to provide appropriate care) through 10/31/2025 with diagnoses of senile degeneration of the brain (an outdated term for dementia, a general decline in cognitive function that is not a normal part of aging), end-stage renal disease (the final stage of chronic kidney disease, occurring when kidneys fail to filter waste and toxins from the blood), and atrial fibrillation (an irregular and often very rapid heart rhythm). The Brief Interview for Mental Status dated 10/08/2025 documented the resident was rarely understood. Resident #1 was not in the facility long enough to receive a complete Minimum Data Set (a resident assessment tool). Resident #1's admission order to the facility from hospice read morphine 100 milligrams per five (5) milliliter concentrated solution, take five (5) milligrams by mouth every four (4) hours for indications of pain and/or shortness of breath. A Home Hospice Note dated 10/08/2025 at 8:30 AM by Registered Nurse #6, documented Resident #1 was receiving acetaminophen, tramadol, and diclofenac gel as needed in their home prior to admission. There was no documented evidence that Resident #1 had received morphine sulfate in their home prior to facility respite admission. During an interview on 11/17/2025 at 10:19 AM, Health Care Proxy #1 stated Resident #1 was not receiving morphine sulfate at home. They stated the home hospice nurse, Registered Nurse #6, saw Resident #1 at home just prior to admission to the facility and stated the resident was stable for a respite stay. During an interview on 11/18/2025 at 12:12 PM, Health Care Proxy #2 stated Resident #1 had not received any medications prior to their admission to the facility. During an interview on 11/19/2025 at 1:49 PM, Licensed Practical Nurse #2 stated they were Resident #1's medication nurse for the overnight shift starting 10/08/2025. They recalled giving the resident the ordered morphine sulfate. They stated they assumed the order was correct and did not question the dosage of morphine sulfate because the resident was on hospice. They stated they administered 20 milligrams of morphine on 10/09/2025 at 2:00 AM and 6:00 AM as ordered. During an interview on 11/18/2025 at 10:45 AM, Licensed Practical Nurse #1 stated that the dose seemed excessive, however because Resident #1 was on hospice, they did not question it prior to giving the medication. Licensed Practical Nurse #1 stated they questioned the morphine dose after they had given the second dose on their shift at 2:00 PM on 10/09/2025. During an interview on 11/19/2025 at 10:40 AM, Registered Nurse #4 stated on 10/09/2025, Licensed Practical Nurse #1 came to them to question the morphine sulfate order, and that when they left for the day around 3:45 PM, they stated Resident #1 was stable and because Resident #1 was a hospice patient, the goal was to be comfortable, which they believed the resident to be. During an interview on 11/18/2025 at 12:12 PM, Health Care Proxy #2 stated Resident #1 had not received any medications prior to their admission to the facility. They stated they left the facility around 2:00 PM on 10/08/2025 and returned around 4:00 PM on 10/09/2025. They stated Resident #1 was sleeping soundly enough to be snoring and they were unable to wake them. Health Care Proxy #2 stated they asked unnamed staff if Resident #1 had been like that all day and the unnamed staff reportedly stated yes. An unnamed doctor spoke to Health Care

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review conducted during the abbreviated survey (Complaint #2665818), the facility did not ensure that hospice or the resident representative/emergency contact was notified of a significant medication error for 1 (one) (Resident #1) of 5 (five) residents reviewed. Specifically, Resident #1 experienced a significant medication error on 10/09/2025, and there was no documented evidence that hospice was notified, and the resident's representative was not made aware until 10/28/2025. This is evidenced by: Cross reference to F-600: Free from Abuse and Neglect. Cross reference to F-760: Residents Are Free of Significant Med Errors. The document Service Agreement by and between [Hospice Vendor #1] and [Facility] dated 10/24/2027, documented promptly upon admission of a hospice patient, who has not been residing in a nursing home, to the Nursing Facility and consent of the Hospice Patient (or his/her Authorized Representative), Hospice would furnish nursing with a copy of the then-current hospice plan of care. Hospice and nursing facility agreed to immediately notify each other of any identified change in the condition of a residential hospice patient which required supplementation, modification or alteration of the Plan of Care, including but not limited to changes in medications or the ordering of clinical laboratory testing or other services. The policy Resident Rights effective date 5/28/2024, documented Under Notification of Change that the facility must immediately notify the resident, physician, and/or the resident's representative when there was an accident that resulted in injury, a significant change in the resident's health status, or a need to alter treatment significantly, including a need to change a current treatment, in addition to discontinuing a current treatment or commencing a new treatment. The policy Medication Errors and reporting dated 10/10/2021, documented medication events included transcription errors. The purpose of the policy was to ensure prompt identification, reporting, documentation, investigation and correction of all medication events (including errors and near misses) to protect resident safety and comply with regularity requirements. It was further documented that the family and/or the designated representative would be notified about the error and follow up plan. Resident #1 was admitted on [DATE] for respite care. The resident received four (4) incorrect doses of morphine sulfate totaling eighty (80) milligrams over a twelve (12) hour period on 10/09/2025. There was no documented evidence that hospice was notified of the medication error that Resident #1 received. There was no documented evidence that the resident's representative was notified of the medication error until 10/28/2025, as evidenced by a progress note entered by Medical Director #1 documenting a meeting with the resident's representatives to review the events surrounding the resident's passing. During an interview on 11/19/2025 at 11:40 AM, Registered Nurse #4 stated on 10/09/2025 Licensed Practical Nurse #1 informed them that the morphine dosage was likely wrong and they checked it. Registered Nurse #1 stated they immediately discontinued the order, informed Physician #1 of the error, and received a new correct order for morphine, which was entered into the system. They further stated, the did not notify Director of Nursing #1 or Administration, contacting the doctor was their first priority. During an interview on 11/19/2025 at 12: 34 PM, Administrator #1 stated they were not in the facility when the incident occurred. They had a received a voicemail from the resident representative when they returned to work. They stated the resident representative had reached out to Director of Nursing #2, but Director of Nursing #2 did not return their call. Administrator #1 stated they met in person with the family on 10/28/2025. During an interview on 11/19/2025 at 2:04 PM, Medical Director #1 stated the family was not communicated immediately about the medication error. 10 New York Codes, Rules, and Regulations 415.3(f)(2)(ii)(d)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews conducted during the abbreviated survey (#2665815), the facility failed to ensure residents' right to be free from neglect for one (1) of five (5) residents reviewed. (Resident #1). Specifically, on [DATE] at 2:00 PM, the facility identified that Resident #1 received four (4) incorrect doses of morphine sulfate (a strong opioid analgesic used to treat moderate to severe pain) totaling 80 milligrams over a 12-hour timeframe. This resulted in the resident becoming lethargic and unresponsive with unstable vital signs including blood pressure and oxygen saturation. The facility failed to provide interventions to reverse the effects of the medication despite the family inquiry to Narcan (also known as naloxone, a medication used to reverse or reduce the effects of opioids). The resident expired on [DATE] at 6:20 AM. This resulted in Substandard Quality of Care that was Immediate Jeopardy that resulted in the death of Resident #1, with the likelihood of serious injury, harm, impairment, or death adverse outcomes occurring to all 108 residents in the facility.This is evidenced by: Cross Reference to F-760: Residents Are Free of Significant Med Errors The facility policy titled ' Abuse Prevention and Investigation Policy, effective [DATE], documented residents had the right to be free from verbal, sexual, physical, and mental abuse, neglect, mistreatment, corporal punishment, involuntary seclusion, exploitation, and misappropriation of property. Under Investigation/Identification, the policy documented the resident should be assessed, and any necessary care and treatment provided. Neglect was defined as failure to provide timely, consistent, safe, adequate and appropriate services, treatment and care necessary to avoid physical harm, mental anguish, or mental illness such as nutrition, medication, therapies, sanitary clothing and surroundings and activities of daily living. For example: facility failure to implement an effective communication system across all shifts for communicating necessary care needs, information between staff, practitioners, and resident representatives. The facility policy titled Management of Opioid Overdose (Naloxone administration), effective date [DATE], documented an opioid overdose needed urgent medical attention. Naloxone should be administered to anyone who presented with signs of opioid overdose. Under procedure it was documented: a.) evaluate for signs of opioid overdose, which included unconsciousness or inability to awaken, slow or shallow breathing or difficulty breathing such as chocking sounds or a gurgling/snoring noise from a person who cannot be awakened, fingernails or lips turning blue/purple; b.) if an opioid overdose was suspected, stimulate the person, call the person's name, if that did not work to vigorously grind knuckles into the sternum or run knuckles on the person's upper lip, continue to monitor the person, including breathing and alertness, and try to keep the person awake and alert; c.) if the person did not respond, provide rescue breathing if the person was not breathing on their own, d.) administer naloxone per manufacturer recommendation. The facility policy, Medication Errors and reporting, dated [DATE], documented medication events included transcription errors. The purpose of the policy was to ensure prompt identification, reporting, documentation, investigation and correction of all medication events (including errors and near misses) to protect resident safety and comply with regularity requirements. The procedure read: 1. assess the resident to ensure safety; 2.) notify the Nurse Manager and/or nursing supervisor immediately. Any potentially reportable error, per New York State would be escalated to the Medical Director, Director of Nursing and the Executive Director; 3.) the Nurse Manager/supervisor would notify the provider immediately and would obtain direction regarding necessary resident monitoring, duration of monitoring and expected follow up communications; 4.) notify pharmacy for any dispensing errors; 5.) notify the resident and/or the designated representative about the error and follow up plan 6.) document nature of the event, individuals notified, actions taken, order received, resident's response to the event and mentoring plan in the resident progress notes. Results of continued monitoring, assessments and communications would also be documented. Record review revealed Resident #1 was admitted to the facility on [DATE] for five (5) days of respite care (a short-term, substitute care for a person who requires assistance by a caregiver. Respite care provides temporary relief for primary caregivers, giving the caregiver a break for rest, errands, or personal time, preventing caregiver burnout, and ensuring the care recipient is still looked after in a setting able to provide appropriate care) with diagnoses of senile degeneration of the brain (an outdated term for dementia, a general decline in cognitive function that is not a normal part of aging), end-stage renal disease (the final stage of chronic kidney disease, occurring when kidneys fail to filter waste and toxins from the blood), and atrial fibrillation (an irregular and often very rapid heart rhythm). The Brief Interview for Mental Status dated [DATE] documented the resident was rarely

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review conducted during an abbreviated survey (Case #2665815), the facility did not ensure that all alleged violations involving neglect were reported immediately, but not later than 2 (two) hours after the allegation was made, if the event that caused the allegation resulted in serious bodily injury to the Administrator and to the State Survey Agency in accordance with State Law for one (1) (Resident #1) of 1 resident reviewed. Specifically, Resident #1 was involved in a serious adverse event / medication error that resulted in their death on [DATE]. The event was not reported to the New York State Department of Health. This is evidenced by: Cross reference to F-600: Free from Abuse and Neglect. Cross reference to F-760: Residents Are Free of Significant Med Errors. The Facility Policy titled Medication Errors and Reporting effective [DATE], documented the facility maintained a nonpunitive reporting culture, which encouraged all staff to report medication events immediately. All events must be documented, investigated and reviewed regularly to improve systems and reduce future errors. Medication events included transcription errors. It further documented that any reportable error, per New York State (refer to: Reporting Serious Adverse Events to New York State Department of Health Policy) would be escalated to the Medical Director, Director of Nursing, and the Executive Director. The Facility Policy titled Reporting Serious Adverse Events to NYS DOH effective [DATE], documented the purpose and the scope was to ensure timely and accurate reporting of serious adverse events in compliance with New York Department of Health regulations and federal requirements. It was documented that a medication or treatment error that resulted in harm was considered a reportable serious adverse event and required reporting to the New York State Department of Health. It was also documented to document all details in the resident's medical record. Resident #1 was admitted on [DATE] for respite care. The resident received four (4) incorrect doses of morphine sulfate totaling eighty (80) milligrams over a twelve (12) hour period on [DATE]. This resulted in the resident becoming lethargic and unresponsive with unstable vital signs including blood pressure and oxygen saturation. The facility failed to provide interventions to reverse the effects of the medication despite the family inquiry to Narcan (also known as naloxone, a medication used to reverse or reduce the effects of opioids). The resident expired on [DATE] at 6:20 AM. An undated Medication Event Investigation documented, on [DATE] it was discovered that Resident #1's morphine sulfate order had been transcribed in error by milliliters and not milligrams. The order continued until [DATE] at 2:00 PM, when the medication nurse questioned the order. There was no documented evidence that the serious adverse event or medication error involving Resident #1 was reported to the New York State Department of Health. During an interview on [DATE] at 11:20 AM, Administrator #1 stated that they did not feel that Resident #1's passing was caused by the morphine sulfate administration. They stated Executive Director #1 and Medical Director #1 did not connect the morphine administration to Resident #1's death when Administrator #1 reached out to them regarding the incident. When asked if Administrator #1 reported incidents to the New York State Department of Health without speaking to Executive Director #1 or Medical Director #1, Administrator #1 stated that in this particular case, they felt like they needed guidance and was advised to not report it. 10 New York Codes, Rules, and Regulations 483.12 (c) (1)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review conducted during an abbreviated survey (Case #2665815), the facility did not ensure that residents received treatment and care in accordance with professional standards of practice for four (4) (Resident #'s 10, 11, 12, and 13) of four (4) residents reviewed for medication administration. Specifically, the resident's medications were administered late across various units and their medical providers were not notified. This is evidenced by: The Facility Policy titled Medication Administration effective date 12/21/2025, documented it was the policy of the facility that each patient/resident/elder would receive medications according to provider orders and accepted professional standards. Times entered into the electronic medication administration record are used to organize the nursing workflow and do not reflect times ordered by the medical staff. Red alerts highlighted in the electronic medication administration record do not reflect late medications. The nurse was responsible for having knowledge for the therapeutic effects, contraindications, side effects and drug interactions of medications given. Resident #10 Resident #10 was admitted to the facility with diagnoses of fracture of left radius (when the radius bone on the arm breaks near the wrist), unspecified dementia (a group of conditions that cause a progressive decline in cognitive abilities), and hypertensive crises (when blood pressure is 180/120 or higher). The Minimum Data Set, dated [DATE], documented the resident had moderate cognitive impairments, could be understood, and could understand others. A physician order dated 10/14/2025, read Lidocaine External Patch 4 percent, apply to lower back topically 1 (one) time a day for pain and remove per schedule. A physician order dated 10/13/2025, read Metoprolol Succinate extended release 24 hour 100 milligrams, give 1 (one) tablet by mouth for hypertension, hold for systolic blood pressure (pressure in the arteries when the heart contracts and pumps blood out, representing the maximum pressure during a heartbeat. It is the top (first) number in a blood pressure reading) less than 100 or heart rate less than 55. Resident #10's Medication Administration Record for November documented Lidocaine External Patch 4% was scheduled to be administered within one (1) hour before or one (1) hour after 8:00 AM. Resident #10's Medication Administration Record for November documented Metoprolol Succinate was scheduled to be administered within one (1) hour before or one (1) hour after 9:00 AM. During an observation on 11/24/2025 at 10:34 AM, Licensed Practical Nurse #9 was observed pulling Resident #10's medications for their medication pass. Their medications included Lidocaine Patch 4 percent, Ensure Plus, Tylenol 500 milligrams 2 (two) tablets, Metoprolol 100 milligrams, Zoloft 25 milligrams, Calcitonin Nasal Solution, and Apixaban 2.5 milligrams. During an interview on 11/24/2025 at 10:34 AM, Licensed Practical Nurse #9 stated they would need to call the doctor about late medications. They stated morning medications were typically administered late. Licensed Practical Nurse #9 stated it was a heavy medication pass on the unit, the system had shut down briefly earlier in the day, and there were residents that needed to go out for appointments. Licensed Practical Nurse #9 further stated they still had four more residents to give medications to. Resident # 11 Resident #11 was admitted to the facility with diagnoses of idiopathic peripheral autonomic neuropathy (nerve damage that affects the autonomic nervous system that control involuntary bodily functions such as heart rate, digestion, and breathing), anxiety disorder (mental health condition characterized by excessive fear or anxiety that interferes with daily activities), and hypertension (also known as high blood pressure,condition where the force of blood against the artery walls is consistently too high). The Minimum Data Set, dated [DATE], documented the resident was cognitively intact, could be understood, and could understand others. A physician order dated 9/23/2023 read Buspirone Hydrochloride oral tablet 15 milligrams, give 1 (one) tablet by mouth 3 (three) times a day for anxiety. A physician order dated 10/17/2025 read Procardia XL tablet extended release 24 hour 60 milligram, give 1 (one) tablet by mouth one time a day for hypertension. Resident #11's Medication Administration Record for November documented Buspirone was scheduled to be administered within one (1) hour before or one (1) hour after 8:00 AM. Resident #11's Medication Administration Record for November documented Procardia XL was scheduled to be administered within one (1) hour before or one (1) hour after 9:00 AM. During an observation on 11/24/2025 at 10:30 AM, Licensed Practical Nurse #10 was observed administering Resident 11's medications. Their medications included Buspirone 15 milligrams, Calcium 600 milligrams, Methenamine Hippurate I gram, Omeprazole 20 milligrams, hydrochlorothiazide 12.5 milligrams, Metamucil packet, Procardia ER 60 milligrams, Duloxetine HCl 30 milligrams, Vitamin C, Vitamin D, Magnesium Oxide, Aspirin 81 milligrams, Ferrous Sulfate 325 milligrams, Colace 100 milligrams, Saline Spray and Artificial

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. (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 0710 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 observations, interviews, and record reviews conducted during the abbreviated survey (Case # 2665815) from 11/17/2025 to 11/26/2025, for 1 (one) (Resident #1) of 3 (three) residents reviewed, the facility did not ensure that the Physician provided supervision of medical care. Specifically, Physician #1 signed 5 incorrect orders for morphine concentrate oral liquid resulting in Resident #1 receiving 80 milligrams of morphine over a 12-hour period. Additionally, there was no documented evidence that Physician #1 provided any follow up instructions or care to Resident #1 after the medication administration was discovered. This is evidenced by: Cross reference to F-600: Free from Abuse and Neglect. Cross reference to F-760: Residents Are Free of Significant Med Errors. Record review revealed Resident #1 was admitted to the facility on [DATE] for five (5) days of respite care (a short-term, substitute care for a person who requires assistance by a caregiver. Respite care provides temporary relief for primary caregivers, giving the caregiver a break for rest, errands, or personal time, preventing caregiver burnout, and ensuring the care recipient is still looked after in a setting able to provide appropriate care) under hospice services. Record review of the Medication Administration Record revealed Physician #1 signed multiple morphine sulfate orders within a short timeframe on 10/08/2025 and 10/09/2025, including orders with varying concentrations, volumes, frequencies, and directions, resulting in unclear medication instructions. Signed orders included morphine sulfate concentrate with directions ranging from 5 (five) milliliters every 4 (four) hours, 1 (one) milliliter every 4 (four) hours, 1 (one)-time doses, and subsequent corrections, reflecting inconsistent and inaccurate prescribing. Resident #1's Medication Administration Record for October 2025, documented that Resident #1 had an order for the following: Morphine Sulfate (Concentrate) Oral Solution 100 milligrams per 5 milliliters, may give 0.5 milliliters one time only for pain for 1 day. This order was started on 10/08/2025 at 7:15 PM and discontinued on 10/09/2025 at 3:11 PM. This order was signed by Physician #1. Morphine Sulfate (Concentrate) Oral Solution 100 milligrams per 5 milliliters, give 1 milliliter by mouth every 4 hours for pain. This order was started on 10/08/2025 at 10:00 PM and discontinued on 10/09/2025 at 3:10 PM. This order was signed by Physician #1. Morphine Sulfate (Concentrate) Oral Solution 100 milligrams per 5 milliliters, give 5 milliliters by mouth every 4 hours for pain. This order was started 10/08/2025 at 2 PM and discontinued on 10/08/2025 at 6:07 PM. This order was signed by Physician #1. Morphine Sulfate (Concentrate) Solution 20 milligrams per milliliter, give 1 milliliter by mouth one time only for pain for 2 days may remove from pyxis. This order was started 10/08/2025 at 6:15 PM and discontinued on 10/09/2025 at 3:11 PM. This order was signed by Physician #1. Morphine Sulfate (Concentrate) Solution 20 milligrams per milliliter, give 5 milligrams by mouth every 4 hours for pain/shortness of breath 5 milligrams every 4 hours. This order was started on 10/09/2025 at 4 PM and discontinued on 10/09/2025 at 5:52 PM. This order was signed by Physician #1. Pharmacy records documented multiple contacts with facility staff on 10/08/2025 and 10/09/2025 to clarify the accuracy of the morphine sulfate orders of dosing and concentration. Per pharmacy records received from Pharmacy Vendor #1, the following contacts were made with the facility regarding the multiple morphine orders and the questionable accuracy of the orders: On 10/08/2025 at 4:56pm- Morphine 100 milligrams per 5 milliliter electronic prescription medication order sent into pharmacy for Resident #1 with directions Give 5 milliliter by mouth every 4 hours for pain Quantity: 30 each packages. Clarified directions as a 1 milliliter dose equals 20 milligrams per Registered Nurse #3 per Physician #1 at 6:29 PM by pharmacist. On 10/08/2025 at 6:14 PM- Morphine 20 milligrams per 1 milliliter electronic prescription medication order sent into pharmacy for Resident #1 with directions Give 1 milliliter by mouth one time for pain for 2 days may remove from pyxis Quantity: 3. Quantity clarified per Registered Nurse #3, per Physician #1 at 7:36 PM as 1 milliliter and authorized to use 4 times 5 milligram doses out of Omnicell by pharmacist. On 10/08/2025 at 6:14 PM- Morphine 100 milligrams per 5 milliliters electronic prescription medication order sent into pharmacy for Resident #1 with directions Give 1 milliliter by mouth every 4 hours for pain Quantity:1. Clarified as 1 milliliter per Physician #1 at 7:15 PM by pharmacist. Authorized to use out of Omnicell to Registered Nurse #1 by pharmacist at 7:19 PM. On 10/09/2025 at 3:46 PM- Morphine 20 milligrams per 1 milliliter electronic prescription medication order sent into pharmacy for Resident #1 with directions Give 5 milligrams by mouth every 4 hours for pain/shortness of breath every 4 hours. Quantity clarified as 30 doses per Physician #1 at 4:15 PM by pharmacist. On 10/09/2025 at 6:42 PM Pharmacist recorded an alert in the profile for Resident #1 as Spoke with Director of Nursing #2. Physician #1 sent Morphine 20 milligram syringe in error and it got

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	335760	A. Building B. Wing	11/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eddy Heritage House Nursing and Rehabilitation Ctr	2920 Tibbits Avenue Troy, NY 12180

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews conducted during the abbreviated survey (Case # 2668815), the facility did not ensure that a resident's drug regimen was free from unnecessary medications for 1 (one) of 5 (five) residents reviewed (Resident #1). Specifically, the facility administered morphine sulfate (strong opioid used to treat moderate to severe pain) as a routine, standing medication despite no documented clinical evidence of pain or shortness or breath, exposing Resident #1 to unnecessary risk of adverse drug effects including over-sedation and respiratory depression. This is evidenced by: Cross reference to F-600: Free from Abuse and Neglect. Cross reference to F-760: Residents Are Free of Significant Med Errors. The Policy and Procedure titled Medication Administration, dated 12/21/2023 stated each resident will receive medications according to the provider orders and accepted professional standards and the nurse is responsible for having knowledge of the therapeutic effects, contraindications, side effects, and drug interactions of medications needed. The Policy and Procedure titled Clinical Documentation dated 12/01/2022 documented that resident's medical records reflect an ongoing account of the following, including but not limited to: 1) Findings of assessment and reassessment, 20 Identification of problems, 3) Treatment goals, plan of care and revisions to plan of care, 4) Care, treatment and services provided, 5) Resident's response to care, treatment, and services provided, 6) Resident's progress toward the achieved goals/outcomes, 7) Resident's declination of treatment, 8) Education of residents on risks/benefits of treatment and refusal of treatment including information about available alternatives, 9) Discharge plan, and 10) Notification of attending physician and family of all of the above. Record review revealed Resident #1 was admitted to the facility on [DATE] for five (5) days of respite care (a short-term, substitute care for a person who requires assistance by a caregiver. Respite care provides temporary relief for primary caregivers, giving the caregiver a break for rest, errands, or personal time, preventing caregiver burnout, and ensuring the care recipient is still looked after in a setting able to provide appropriate care) with diagnoses of senile degeneration of the brain (an outdated term for dementia, a general decline in cognitive function that is not a normal part of aging), end-stage renal disease (the final stage of chronic kidney disease, occurring when kidneys fail to filter waste and toxins from the blood), and atrial fibrillation (an irregular and often very rapid heart rhythm). The Brief Interview for Mental Status dated 10/08/2025 documented the resident was rarely understood. Resident #1 was not in the facility long enough to receive a complete Minimum Data Set (a resident assessment tool). A Home Hospice visit note on 10/08/2025 at 8:30 AM, by Registered Nurse #6 documented Resident #1 was noted to be taking Tylenol and Tramadol (opioid pain medication used to treat moderate to severe pain) 1 (one) time a day (mainly at bedtime), and Diclofenac gel (topical medication used to relive pain and inflammation) 2 (two) to 4 (four) times a day. Morphine Sulfate was available to Resident #1 as part of the comfort pack provided by hospice but Resident #1 had not yet used it at home, nor did they have pain at time of visit. Registered Nurse #6 called facility at completion of visit in the home and spoke with receiving nurse to give report. A late entry Hospice note on 10/10/2025 at 4:06 PM, by Registered Nurse #2 documented that on the visit on 10/08/2025 at 2:05 PM they reviewed the Morphine Sulfate dosage with Registered Nurse #1. The Medication Administration Recorded for October 2025, documented Resident #1 received the order for Morphine Sulfate (concentrate) oral solution 100 milligram per milliliter, give 1 milliliter by mouth every 4 hours for pain on 10/09/2025 at 2:00 AM, 6:00 AM, 10:00 AM, and 2:00 PM. Documented pain level for each morphine administration was 0 (zero). There was no documented evidence of resident pain requiring morphine sulfate. During an interview on 11/18/2025 at 10:45 AM, Licensed Practical Nurse #1 stated it should have been caught as an excessive dose. 10 New York Codes, Rules, and Regulations 415.12(l)(1)

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	335760	A. Building B. Wing	11/26/2025

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Eddy Heritage House Nursing and Rehabilitation Ctr	2920 Tibbits Avenue Troy, NY 12180

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that residents are free from significant medication errors. (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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews conducted during the abbreviated survey (#2665815), the facility failed to ensure residents were free from significant medication errors for one (1) of five (5) residents reviewed (Resident #1). Specifically, the facility administered four (4) incorrect doses of morphine sulfate (a strong opioid analgesic used to treat moderate to severe pain), totaling 80 milligrams over a 12-hour period. This resulted in Substandard Quality of Care that was Immediate Jeopardy and resulted in the death of Resident #1, with the likelihood of serious injury, harm, impairment, or death to all 108 residents in the facility.This is evidenced by:Cross reference to F-600: Free from Abuse and Neglect.The facility policy and procedure titled Medication Administration dated [DATE], documented that each resident would receive medications according to the provider orders and accepted professional standards. The nurse was responsible for having knowledge of the therapeutic effects, contraindications, side effects, and drug interactions of medications given. New medications or changing in dosing would be documented in the progress notes. The facility policy titled Medication Errors and Reporting dated [DATE], documented medication events included transcription errors. The purpose of the policy was to ensure prompt identification, reporting, documentation, investigation and correction of all medication events (including errors and near misses) to protect resident safety and comply with regularity requirements. The procedure read: 1.) assess the resident to ensure safety; 2.) notify the Nurse Manager and/or nursing supervisor immediately. Any potentially reportable error, per New York State would be escalated to the Medical Director, Director of Nursing and the Executive Director; 3.) the Nurse Manager/supervisor would notify the provider immediately and would obtain direction regarding necessary resident monitoring, duration of monitoring and expected follow up communications; 4.) notify pharmacy for any dispensing errors; 5.) notify the resident and/or the designated representative about the error and follow up plan 6.) document nature of the event, individuals notified, actions taken, order received, resident's response to the event and mentoring plan in the resident progress notes. Results of continued monitoring, assessments and communications would also be documented.Record review revealed Resident #1 was admitted to the facility on [DATE] for five (5) days of respite care (a short-term, substitute care for a person who requires assistance by a caregiver. Respite care provides temporary relief for primary caregivers, giving the caregiver a break for rest, errands, or personal time, preventing caregiver burnout, and ensuring the care recipient is still looked after in a setting able to provide appropriate care) through [DATE] with diagnoses of senile degeneration of the brain (an outdated term for dementia, a general decline in cognitive function that is not a normal part of aging), end-stage renal disease (the final stage of chronic kidney disease, occurring when kidneys fail to filter waste and toxins from the blood), and atrial fibrillation (an irregular and often very rapid heart rhythm). The Brief Interview for Mental Status dated [DATE] documented the resident was rarely understood. Resident #1 was not in the facility long enough to receive a complete Minimum Data Set (a resident assessment tool).Resident #1's admission order to the facility from hospice read morphine 100 milligrams per five (5) milliliter concentrated solution, take five (5) milligrams by mouth every four (4) hours for indications of pain and/or shortness of breath. A Home Hospice Note dated [DATE] at 8:30 AM by Registered Nurse #6, documented Resident #1 was receiving acetaminophen, tramadol, and diclofenac gel as needed in their home prior to admission. There was no documented evidence that Resident #1 had received morphine sulfate in their home prior to facility respite admission. A Hospice Note dated [DATE] at 1:59 PM documented Registered Nurse #2 verbally reviewed the morphine order with Registered Nurse #1 and the dose was 5 milligrams every four (4) hours. The note documented Resident #1 was drowsy with no complaints of pain upon admission to the facility. An order dated [DATE] at 6:07 PM documented morphine sulfate (concentrate) oral solution 100 milligrams per five (5) milliliters, give one (1) milliliter every four (4) hours for pain. The dose per administration was 20 milligrams per one (1) milliliter. The Medication Administration Record for [DATE], documented Resident #1 received 20 milligrams of morphine sulfate four (4) times over a 12-hour period ([DATE] at 2:00 AM, 6:00 AM, 10:00 AM, and 2:00 PM). The order was discontinued later in the afternoon of [DATE].During an interview on [DATE] at 10:19 AM, Health Care Proxy #1 stated Resident #1 was not receiving morphine sulfate at home. They stated the home hospice nurse, Registered Nurse #6, saw Resident #1 at home just prior to admission to the facility and stated the resident was stable for a respite stay.During an interview on [DATE] at 12:12 PM, Health Care Proxy #2 stated Resident #1 had not received any medications prior to their admission to the facility. They stated they left the

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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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on record reviews and interviews conducted during the abbreviated survey (Case # 2665815), the facility was not administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of ar resident (Resident #1). Specifically, the facility lacked oversight in place to use its resources (staff, policies, and communication systems) effectively and efficiently to protect Resident #1. This is evidenced by: Reference is made to deficiencies related to ineffective administration: Please refer to F600 as it pertains to the facility's failure to ensure freedom from neglect. Please refer to F760 as it pertains to the facility's failure to ensure freedom from significant medication errors. Please refer to F550 as it pertains to the facility's failure to ensure resident dignity. Please refer to F609 as it pertains to the facility's failure to ensure adverse events were reported to the State Survey Agency. Please refer to F684 as it pertains to the facility's failure to ensure services provided met professional standards. Please refer to F757 as it pertains to the facility's failure to ensure each resident's drug regimen was free from unnecessary medications without adequate indications. Please refer to F841 as it pertains to the facility's failure to ensure the responsibilities of the Medical Director were completed and accurate. Please refer to F710 as it pertains to the facility's failure to ensure that resident's care was supervised by a Physician. Facility administration leadership failed to provide effective oversight, policy enforcement, and resource allocation to ensure resident safety, resulting in Neglect (F600) and a Significant Medication Error (F760) that contributed to the death of Resident #1. These deficiencies collectively reflect ineffective facility administration and failure to ensure systems were in place to protect resident safety. During an interview on 11/19/2025 at 10:05 AM, Director of Nursing #2 stated they were largely unaware of the circumstances surrounding Resident #1's decline and did not recall being notified at the time of the resident's passing. During an interview on 11/19/2025 at 12:08 PM, Director of Nursing #1 stated that they were not directly involved in the incident investigation and were unaware of any systematic changes implemented following the medication error. They further stated that there was a triple check system that was used to ensure errors like what had occurred didn't happen, and it was in place prior to the incident. During an Interview on 11/19/2025 at 12:34 PM, Administrator #1 stated the medication transcription error could be attributed to confusing hospice orders and staff overstimulation, and stated hat leadership reviewed errors after the incident. They stated as a result of the incident, staff looked at all the errors beginning with those that came from the hospital. They stated Morphine Sulfate transcription error began as a scheduled dose when it should have been written as needed During an interview on 11/19/2025 at 2:04 PM, Medical Director #1 stated the event was a significant medication error and that family communication occurred at a later date. During an interview on 11/26/2025 at 11:20 AM, Administrator #1 stated that they did not feel that Resident #1's passing was caused by the morphine sulfate administration. They stated Executive Director #1 and Medical Director #1 did not connect the morphine administration to Resident #1's death when Administrator #1 reached out to them regarding the incident. When asked if Administrator #1 reported incidents to the New York State Department of Health without speaking to Executive Director #1 or Medical Director #1, Administrator #1 stated that in this particular case, they felt like they needed guidance and was advised to not report it. 10 New York Codes, Rules, and Regulations 483. 70(i)